

132nd LEGISLATURE
JOINT STANDING COMMITTEE ON HEALTH
COVERAGE, INSURANCE AND FINANCIAL SERVICES

Interim Committee Meeting Agenda
August 27, 2026
10:00 am

- 10:00 am** Welcome and Committee members and staff introductions
Committee Chairs, Sen. Donna Bailey and Rep. Kristi Mathieson
- 10:00 am** Confirmation Hearing: Appointment to the Advisory Council on Affordable Health Care
- Dr. Patrick Connolly of Falmouth
- 10:15 am** Overview of State authority and DHHS programs to address maternal health services in the State
Department of Health and Human Services
- 11:00 am** Briefing on status of labor and delivery units in Maine hospitals, including recent closures and anticipated closures
- *Maine Health*
 - *Northern Light Health*
- 12:00 pm** Break
- 1:00 pm** Overview of background materials
- Maine requirements for licensing of health professionals as it relates to maternal health services
 - Reports relating to access to maternal health services and availability of maternal health workforce in other states
- 1:30 pm** Public Comment
- *Comment from interested parties and members of public*
 - *Approx. 3 minutes each*
- 2:45 pm** Committee Discussion
- 3:00 pm** Adjourn

Times are approximate and may be adjusted as necessary by the committee chairs

Public access also available through the Maine Legislature's livestream:

<https://legislature.maine.gov/Audio/#220>

STATE OF MAINE

IN THE YEAR OF OUR LORD
TWO THOUSAND TWENTY-SIX

H.P. 1470 - L.D. 2189

An Act to Require Prior Notification of Closures of Labor and Delivery Units and Changes in Maternity or Newborn Care Services by Hospitals as Recommended by the Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the notification required by this legislation is needed as soon as possible to give affected residents adequate time to prepare for closures of labor and delivery units and make other plans; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1822-B is enacted to read:

§1822-B. Notice of termination of or change in maternity or newborn care services

1. Termination of maternity or newborn care services. A hospital shall file with the department at least 120 days prior to the effective date of the termination of maternity or newborn care services a notice setting forth the following information:

- A. The effective date of the proposed termination and the reason for the termination;
- B. The name, title, e-mail address and phone number for a contact person at the hospital;
- C. The hospital's plan for emergency care, including the development and review of policy and procedure for maternity emergencies and training for emergency department and family practice staff on emergency obstetric care;

D. A list and descriptions of notifications sent to surrounding hospitals within 50 miles and Level II, Level III and Level IV newborn nursery units, to any local emergency management, fire and law enforcement services and to any registered patients that are affected by the termination; and

E. A description of how the hospital provided public notification of the termination.

2. Change in level of care of maternity or newborn care services. A hospital shall file with the department at least 120 days prior to the effective date of a change in the level of care of maternity or newborn care services a notice setting forth the following information:

A. The effective date of the proposed change in the level of care and the reason for the change;

B. The name, title, e-mail address and phone number for a contact person at the hospital;

C. A list and descriptions of notifications sent to surrounding hospitals within 50 miles and Level II, Level III and Level IV newborn nursery units, to any local emergency management, fire and law enforcement services and to any registered patients that are affected by the change; and

D. A description of how the hospital provided public notification of the change.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner

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MEMORANDUM

To: Joint Standing Committee on Health Coverage, Insurance and Financial Services
From: Bill Montejo, Director, DHHS Division of Licensing and Certification (DLC)
Date: August 27, 2026
Re: State Authority to Manage Access to Labor & Delivery Care

1. Certificate of Need (CON) Authority:

The Department currently has limited existing authority within the Certificate of Need statutes (22 MRS, Chapter 103-A) to review and approve new healthcare services or conduct a review for compliance with a Certificate of Need within 3 years of the date of issuance:

The Department does not have the authority to deny the closure of a service through a Certificate of Need.

Excerpt of Statutory Authority within Title 22:

- **§329 Certificate of need required:**

A person may not enter into any commitment for financing a project that requires a certificate of need or incur an expenditure for the project without having sought and received a certificate of need, except that this prohibition does not apply to obligations for financing conditioned upon the receipt of a certificate of need or to obligations for predevelopment activities.

A certificate of need from the department is required for:

4. New health service. The offering or development of any new health service;

2. Licensure Authority:

The Department currently has limited existing authority in Title 22, Chapter 405 to license hospitals and adopt rules for licensure.

Excerpt of Statutory Authority within Title 22:

- **§1813. Licenses for new and existing hospitals**

A person, partnership, association or corporation or any state, county or local governmental unit may not continue to operate an existing hospital, sanatorium, convalescent home, rest home, nursing home or ambulatory surgical facility or open a hospital, sanatorium, convalescent home, rest home, nursing home or ambulatory surgical facility unless the operation is approved and regularly licensed by the State.

- **§1817. Issuance of licenses**

The department is authorized to issue licenses to operate hospitals, sanatoriums, convalescent homes, rest homes, nursing homes, ambulatory surgical facilities and other related institutions that, after inspection, are found to comply with this chapter and any rules adopted by the department. An initial license may be issued for up to 12 months. A license may be renewed for up to 24 months. The fee for this temporary or conditional license is \$15 and is payable at the time of issuance of the license regardless of the term. When an institution, upon inspection by the department, is found not to meet all requirements of this chapter or department rules, the department is authorized to issue either:

1. **Temporary license.** A temporary license for a specified period not to exceed 90 days, during which time corrections specified by the department must be made by the institution for compliance with this chapter and departmental rules, if in the judgment of the commissioner the best interests of the public will be so served; or

2. **Conditional license.** A conditional license setting forth conditions that must be met by the institution to the satisfaction of the department.

- **§1822. Notice of voluntary closure of hospital, sanatorium, convalescent home, rest home, nursing home or similar institution**

Any person, including county or local government units, who is conducting, managing or operating any hospital, sanatorium, convalescent home, rest home, nursing home or institution within the meaning of this chapter and who is properly licensed therefor in accordance with this chapter shall give at least 30 days' advance notice of the voluntary closing of such facility to the patients therein and to those persons, governmental units or institutions who are primarily responsible for the welfare of those patients who are being cared for by said hospital, sanatorium, convalescent home, rest home, nursing home or institution so that adequate preparation may be made for the orderly transfer of said patients to another qualified facility.

- Newly enacted §1822-B, pursuant to LD 2189/Public Law 2025 Ch. 606, *An Act to Require Prior Notification of Closures of Labor and Delivery Units and Changes in Maternity or Newborn Care Services by Hospitals*. This was adopted and requires a hospital to provide notice and meet certain criteria but does not include any change in the State's authority to delay, deny, or manage that closure

§1822-B. Notice of termination of or change in maternity or newborn care services

1. **Termination of maternity or newborn care services.** A hospital shall file with the department at least 120 days prior to the effective date of the termination of maternity or newborn care services a notice setting forth the following information:

- A. The effective date of the proposed termination and the reason for the termination;

- B. The name, title, e-mail address and phone number for a contact person at the hospital;
- C. The hospital's plan for emergency care, including the development and review of policy and procedure for maternity emergencies and training for emergency department and family practice staff on emergency obstetric care;
- D. A list and descriptions of notifications sent to surrounding hospitals within 50 miles and Level II, Level III and Level IV newborn nursery units, to any local emergency management, fire and law enforcement services and to any registered patients that are affected by the termination; and
- E. A description of how the hospital provided public notification of the termination.

2. Change in level of care of maternity or newborn care services. A hospital shall file with the department at least 120 days prior to the effective date of a change in the level of care of maternity or newborn care services a notice setting forth the following information:

- A. The effective date of the proposed change in the level of care and the reason for the change;
- B. The name, title, e-mail address and phone number for a contact person at the hospital;
- C. A list and descriptions of notifications sent to surrounding hospitals within 50 miles and Level II, Level III and Level IV newborn nursery units, to any local emergency management, fire and law enforcement services and to any registered patients that are affected by the change; and
- D. A description of how the hospital provided public notification of the change.

3. Authority in Promulgated Rule (10-144 CMR Ch. 112):

The Division of Licensing does not have the authority to prohibit a hospital from terminating a health service or changing how it uses its licensed inpatient beds. Hospitals provide a breakdown of their allocation of inpatient beds but the current authority for the licensure process is limited to total licensed (inpatient) beds.

Excerpt of Requirements and Authority in 10-144 CMR, Ch. 112

Section 2. Licensing and Enforcement:

2.9 Specifications of a license. The license must specify the following:

- 2.9.1 the name of the facility,
- 2.9.2 the name of the Chief Executive Officer or Administrator,
- 2.9.3 the location of the building(s),
- 2.9.4 the maximum allowable number of licensed beds,
- 2.9.5 any state licensing waivers that have been granted,
- 2.9.6 the effective date and term of the license,
- 2.9.7 the identification of each level of care, and
- 2.9.8 the identification of outpatient services.

2.11 Changes in licensing information. No change in licensed capacity may be implemented, and no new construction, additions or alterations shall commence without the applicant having plans approved by the department. This does not apply to minor

alterations which do not effect the primary functional operation or the number of beds, or to routine maintenance and repairs. Changes in Chief Executive Officer or Administrator must be reported to the department within ten (10) working days. A new license shall be issued following notification to the department.

2.12.2 Refusal to issue a license. The department may refuse to issue a license to the applicant if it finds misrepresentation, materially incorrect or insufficient information on the application, or if the premises do not meet the requirements for issuing a license.

2.12.3 Amending, modifying, or refusing to renew a license. The department may amend, modify or refuse to renew a license in conformity with the Maine Administrative Procedure Act.

2.12.4 Grounds for suspension or revocation. The department may file a complaint with the District Court requesting suspension or revocation of any license based on any of the following grounds:

- 2.12.4.1** violation of these rules and applicable laws;
- 2.12.4.2** permitting, aiding or abetting the commission of any illegal act in the facility; or,
- 2.12.4.3** conduct or practices detrimental to the welfare of a patient.



Supporting Perinatal Care in Maine

**Presentation by Maine Department of Health and
Human Services to the Health Coverage, Insurance,
and Financial Services Committee**

August 2026

Agenda

- State Authority to Manage Access to Care, *Director Bill Montejo, DHHS Division of Licensing and Certification*
- Supporting Perinatal System of Care, *Dr. Amy Belisle, DHHS Child Health Officer*
 - Pathway for a stronger Perinatal System of Care
 - Transforming Maternal Health
 - Rural Health Transformation Program

Perinatal: the period around birth, including prenatal, labor & delivery, and postpartum care up to one year after birth

State Authority to Manage Access to Care

DHHS Division of Licensing and Certification

- Certificate of Need
- Statutory Authority related to Licensure
 - LD 2189/Public Law 2025, Ch. 606; minimum notification requirements
- State Rules related to Licensure

Creating a Pathway for a Stronger Perinatal System of Care (PSOC) in Maine

1. Develop a Shared Vision, Goals and Strategies



2. Complete Foundational Work



3. Use Data and Evaluation to Inform Work



4. Align State and Federal Work



5. Institute Policies and Programs to Improve Access and Health Outcomes

1. Develop a Shared Vision & Goals

Achieve the best possible maternal health and birth outcomes in all areas of the state, and across all populations

Increase overall access to high-quality services focused on whole-person care for pregnant people across the state

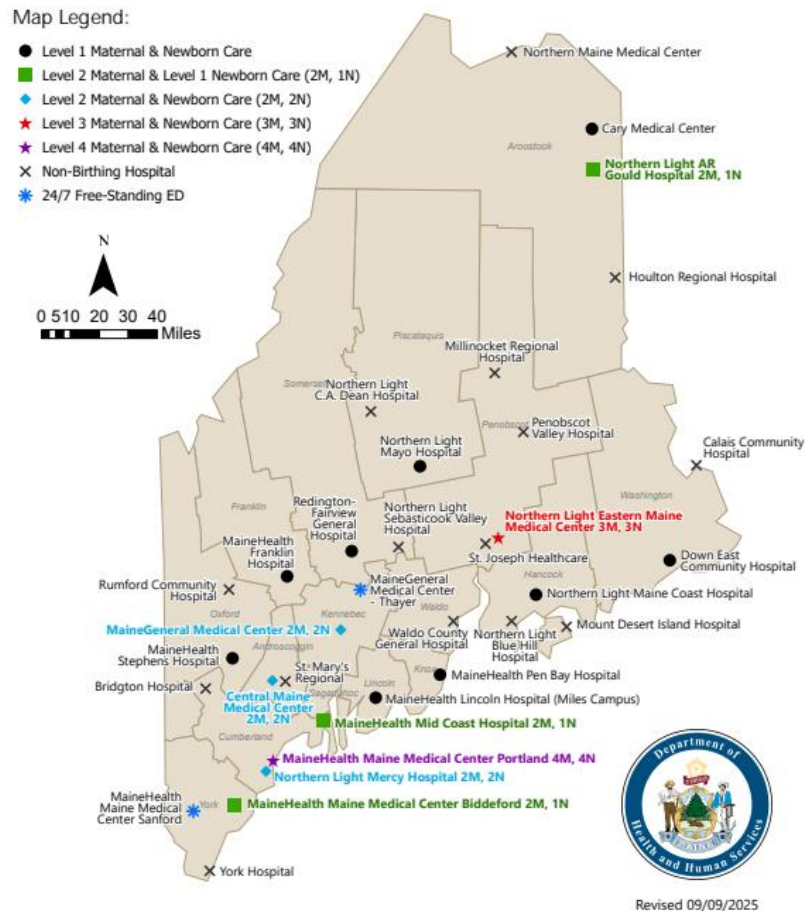
Ensure all mothers, pregnant people, and infants receive the right care in the right place at the right time

**Shared vision
and goals around
Perinatal Health**

2. Complete Foundational Work

Levels of Care Work

Maine Hospitals by Level of Maternal & Newborn Care 2025

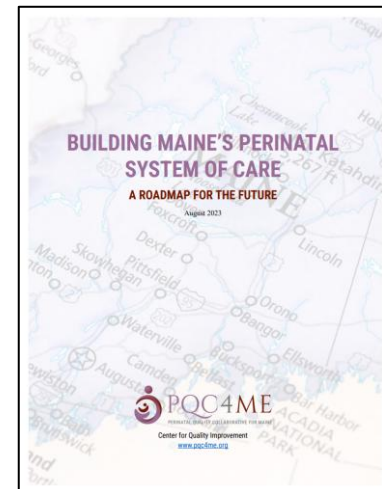


- **Level of Care Map (2022)**, Last update September 2025
- **Level of Care Guidance (2022)**, Last update September 2025
- **Hospital Notification of Changes in Level of Care**, February 2022; **LD 2189**, July 2026
- **Workgroups convened in 2019-22 to create:**
 - Level of Care framework
 - Maternal and fetal transport data collection
 - Preterm labor risk assessment algorithm

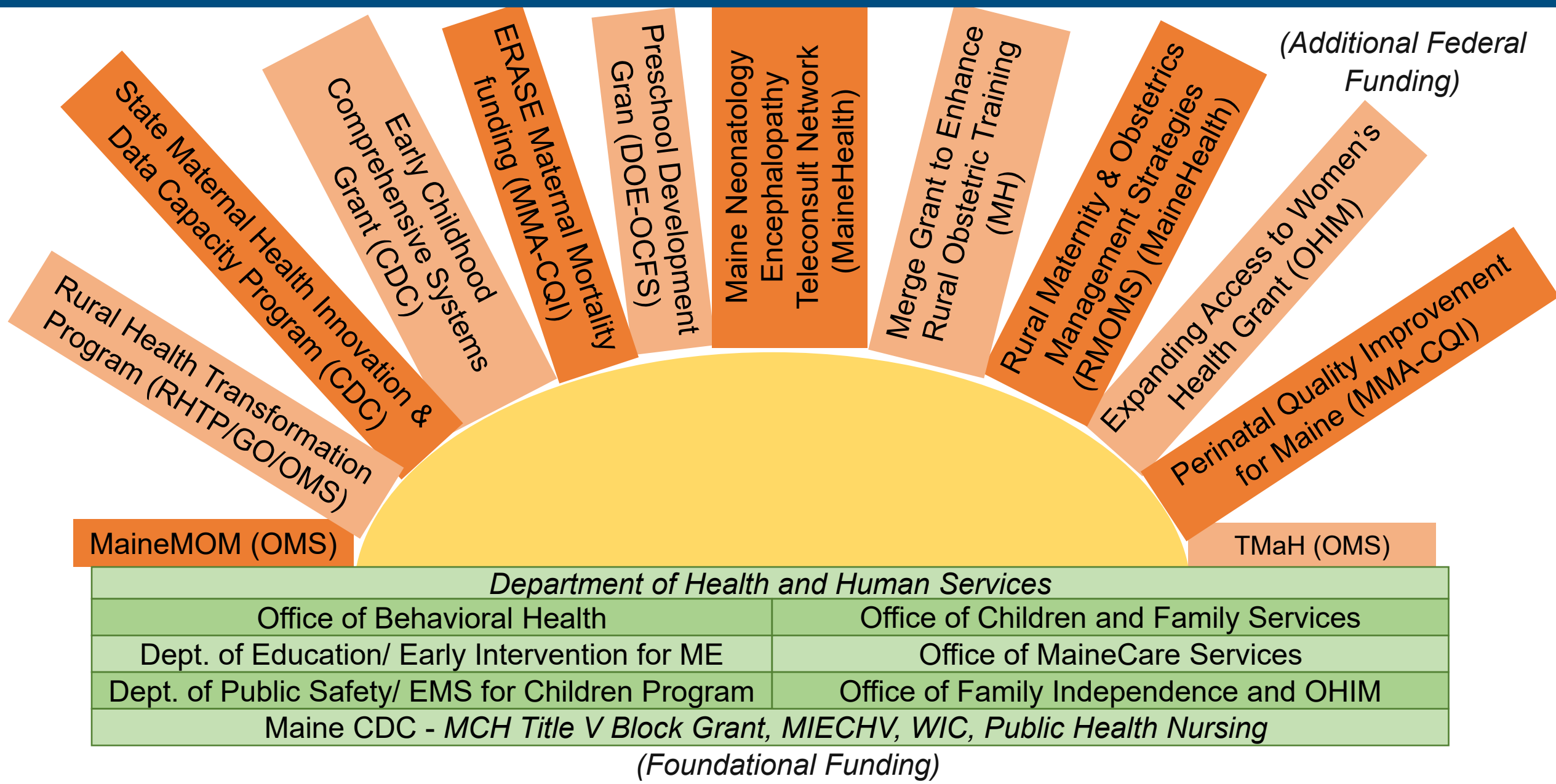
3. Use Data and Evaluation to Inform Strategic Planning

- | | |
|------|--|
| 2020 | <ul style="list-style-type: none">• PQC4ME – Understanding and Addressing the Drivers of Infant Mortality in Maine |
| 2022 | <ul style="list-style-type: none">• Permanent Commission on Racial, Indigenous, and Maine Tribal Populations – Report: <i>Racial Disparities in Prenatal Access in Maine</i>• MECDC – Early Childhood Comprehensive Systems Needs Assessment |
| 2023 | <ul style="list-style-type: none">• PCQ4ME – Building Maine's Perinatal System of Care: A Roadmap for the Future• MECDC – Maternal Health Data Dashboard established online• Market Decisions Research/MECDC– Perinatal Health Disparities Needs Assessment |
| 2024 | <ul style="list-style-type: none">• MECDC – MFIMR Review Panel Report (Annual)• MECDC – MCH 5-Year Needs Assessment• Maine Doula Coalition- Doula Workforce Assessment• Roux Institute/RMOMS – Needs Assessment of the Obstetric Workforce in Maine's Rural Hospitals, Part 1 |
| 2025 | <ul style="list-style-type: none">• MECDC – Perinatal Mental Health in Maine• Roux Institute/RMOMS – Needs Assessment of the Obstetric Workforce in Maine's Rural Hospitals, Part 2 |

[Reports - PQC4ME](#)



4. Align State and Federal Grants Work



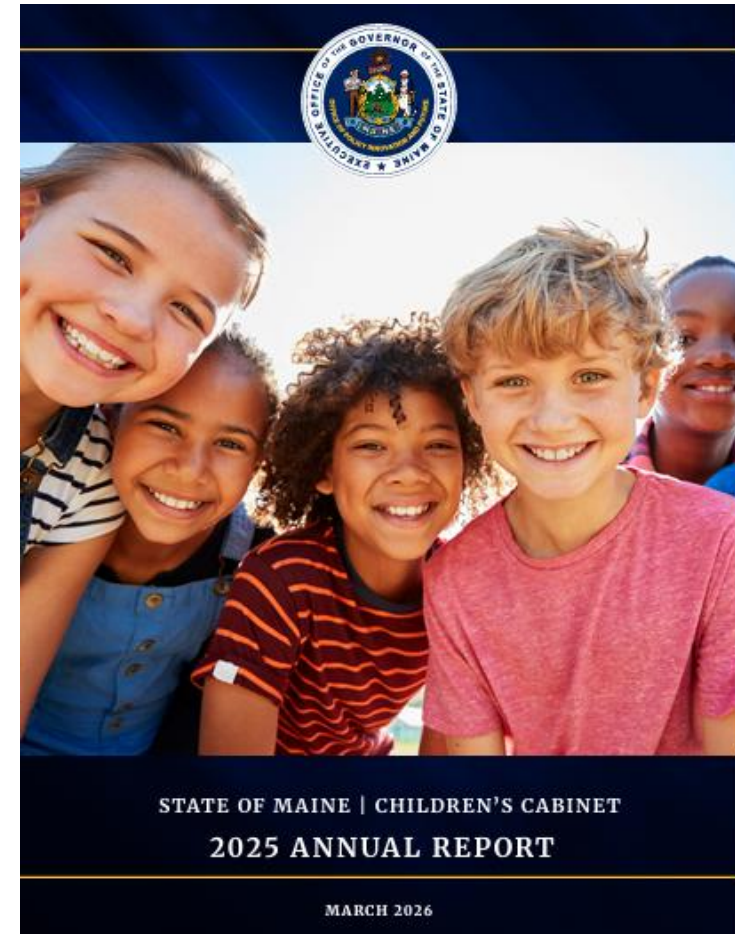
5. Institute Policies and Programs to Improve Access and Perinatal Health Outcomes: *Children's Cabinet Strategies*

Continue **strengthening the Perinatal System of Care infrastructure** (three months preconception to one-year post-partum) including family leadership, parental engagement, and community representation.

Access: Maintain **access** to high-quality perinatal care in Maine by expanding **post-partum coverage** to 12 months for pregnant people, building **linkages between early intervention and medical systems** to better serve diverse and underserved populations, and improving the connection to perinatal consultation by **expanding the obstetric telehealth network** to all birthing hospitals.

Workforce: Support perinatal health by assessing the current capacity of the **perinatal workforce** in Maine, **improving perinatal training and education opportunities** for students and current providers, and exploring the use of community healthcare workers to support maternal and child health.

Quality: Ensure access to high-quality perinatal care, including behavioral health, for all pregnant women, pregnant people, and infants in Maine at the appropriate Level of Care (LOC) by **improving data collection and case reviews** to inform quality improvement and policy and encouraging all birth hospitals to participate in the **Perinatal Quality Collaborative for Maine** and implement **perinatal patient safety bundles**.



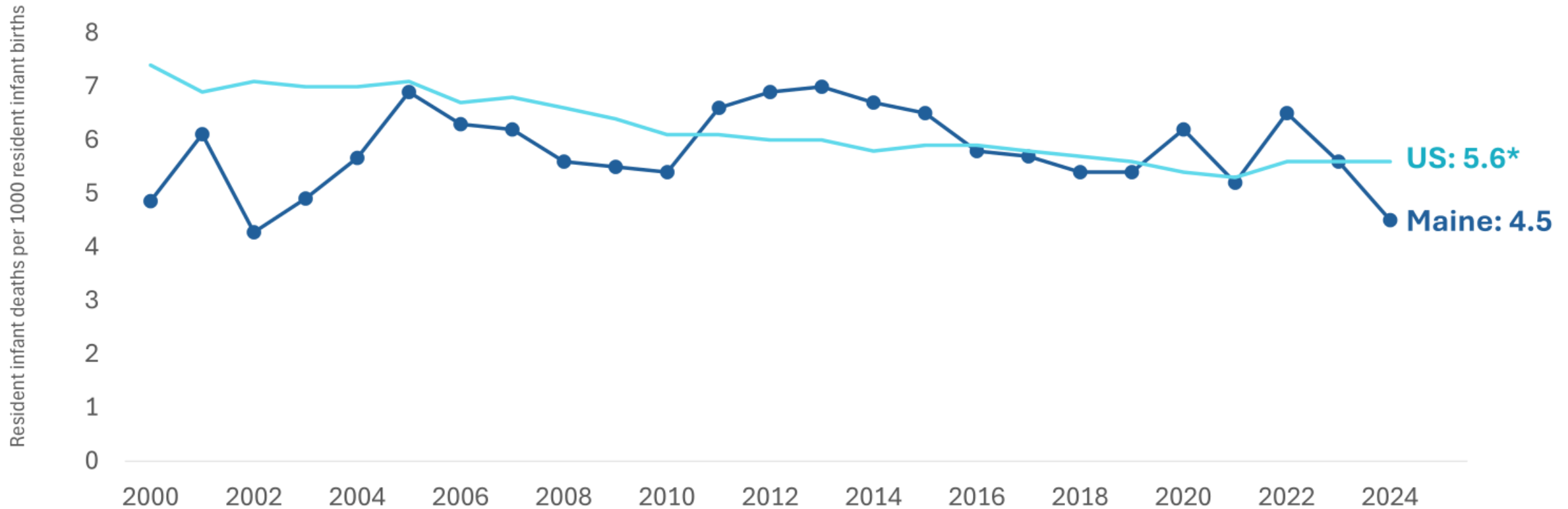
[2025 Annual Report – Maine Children's Cabinet](#)
(p.17-22 details Perinatal work)

5. Institute Policies and Programs to Improve Access and Perinatal Health Outcomes:

- **2021** MaineCare (OMS) Maternal Opioid Misuse model launched in Maine, known as MaineMOM
- **2022** OMS Maternity Coverage expanded through 12-months postpartum
OMS Dental coverage expanded to adults, including pregnant people
MaineCare Rate Reform enacted
- **2023** OMS Coverage expanded to youth under 21 with incomes up to 300% of the Federal Poverty Level
Maine Paid Family Medical Leave (PMFL) Law Passed in 2023. PFML contributions started 2025; Benefit started 2026
- **2025** MaineCare awarded participation in the Transforming Maternal Health (TMaH) Model
MaineMOM coverage formally adopted by MaineCare
- **2026** MaineCare working with state leadership on the Rural Health Transformation Program (RHTP)



In 2024, Maine's infant mortality rate reached its **lowest point since 2002**, at 4.5 deaths per 1,000 live births



Source(s): US: Linked Birth / Infant Death Records, CDC WONDER; Maine: Death and Birth certificates, DRVS

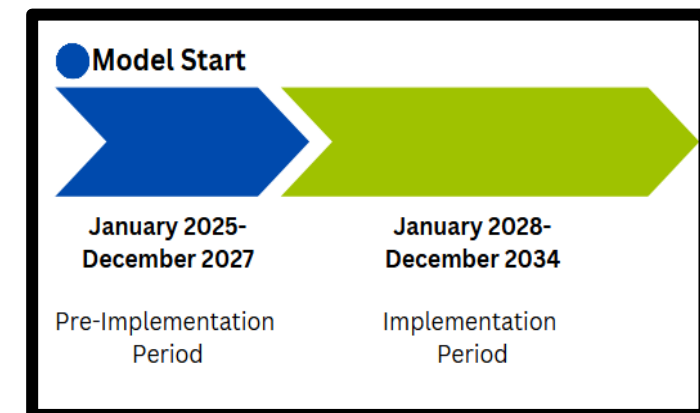
*The 2024 US rate is provisional and subject to change.

Maine Center for Disease Control and Prevention

Maine's Maternal and Child Health Data Dashboard
<https://www.maine.gov/dhhs/mecdc/data-reports/maternal-and-child-health/maternal-child-health-data-dashboard>

The Transforming Maternal Health (TMaH) Model

- Designed to **improve maternal health care** for women enrolled in Medicaid (MaineCare) and the Children's Health Insurance Program (CHIP)
- Led by the **Office of MaineCare Services**
 - DHHS to receive up to \$17 million in funding over 10 years.
 - **Invests in infrastructure, quality improvement, and whole-person care**
 - Expands MaineCare coverage for perinatal supports and services.
 - Model Timeline: **January 2025 – December 2034**
 - 3-year pre-implementation planning period
 - 7-year implementation period



13 Elements of Maine's TMaH Model:

Federally Required

1. Increase access to certified midwifery workforce.
2. Increase access to (licensed) birth centers.
3. Cover doula services.
4. Improve data infrastructure.
5. Develop value-based maternity services payment model.
6. Support implementation of quality improvement initiatives.
7. Support CMS “Birthing Friendly” hospital designation.
8. Increase screening, risk assessments, referrals and follow-ups for perinatal depression, anxiety, tobacco use, substance use disorder, and health related social needs.
9. Increase home monitoring of diabetes and hypertension.

Maine - Specific Selections

1. Increase use of home visits, mobile clinics, or telehealth.
2. Cover perinatal community health worker services.
3. Expand group prenatal care utilization and coverage.
4. Create regional partnerships in rural areas.

Creating regional partnerships in rural areas

Perinatal Rural Regional Planning



TMaH Regional Rural Planning Groups have been created and work began June 25, 2026. Awardees are:

District 1:
York County
Community Action

District 3:
MaineHealth:
Stephens
Memorial and
Franklin
Hospitals

District 4:
MaineHealth:
Lincoln, Waldo,
Pen Bay, and Mid
Coast Hospitals

District 5:
Maine Medical
Association,
Center for Quality
Improvement

District 6:
Northern Light
Health

District 7:
Healthy Acadia

District 8:
Cary Medical
Center

Tribal District:
Wabanaki Public
Health and
Wellness

Rural Regional Planning Groups will:

- Develop regional inventories of perinatal services
- Identify region-specific strengths, opportunities, and aspirations
- **Provide mapping of a regional continuum of maternity and perinatal care**
- Identify overarching goals to improve maternity and perinatal services within the region

TMaH Activities: January 2025 – August 2026

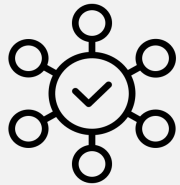
Increase Access to (Licensed) Birth Centers	• Funding the Perinatal Transitions Program, a quality improvement program focused on coordinating hospital, EMS, and community birth provider trainings to more effectively and safely transfer community (out-of-hospital) patients to hospitals, when needed.
Cover Doula Services Under MaineCare	• Doula services will be covered under MaineCare by 2028: ✓ Two doula consultants hired in 2025 ✓ A multi-disciplinary MaineCare Doula Council created in 2025 ✓ Rate determination process for doula services has advanced
Implement Value-based Maternity Services Payment Model	• Funding the FQHC Maternity Services Learning Collaborative to support planning for additional maternal health efforts or services in FQHCs across the state. • Providing Maine-based input to CMS as they develop a maternity services payment model and provider infrastructure support plans.

TMaH Activities: January 2025 – August 2026

Improve Data Infrastructure	• Health Information Exchange: actively exploring how HIN can be leveraged to support and strengthen TMaH efforts.
Increase home monitoring of gestational diabetes and hypertension	• Working with Rural Health Transformation Program to align efforts (and funding) to support creation of state-wide Remote Patient Monitoring program for gestational diabetes and perinatal hypertension.
Increase use of home visits, mobile clinics, or telehealth	• TMaH will assume funding for the Virtual Care Perinatal Behavioral Health Program (VCPBH) beginning in September 2026. The VCPBH is a 100% virtual behavioral health program offering psychotherapy and psychiatric medication management to all pregnant and postpartum people in Maine, regardless of health system affiliation.

Maine CDC Public Health Initiatives for Perinatal Systems of Care

Access



Cradle Me Referral Pathway to connect patients with services:

Public Health Nursing, Maine Families Home Visiting, WIC, MaineMom

Mobile Maternal Health Units (April 2026-June 2026):

14 Counties, 1 Tribal Nation, 33 events, 1,332 contacts

Mammha App (July 2025-June 2026)

136 Apps downloaded, 1134 interactions with a parent

Count the Kicks campaign (YTD 2026 usage)

356 Apps used, Educational materials sent to providers 2,073

Cribs for Kids National Safe Sleep hospital certification program (July 2025-June 2026)

138 Cribettes distributed, 6 participating hospitals

Maine CDC Public Health Initiatives for Perinatal Systems of Care

Workforce



Perinatal Nurse Outreach Educators: Provider education, resources and support

- One contract with Maine Health Maine Medical Center and one contract with Northern Light Eastern Maine Medical Center
- **Provide training in perinatal emergencies including Basic Life Support in Obstetrics (BLSO), Advanced Life Support in Obstetrics (ALSO) classes, resource guides, post-birth alert program, and education via YouTube channel**
 - *54 Trainings, 708 Participants (YTD 2026 Education and usage)*
- **Perinatal Nurse Outreach Educators also provide resources and training to non-birthing hospitals:**
 - ✓ [Triage of Pregnant Patients in Emergency Department \(without Obstetric Coverage\).](#)
 - ✓ **EMS Protocols**
 - ✓ [AIM Obstetric Readiness Resource Kit; ACOG Identifying and Managing Obstetric Emergencies in Nonobstetric Settings](#)
 - ✓ [Maine Perinatal Nurse Outreach Educator OB Resource Guide for non-birthing hospitals 2025](#)

Maine CDC Public Health Initiatives for Perinatal Systems of Care

Data



Maternal, Fetal, Infant Mortality Review Panel (MFIMR) (Calendar year 2025)

- *Reviewed 34 cases: 13 Maternal, 4 Fetal, and 17 infant deaths*
- *119 recommendations*
- Four priority areas: Mental Health, Substance Use, Family Separation, and Social Determinants of Health
- Maine's Maternal, Fetal, and Infant Mortality Review Panel (MFIMR) 2025 Annual Report for 1/1/2025 to 12/31/2025

Quality



AIM Bundle Partnership with the Perinatal Quality Collaborative for ME (PQC4ME):

Perinatal Mental Health Conditions AIM Bundle Spring 2026

- *11 Birthing Hospitals*
- *7 Outpatient Practices*
- *3 Participating Community Partner sites*
- Stipend formula created to encourage community collaboration – Funded by Maine CDC State Maternal Health Innovation(SMHI) Grant



Acknowledgement of RHTP Funding

This program is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$190,008,051 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Maine RHTP Activities: Funding Potentially Available to Support Maternity/Perinatal Care (*noted in italics*)

1. **Population Health:** Promoting timely access to high-quality care – funding for...

- *Increasing/expanding mobile health options*
- *Community Health Worker (CHW) programs*
- Community Paramedicine programs
- *Evidence-Based Programs to improve population health*

2. **Workforce:** Strengthening Maine's rural health workforce – funding for...

- *Educational incentives; recruitment/retention of staff to rural communities (NOTE: 5yr svc commitment)*
- *Rural provider education programs (MERGE/CHET, OB fellowship for Family Medicine physicians)*
- *Expanding mobile simulation labs (e.g. OB adult & infant simulators)*

3. **Technology Innovation:** Modernizing rural care delivery – funding for...

- EMR upgrades, innovations, replacements
- *Telehealth programs – e.g. perinatal specialist telehealth consultation, Mammha app*

4. **Access:** Bridging healthcare affordability gap for rural Mainers

5. **Sustainable rural health ecosystems:** Supporting financial stability of rural providers – funding for...

- *Regional rural health planning*



Thank you!

If you have questions, please contact:

Olivia Demosthenes
Director of Government Relations
Department of Health and Human Services
Olivia.Demosthenes@maine.gov



Health Coverage, Insurance & Financial Committee Meeting
Labor and Delivery Comments from Northern Light Health
August 27, 2026

Senator Bailey, Representative Mathieson and members of the Health Coverage, Insurance and Financial Services Committee my name is Lisa Harvey-McPherson RN, I am here today at your request providing information on Northern Light Health Labor and Delivery Care.

Thank you for the opportunity to share information about our services. There are no plans for a reduction or closure of labor and delivery units at Northern Light Health. During testimony I provided to this committee earlier this year, I shared information that Northern Light Inland Hospital closed a birthing unit in 2025 followed by closure of the hospital. Loss of birthing providers led to the closure announcement, more complex challenges closed the hospital.

Today I am pleased to share that for certain regions, like Bangor and Portland, we are developing plans to grow our services to accommodate population demand for care.

Five Northern Light Health hospitals provide dedicated labor and delivery inpatient care

- Northern Light Eastern Maine Medical Center
- Northern Light AR Gould Hospital
- Northern Light Mayo Hospital
- Northern Light Maine Coast Hospital
- Northern Light Mercy Hospital

Our hospitals provide a comprehensive range of birthing and maternity care services including prenatal care, labor and delivery care, and post-partum care. Births at each hospital are supported by a labor and delivery clinical team, 24/7 surgical unit care, anesthesia, pediatrics and emergency transport. The neonatal intensive care unit at Northern Light Eastern Maine Medical Center is a Level III nursery serving central, northern, and eastern Maine. NICU babies

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Northern Light Health
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A.R. Gould Hospital
Blue Hill Hospital
C.A. Dean Hospital
Eastern Maine Medical Center
Home Care & Hospice
Inland Hospital
Maine Coast Hospital
Mayo Hospital
Mercy Hospital
Northern Light Health Foundation
Northern Light Pharmacy
Sebastcook Valley Hospital

range from 23 weeks gestation premature infants to term infants requiring intensive care. For critical newborns in outlying hospitals, we provide 24- hour neonatal transport service. Our specialty trained team of clinicians travel to the regional hospital to stabilize the baby and transport the baby back to Bangor for NICU level care.

Northern Light Eastern Maine Medical Center provides extensive maternal and neonatal education and outreach to rural hospitals, EMS professionals, and other clinicians across the region. From July 2023 through June 2026, this outreach reached 1,738 participants and provided approximately 8,538 continuing education and training hours. Education focuses on maintaining readiness for high-risk, low-volume maternal and neonatal emergencies and has included Neonatal Resuscitation (NRP), Basic Life Support in Obstetrics (BLSO), STABLE, advanced fetal monitoring, maternal transport case reviews, OB/neonatal skills workshops, neonatal emergency care, and maternal and obstetric emergency management for EMS and emergency department clinicians. Training has been interdisciplinary, reaching RNs, providers, EMS personnel, and other healthcare professionals in rural and community hospitals and training sites throughout the region.

Participating locations include Waldo County General Hospital, Northern Light Maine Coast Hospital, Northern Light Mayo Hospital, Calais Community Hospital, Millinocket Regional Hospital, Redington-Fairview Hospital, Houlton Regional Hospital, and Cary Medical Center, among others. This regional outreach helps ensure that clinicians in rural settings have access to specialized perinatal education, skills training, and ongoing professional development to maintain competency and preparedness for obstetric and neonatal emergencies and to support safe maternal and newborn care across Maine.

Here is a brief summary of data on babies born at each Northern Light Health birthing hospital over the past 5 years.

Green indicates number of births after a regional birthing unit closure

Hospital	# of Labor Delivery Beds	2023	2024	2025	2026 Projected
EMMC	7 Labor & 2 Triage	1564	1472	1670	1613
AR Gould	4	174	194	201	240
Mayo	6	104	112	142	168
Maine Coast	6	203	277	319	314
Mercy	10 (can flex to 17)	673	719	715	755

In 2023 the Journal of the American Medical Association Health Forum published an original investigation “ Obstetric Volume and Severe Maternal Morbidity Among Low-Risk and Higher-Risk Patients Giving Birth at Rural and Urban US Hospitals.” (ATTACHED) The investigation found that in this cross-sectional study of births in US rural and urban counties, risk of severe maternal mortality was elevated for low-risk and higher-risk obstetric patients who gave birth in lower-volume hospitals in rural counties, compared with similar patients who gave birth at rural hospitals with greater than 460 annual births. The authors concluded that the findings imply a need for tailored quality improvement strategies for lower volume hospitals in rural communities.

At Northern Light Health, we have implemented quality improvement strategies at our rural hospitals including

- Ongoing education, validation and simulation training for providers and staff
- Education and competency training for stabilization and care of at-risk newborns prior to transport or higher-level care
- Advanced life support obstetrics training
- Participation in quality collaboratives to benchmark data and support evidenced based practices and quality improvement
- Quality regulatory reporting programs to monitor perinatal quality and outcome measures
- Maternal Safety Bundle Requirements including clinical policies, discharge education, emergency drills and education
- Clinical case reviews, team debriefs and ongoing performance improvement activities

These practices support safe delivery care at our hospitals.

Rural obstetric patients often present with higher rates of medical and social comorbidities, including diabetes, substance use disorders, and tobacco use, increasing the complexity of care. This creates a paradox in which rural birthing centers manage higher-acuity patients with fewer available resources. Today, many rural birthing centers remain operational only through a patchwork of physician coverage arrangements, nursing staffing models, travel clinicians, and locum tenens providers which drive costs higher and strain long-term sustainability.

A primary challenge in sustaining safe delivery care in low volume rural hospitals is the availability of OB/GYN physicians and their ability to sustain clinician competency with a limited number of deliveries. Birthing care is staffed by a

team of clinicians including physicians, mid-level providers, obstetrical nurses and nurse midwives with OB/GYN physician clinical leadership.

According to SimplyHired, a leading job search and recruitment platform, there are estimated 3,000 to 5,000 OB/GYN physician vacancies nationwide. This reflects the persistent national shortage of OB/GYN providers and intense competition for candidates, particularly in rural and underserved communities. As a result, rural hospitals face significant coverage gaps and escalating compensation costs. Similar workforce challenges exist for certified nurse midwives and labor and delivery (L&D) nurses, where recruitment and retention are nearly as difficult in rural regions of Maine.

As noted, low annual birth volumes in rural hospitals further complicate staffing efforts, as providers often worry about maintaining clinical competency and procedural skills. Consequently, candidates may decline positions or leave rural practices because of the perceived professional risk. We are currently recruiting for the following birthing professionals – 5 OB/GYN physicians, one nurse practitioner and one certified nurse midwife. The OB/GYN physician position at Northern Light AR Gould Hospital has been open for 5 years demonstrating the significant challenge of hiring in rural Maine. It also exemplifies the burden on the existing OB/GYN physicians as the two physicians on staff take call every other night for extended periods supplemented by financially unsustainable locums' coverage.

Northern Light Health hospitals, like all hospitals in Maine, are not-for-profit mission focused organizations. Our services respond to the needs of the population and the closure of birthing units in Maine reflects the demographics of Maine's population. The 2025 report on Maine's Population Outlook published by the Office of the State Economist documents that Maine's birth rate, per 1000 population has been below the national birth rate for many years.

The report also documents that the combination of increasing deaths and decreasing births has led to natural population decline, meaning the state has had more deaths than births in recent years. This dynamic has disproportionate impact in rural regions of Maine that have the oldest population density.

Birth Rate (per 1,000) in Maine and the U.S.

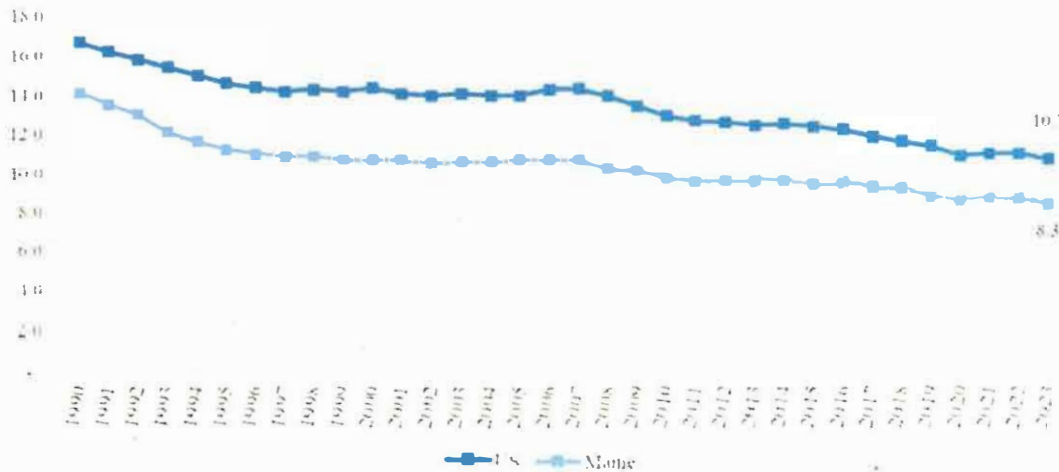


Figure 4. Birth rates in Maine and the U.S.

Source: Maine CDC, Vital Statistics and Population Estimates Program

There is no one solution or easy fix to address access to birthing care in rural areas of Maine. Data demonstrates that severe maternal mortality increases when the volume of deliveries are low. Advancing solutions such as opening more hospital birthing units in rural Maine will jeopardize the safety of moms and babies. Regulations to mandate birthing unit continuation in rural regions with a low volume of births and a sustained lack of staffing is not a viable pathway forward. Birthing teams of professionals including OB/GYN physicians, specialty trained family practice physicians and nurse midwives will still have maternal mortality risks in the care they provide due to a low volume of births. Identifying a pathway forward needs to involve many stakeholders - hospitals, clinicians, EMS providers, state government, legislators, patient advocates and payers, including MaineCare. Each has a role and responsibility for safe birthing care in Maine. Maine also has a unique opportunity over the next few years to prioritize Rural Health Transformation Project funding to invest in stakeholder recommendations addressing rural birthing care.

Thank you for the opportunity to provide comments today, I welcome any questions that you have.



Original Investigation

Obstetric Volume and Severe Maternal Morbidity Among Low-Risk and Higher-Risk Patients Giving Birth at Rural and Urban US Hospitals

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Abstract

IMPORTANCE Identifying hospital factors associated with severe maternal morbidity (SMM) is essential to clinical and policy efforts.

OBJECTIVE To assess associations between obstetric volume and SMM in rural and urban hospitals and examine whether these associations differ for low-risk and higher-risk patients.

DESIGN, SETTING, AND PARTICIPANTS This retrospective cross-sectional study of linked vital statistics and patient discharge data was conducted from 2022 to 2023. Live births and stillbirths (≥ 20 weeks' gestation) at hospitals in California (2004-2018), Michigan (2004-2020), Pennsylvania (2004-2014), and South Carolina (2004-2020) were included. Data were analyzed from December 2022 to May 2023.

EXPOSURES Annual birth volume categories (low, medium, medium-high, and high) for hospitals in urban (10-500, 501-1000, 1001-2000, and >2000) and rural (10-110, 111-240, 241-460, and >460) counties.

MAIN OUTCOME AND MEASURES The main outcome was SMM (excluding blood transfusion); covariates included age, payer status, educational attainment, race and ethnicity, and obstetric comorbidities. Analyses were stratified for low-risk and higher-risk obstetric patients based on presence of at least 1 clinical comorbidity.

RESULTS Among more than 11 million urban births and 519 953 rural births, rates of SMM ranged from 0.73% to 0.50% across urban hospital volume categories (high to low) and from 0.47% to 0.70% across rural hospital volume categories (high to low). Risk of SMM was elevated for patients who gave birth at rural hospitals with annual birth volume of 10 to 110 (adjusted risk ratio [ARR], 1.65; 95% CI, 1.14-2.39), 111 to 240 (ARR, 1.37; 95% CI, 1.10-1.70), and 241 to 460 (ARR, 1.26; 95% CI, 1.05-1.51), compared with rural hospitals with greater than 460 births. Increased risk of SMM occurred for low-risk and higher-risk obstetric patients who delivered at rural hospitals with lower birth volumes, with low-risk rural patients having notable discrepancies in SMM risk between low (ARR, 2.32; 95% CI, 1.32-4.07), medium (ARR, 1.66; 95% CI, 1.20-2.28), and medium-high (ARR, 1.68; 95% CI, 1.29-2.18) volume hospitals compared with high volume (>460 births) rural hospitals. Among hospitals in urban counties, there was no significant association between birth volume and SMM for low-risk or higher-risk obstetric patients.

CONCLUSIONS AND RELEVANCE In this cross-sectional study of births in US rural and urban counties, risk of SMM was elevated for low-risk and higher-risk obstetric patients who gave birth in lower-volume hospitals in rural counties, compared with similar patients who gave birth at rural

(continued)

Key Points

Question What is the association between obstetric volume and severe maternal morbidity in US rural and urban hospitals, and do these associations differ for low-risk and higher-risk patients?

Findings In this cross-sectional study of more than 11 million births in urban counties and 519 953 births in rural counties, risk of severe maternal morbidity was elevated for low-risk and higher-risk obstetric patients who gave birth in lower-volume rural hospitals, compared with similar patients who gave birth at rural hospitals with more than 460 annual births. No significant volume-outcome association was detected among urban hospitals.

Meaning These findings imply a need for tailored quality improvement strategies for lower-volume hospitals in rural communities.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

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Abstract (continued)

hospitals with greater than 460 annual births. These findings imply a need for tailored quality improvement strategies for lower volume hospitals in rural communities.

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Introduction

Maternal mortality and morbidity rates in the US are far above those for other high-income countries, with US maternal mortality rates doubling since 1987¹ and rising rates of maternal hemorrhage.² One potential driver of maternal health is the characteristics of hospitals where patients give birth, including obstetric volume. There is a positive volume-outcome association for many surgical conditions, such as trauma care and complex surgical procedures,³⁻⁵ and for neonatal intensive care units,⁶⁻⁸ but there are less available data for obstetric services. Some evidence indicates that the volume of births is associated with maternal outcomes, with lower-volume facilities having higher risks of mortality and serious morbidity,^{9,10} although this evidence is not consistent for all maternal outcomes or across all types of rural/urban geographic locations.

Whether hospital obstetric volume may be associated with poor maternal health could have important policy implications. Given that the existing literature suggests some potential benefits of increased obstetric volume, there could be benefits from strategic consolidation of obstetric services in select settings.^{9,10} However, there are trade-offs between service consolidation and access. Currently, to our knowledge, there are no standards on appropriate birth volume thresholds or data on how such thresholds change when routine access to medical care is limited, such as in rural areas, or if there are differences for obstetric patients with varying levels of clinical risk, including low-risk patients.¹¹

This study examined the associations between annual birth volume and severe maternal morbidity (SMM) in rural and urban US hospitals. We also examined whether the volume-outcome association differs for low-risk and higher-risk patients giving birth in rural and urban hospital settings in the US.

Methods

This retrospective, cross-sectional study was reviewed and approved by the Institutional Review Board at Stanford University and the human research committees at each of the states that released data for this study. The need for informed consent was waived under 45 CFR 46 (the Common Rule). This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.

Setting and Participants

This analysis used linked vital statistics–patient discharge data, which comprised live birth and fetal death certificate records linked to maternal and infant patient-level hospital discharge data (including transfers and readmissions) from California (2004-2018), Michigan (2004-2020), Pennsylvania (2004-2014), and South Carolina (2004-2020). While not a nationally representative sample, these states make linked data available and reflect a diversity of geography (rural and urban areas), sociodemographic characteristics, and health care systems.

We identified hospitals based on their location and by metropolitan vs nonmetropolitan Urban Influence Codes. These codes are based on each county's US Census Bureau Metropolitan Statistical Area designation.¹ We categorized hospitals in metropolitan counties as urban, and hospitals located in nonmetropolitan counties as rural, including both micropolitan (rural county with population center of 10 000 to <50 000 people) and noncore (rural county with a population center of

<10 000) rural counties.¹² There are multiple methods for measuring rurality,³ and this definition was chosen based on availability of data elements, consistency with prior research, and policy and administrative relevance for rural communities, in particular.⁴⁻⁷

Each hospital was included during the years for which data were available in each state; a hospital-year is the number of observations of annual birth volume and SMM rates (per hospital, per year). This analysis included data on 11 023 423 births that occurred in 5846 hospital-years in urban counties, and 519 953 births in 1335 hospital-years in rural counties from 2004 to 2020 in 4 US states.

Exposures

Hospital obstetric volume was determined by the total number of live births and stillbirths (≥ 20 weeks' gestation) occurring during a calendar year; including stillbirths is important, as SMM rates are elevated for this population.¹³ We excluded records from hospitals that had fewer than 10 annual births for half or more of the years they appeared in the data.

Annual birth volume categories were created (low, medium, medium-high, and high) for hospitals located in urban and rural US counties. Replicating prior research that measured birth volume quartiles for rural and urban hospitals, the categories for urban counties were defined as low (10-500 births), medium (501-1000 births), medium-high (1001-2000 births), and high (>2000 births).⁴ The birth volume categories for rural counties were defined as low (10-110 births), medium (111-240 births), medium-high (241-460 births), and high (>460 births).⁷

To distinguish those with no clinical risk factors from those with 1 or more risk factors for SMM, analyses are stratified for low-risk and higher-risk obstetric patients based on the presence of at least 1 clinical comorbidity.^{14,15} measured by an enhanced obstetric comorbidity score that was developed and validated to improve comparisons of SMM rates across patient populations with different comorbidity case mixes. This index includes 27 comorbidities ranging in prevalence and weighted by severity in relation to SMM risk (ie, placenta accreta spectrum to advanced maternal age ≥ 35 years); those designated as higher-risk have at least 1 of these comorbidities. We distinguished patients as low-risk if they had no indication of any of these 27 comorbidities in their clinical records. Low-risk patients comprised 50.2% ($n = 5\,532\,658/11\,023\,423$) of urban and 50.9% ($n = 264\,435/519\,953$) of rural patients in this analysis.

Main Outcome and Measures

The main outcome was SMM, defined by the US Centers for Disease Control and Prevention^{2,16} and its partners. Severe maternal morbidity includes unexpected outcomes of labor and delivery that result in significant short-term or long-term health consequences. We used *International Classification of Diseases, Clinical Modification* (ICD-CM) diagnosis and procedure codes to identify if any of the 20 indicators of SMM occurred during the delivery hospitalization. As is now recommended by the US Health Resources and Services Administration and others, we did not include blood products transfusion as an indicator of SMM.⁸⁻⁹ The SMM indicators represent either serious complications of pregnancy or delivery, such as sepsis or acute kidney failure, or procedures used to manage serious conditions, such as mechanical ventilation or hysterectomy.

Measured covariates included maternal age, primary payer at the time of childbirth, educational attainment, and maternal race and ethnicity, all of which are associated with SMM.¹⁷⁻¹⁹ All covariates are measured from the birth certificate records, except for primary payer, which come from patient discharge records for all states, and race and ethnicity, which come from the patient discharge records for the state of South Carolina.

Statistical Analysis

First, we calculated the distribution of hospital birth volume and SMM for hospitals located in rural and urban US counties. Then, we measured the distribution of patient characteristics by hospital birth volume category (stratified by rural/urban). We estimated risk ratios and 95% CIs for the association between birth volume category and SMM using logistic regression models, with robust

standard errors to account for hospital-level clustering. We included year fixed effects for all analyses. Analyses were stratified by rural or urban hospital location, because rural and urban hospitals had different birth volume distributions and distinct volume category definitions. We then stratified both the rural and urban analyses by clinical risk, modeling the association between volume category and risk of SMM for low-risk and higher-risk obstetric patients. Because SMM is a relatively rare outcome, we reported risk ratios, rather than odds ratios, as risk ratios have greater clinical interpretability than odds ratios and are similar when the outcome examined is rare.

A total of 11 543 376 records were included in the analysis (eFigure in Supplement 1). We included all linked data for obstetric patients aged 12 to 55 years. There were 460 records excluded based on age. This analysis also required that the data included county, and 16 850 records were excluded because rural/urban location could not be determined. Missing data for other variables were included as a "missing" category, and sensitivity analysis was conducted with complete cases only.

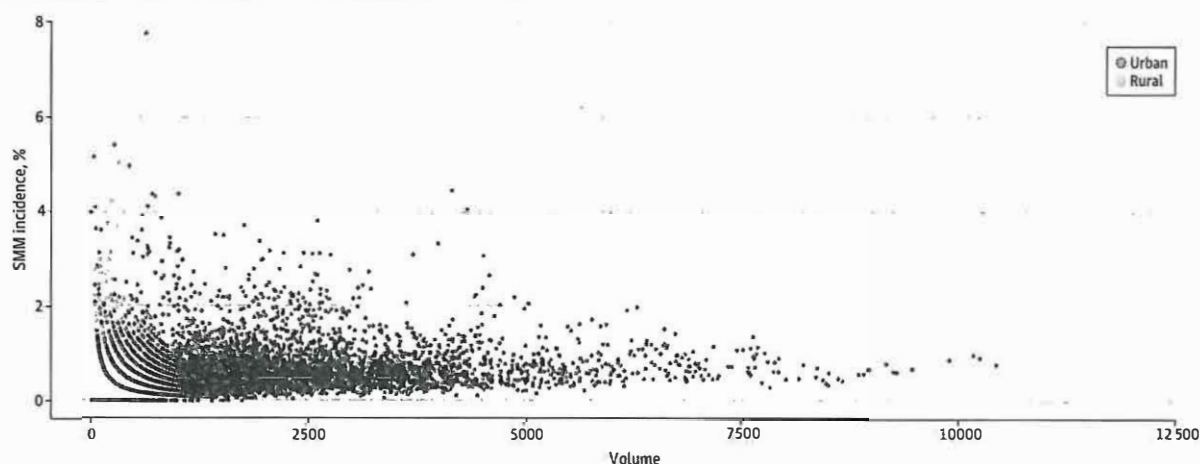
Obstetric patients who are transferred have elevated risk of SMM and may be transferred because of this risk.²⁰ This analysis was based on the hospital where the childbirth occurred, and 0.13% (n = 15 483) of patients included in this analysis had hospital records indicating that they were transferred prior to childbirth, and 0.22% (n = 25 044) were transferred after childbirth.

We conducted a series of sensitivity analyses (eTables 1-5 in Supplement 1). First, blood transfusion codes were not included in this definition of SMM, consistent with current recommendations and owing to potential coding differences across hospitals.^{21,22} Second, we assessed the stability of results using alternate volume cut points. Specifically, we categorized hospitals as rural or urban and then divided hospitals into quartiles by birth volume and conducted the analysis with volume quartiles; results were substantively unchanged. Third, we conducted the main analyses stratifying by state. Fourth, we conducted a complete case analysis, excluding any records with missing data. Fifth, recognizing that obstetric transfer, while rare, may be more common for rural vs urban patients,²³ we conducted an analysis excluding patients with indication of transfer. Results were robust to all sensitivity analyses. Analyses were conducted using Stata, version 17 (StataCorp LLC).

Results

More than 11 million urban births and 519 953 rural births were included. The **Figure** shows a scatterplot of the association between hospital obstetric volume and SMM for rural and urban

Figure. Associations Between Hospital Obstetric Volume and Severe Maternal Morbidity (SMM) Incidence for US Hospitals in Urban and Rural US Counties



hospitals. Rural hospitals were concentrated at the lower end of obstetric volume, where there was also wide variation in SMM incidence. Table 1 shows the associations between birth volume category and SMM for hospitals in urban and rural counties, as well as unadjusted risk ratios and adjusted risk ratios (ARRs) across volume categories. Patient characteristics across volume categories are shown in eTable 6 (urban) and eTable 7 (rural) in Supplement 1. For both urban and rural hospitals, the referent category is the highest birth volume category. The rate of SMM varied from 0.73% to 0.50% across hospital volume categories (high to low) for urban hospitals. Unadjusted risk ratios indicated lower rates of SMM for lower volume urban hospitals, compared with higher volume urban hospitals (>2000 births per year). After adjusting for patient and clinical characteristics, there was no significant association between birth volume category and SMM for urban hospitals.

Among rural hospitals, the SMM rate varied from 0.47% to 0.70% across hospital volume categories (high to low). Unadjusted risk ratios indicated higher SMM rates among lower-volume rural hospitals, compared with higher rural hospitals with greater than 460 births per year, but the difference was only statistically significant between the lowest volume category and the highest. However, after adjusting for relevant patient and clinical characteristics, the risk of SMM was elevated for patients who gave birth at rural hospitals with 10 to 110 annual births (ARR, 1.65, 95% CI, 1.14-2.39), 111 to 240 annual births (ARR, 1.37; 95% CI, 1.10-1.70), and 241 to 460 annual births (ARR, 1.26; 95% CI, 1.05-1.51), compared with those who gave birth at rural hospitals with greater than 460 births annually.

There was a wide range of facilities within the low birth volume category of urban hospitals (10-500 births). To assess SMM rates at rural and urban hospitals of similar birth volume, Table 2 shows the association between SMM and birth volume for low-volume urban hospitals, using the same cut points described above for rural hospital volume categories; there was no significant association detected between obstetric volume and SMM among low-volume urban hospitals.

Table 3 shows the association between hospital birth volume category and SMM for low-risk and higher-risk obstetric patients at urban hospitals. There was no statistically significant association between birth volume category and SMM, for either low-risk or higher-risk patients who gave birth at urban hospitals, after adjusting for patient and clinical characteristics.

Table 4 shows the association between hospital birth volume category and SMM for low-risk and higher-risk obstetric patients at rural hospitals. After adjusting for clinical and patient characteristics, the risk ratios for both low-risk and higher-risk patients were elevated at lower-volume facilities, compared with rural hospitals with more than 460 births a year. Among higher-risk patients (those with 1 or more comorbidities that put them at greater risk for SMM), the risk ratio was elevated for low (ARR, 1.49; 95% CI, 1.01-2.20), medium (ARR, 1.30; 95% CI, 1.03-1.65), and medium-high (ARR, 1.16; 95% CI, 0.95-1.43) volume hospitals, compared with high-volume rural hospitals, though the difference between medium-high and high volume rural hospitals was not

Table 1. Associations Between Annual Birth Volume Category and Severe Maternal Morbidity (SMM) for Hospitals in Urban and Rural US Counties

Birth volume category	Total patients, No.	SMM incidence, No. (%)	Risk ratio (95% CI)	
			Unadjusted	Adjusted
Urban counties				
Low (10-500 births)	261553	1316 (0.50)	0.69 (0.61-0.79)	1.00 (0.90-1.11)
Medium (501-1000 births)	860892	4908 (0.57)	0.78 (0.66-0.93)	1.01 (0.90-1.13)
Medium-high (1001-2000 births)	2535466	16476 (0.65)	0.89 (0.80-1.00)	1.03 (0.96-1.10)
High (>2000 births)	7365512	53507 (0.73)	1 [Reference]	1 [Reference]
Rural counties				
Low (10-110 births)	8182	57 (0.70)	1.48 (1.01-2.18)	1.65 (1.14-2.39)
Medium (111-240 births)	59374	324 (0.55)	1.16 (0.90-1.49)	1.37 (1.10-1.70)
Medium-high (241-460 births)	175176	967 (0.55)	1.17 (0.96-1.44)	1.26 (1.05-1.51)
High (>460 births)	277221	1304 (0.47)	1 [Reference]	1 [Reference]

statistically significant for higher-risk patients. Associations between birth volume and SMM were more pronounced for low-risk patients at rural hospitals (those with no comorbidities). For these patients, the risk of SMM more than doubled for patients giving birth at the lowest volume hospitals, compared with the highest volume category (ARR, 2.32; 95% CI, 1.32-4.07), and rates were also elevated for rural patients at medium (ARR, 1.66; 95% CI, 1.20-2.28) and medium-high (ARR, 1.68; 95% CI, 1.29-2.18) volume hospitals, compared with high birth volume hospitals in rural counties.

Discussion

For hospitals located in rural counties, risk of SMM was elevated for patients who gave birth at lower volume hospitals, compared with patients who delivered at higher volume hospitals. Increased risk of SMM occurred for both low-risk and higher-risk obstetric patients who delivered at rural hospitals with lower birth volumes, with low-risk patients who gave birth at low-volume rural facilities (10-110 births annually) having more than double the risk of SMM, compared with low-risk patients who gave birth at high-birth volume rural hospitals (>460 births annually).

Table 2. Associations Between Annual Birth Volume Category and Severe Maternal Morbidity (SMM) for Hospitals in Urban and Rural US Counties, Only Including Urban Hospitals With 600 or Fewer Annual Births

Births, No.	Total patients, No.	SMM incidence, No. (%)	Risk ratio (95% CI)	
			Unadjusted	Adjusted
Low-volume hospitals in urban counties				
10-110	5308	37 (0.70)	1.24 (0.88-1.76)	1.28 (0.93-1.77)
111-240	24238	98 (0.40)	0.72 (0.54-0.95)	0.90 (0.72-1.12)
241-460	178076	875 (0.49)	0.87 (0.71-1.08)	0.96 (0.83-1.12)
461-600	176027	989 (0.56)	1 [Reference]	1 [Reference]
Rural counties				
10-110	8182	57 (0.70)	1.48 (1.01-2.18)	1.65 (1.14-2.39)
111-240	59374	324 (0.55)	1.16 (0.90-1.49)	1.37 (1.10-1.70)
241-460	175176	967 (0.55)	1.17 (0.96-1.44)	1.26 (1.05-1.51)
>460	277221	1304 (0.47)	1 [Reference]	1 [Reference]

Table 3. Association Between Birth Volume Category and Severe Maternal Morbidity for Higher-risk and Low-risk Obstetric Patients at Hospitals in Urban Counties

Annual birth volume	Risk ratio (95% CI)			
	Higher-risk patients		Low-risk patients	
	Unadjusted	Adjusted	Unadjusted	Adjusted
Low (10-500 births)	0.71 (0.63-0.80)	1.04 (0.93-1.15)	0.84 (0.69-1.03)	0.92 (0.76-1.11)
Medium (501-1000 births)	0.81 (0.69-0.96)	1.06 (0.94-1.19)	0.80 (0.67-0.94)	0.85 (0.73-1.00)
Medium-high (1001-2000 births)	0.91 (0.82-1.00)	1.04 (0.98-1.11)	0.95 (0.83-1.09)	0.99 (0.87-1.14)
High (>2000 births)	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]

Table 4. Association Between Birth Volume Category and Severe Maternal Morbidity for Higher-risk and Low-risk Obstetric Patients at Hospitals in Rural Counties

Annual birth volume	Risk ratio (95% CI)			
	Higher-risk patients		Low-risk patients	
	Unadjusted	Adjusted	Unadjusted	Adjusted
Low (10-110 births)	1.29 (0.87-1.90)	1.49 (1.01-2.20)	2.37 (1.31-4.30)	2.32 (1.32-4.07)
Medium (111-240 births)	1.09 (0.84-1.41)	1.30 (1.03-1.65)	1.60 (1.15-2.22)	1.66 (1.20-2.28)
Medium-high (241-460 births)	1.05 (0.85-1.29)	1.16 (0.95-1.43)	1.54 (1.13-2.10)	1.68 (1.29-2.18)
High (>460 births)	1 [Reference]	1 [Reference]	1 [Reference]	1 [Reference]

Notably, the patterns of SMM rates across volume categories were distinct for hospitals in rural and urban counties. In urban counties, the highest unadjusted rates of SMM were seen at the highest volume hospitals, whereas in rural counties, higher rates of SMM were in the lowest birth volume hospitals. The differences between unadjusted risk ratios and ARRs, where risk differences across volume categories were attenuated, generally implied effective referral patterns of the sicker, higher-risk patients to hospitals with appropriate services for these patients in urban counties. That is, before risk adjustment, patients at hospitals with lower volume in urban areas had lower risk of SMM; this was particularly notable among higher-risk patients. This association was no longer significant after risk adjustment, which implies that in urban areas, lower-volume hospitals likely referred clinically complex patients to the high-volume hospitals, which generally have more resources to care for high-acuity patients.²⁴⁻²⁶

However, this pattern did not hold for patients in rural areas, especially for low-risk patients. Our finding of elevated rates of SMM among lower-volume rural hospitals is consistent with prior literature,²⁷ and this study adds to what is known by further distinguishing low-risk and higher-risk patients. That the association between birth volume and SMM was amplified among low-risk patients in rural counties is concerning for efforts to support local access to childbirth care for low-risk patients in rural communities. In several international contexts, national (Portugal) or state/provincial (British Columbia, Canada) governments have successfully implemented large-scale regionalization policies that closed small-volume rural obstetric units in order to care for obstetric patients in higher-volume settings.^{10,28} However, closure of low-volume obstetric units is not recommended as a policy strategy in the US based on the current findings. In urban counties, there was no significant SMM decrement detected for hospitals with birth volume less than 500 compared with greater than 2000 births per year. In rural counties, closure of hospital-based obstetric units, which are at greater risk of closure when they are lower volume and located in more remote areas, is associated with increases in emergency birth and preterm birth,²⁹ and travel distances are associated with adverse infant and maternal outcomes.³⁰

Rather than implying a policy strategy of consolidation and closure, these findings and the available evidence suggest a need for tailored quality improvement resources for rural hospitals, greater investment in rural clinician training, and establishment of referral or transfer networks for rural hospitals to improve obstetric patient safety.³¹ Participation in state perinatal care quality collaboratives may hold promise for rural hospitals,³² but many maternal and perinatal quality improvement initiatives are not rural-relevant or rural-tailored. For example, currently available obstetric care quality improvement initiatives have had tremendous success in reducing SMM, but the cost-effectiveness of adopting care bundles decreases as birth volume decreases,³³ requiring attention to the financial feasibility in low-volume settings, especially in rural areas.⁶

To address the elevated risks of SMM for both low-risk and higher-risk patients who give birth at low-volume hospitals in rural counties, investments and adjustments to current policies and programs may help. Medicaid finances more than half of births at rural hospitals, and low-volume payment enhancements could address resource constraints, clinician availability and training, and financial viability concerns faced by small-volume rural hospitals.⁶ Additionally, the Centers for Medicare & Medicaid Services (CMS) recently launched a plan to establish a Birthing-Friendly Hospital designation.³⁴ Such a designation holds potential to improve obstetric services in rural settings if it incorporates rural-specific resources and investments to help low-volume rural hospitals achieve and maintain evidence-based support services and an adequate workforce, as well as simulation and other training to maintain staff skills.^{6,35} Finally, the recent CMS Rural Emergency Hospital designation will support rural hospitals in converting from an inpatient facility to an emergency-focused facility with the capacity to stabilize and transfer patients. Most hospitals likely to qualify for this designation are smaller-volume rural facilities,³⁶ and investments in resources for emergency obstetrics and appropriate transfer capacity for obstetric patients at Rural Emergency Hospitals may improve safety for people giving birth in rural counties.

In addition to investments in critical access obstetrics in rural communities and to clinical care and support, policy attention to the broader social determinants of maternal and infant health in remote, rural communities is important.^{37,38} In particular, attention to the intersection of structural racism and structural urbanism requires investment in rural communities with substantial Black and Indigenous populations, where maternal health risks are most acute and access to obstetric care is most limited.^{17,39-42}

Limitations

Measuring rurality is complex, and using county-based measures has drawbacks, especially given the variability in the geographic size of a county and the distribution of people, infrastructure, and resources across and within counties.³ Such measures may classify remote hospitals in geographically large counties that contain urban centers as "urban." Additionally, rurality is a continuum, not a dichotomy, but is measured dichotomously in this analysis. Second, the linked vital statistic-hospital discharge administrative data used in this analysis do not contain vital signs, laboratory values, clinical notes, obstetric care workforce, or details on social determinants of SMM, but provide advantages beyond using birth certificates or discharge data alone. Third, unmeasured patient risk factors could potentially bias results downward (toward a lack of association between birth volume and SMM) if there are unmeasured patient complications that disproportionately occur at higher-volume hospitals. Fourth, these data come from 4 geographically and demographically diverse US states, representing more than a quarter of all US births, but some measured characteristics differ across states (eTable 8 in Supplement 1), 2 states did not have data available for all study years, and there is limited representation from highly rural states, which may have distinct contexts for access, quality, and safety of obstetric care.^{4,5} Fifth, these data do not contain comprehensive information on patient referral or transfer, limiting our ability to understand their role in the associations uncovered in this analysis.

Conclusions

In this cross-sectional study of births in US rural and urban counties, risk of SMM was elevated for both low-risk and higher-risk obstetric patients who gave birth in lower-volume hospitals in rural counties, compared with similar patients who gave birth at rural hospitals with higher annual birth volume. These findings imply a need for tailored quality improvement strategies for lower-volume hospitals in rural communities.

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SUPPLEMENT 1.

eFigure: Study population flowchart

eTable 1: Associations between annual birth volume category and SMM (with transfusion) for hospitals in urban and rural U.S. counties

eTable 2: Associations between annual birth volume category and SMM for hospitals in urban and rural U.S. counties, alternate birth volume categories

eTable 3: Associations between annual birth volume category and SMM for hospitals with in urban and rural U.S. counties, stratified by state

eTable 4: Associations between annual birth volume category and SMM for hospitals in urban and rural U.S. counties, complete case analysis (excluding missing data)

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eTable 6: Characteristics of obstetric patients at hospitals in urban US counties, by birth volume category

eTable 7: Characteristics of obstetric patients at hospitals in rural US counties, by birth volume category

eTable 8: Characteristics of obstetric patients in the study population, based on state of residence

SUPPLEMENT 2.

Data Sharing Statement



**HEALTHY
MOMS.
STRONG
BABIES.**

Nowhere to Go: Maternity Care Deserts Across the U.S.

2026 REPORT



The Bell family

For Latasha Bell, living in Lowndes County, Alabama, meant a 45-minute drive to the nearest hospital when she was ready to give birth. The county is one of roughly 1 in 3 U.S. counties classified as a maternity care desert, with no birthing hospital or obstetric clinician.

When she went into labor with her youngest daughter, Kylen, doctors determined she was not yet in active labor and sent her home. Rather than risk the long drive again, she and her husband, Karl, rented a nearby hotel room. An hour later, they returned to the hospital. Kylen was born with breathing complications and rushed to the neonatal intensive care unit (NICU).

“If I had delivered at home, would I even have her here with me right now?” Latasha said.

A nurse, maternal mortality prevention advocate, and mother of four, Latasha is now helping bring solutions to her community, including a March of Dimes Mom & Baby Mobile Health Center®. She hopes future generations have maternity care closer to home.

Executive Summary

Across the United States, access to maternity care continues to be a significant challenge, leaving millions of moms and babies with fewer opportunities to receive high-quality care.

What the report shows

The “Nowhere to Go: Maternity Care Deserts Across the U.S.” (2026 report) examines access to maternity care using county-level analyses of obstetric clinicians, birthing facilities, insurance coverage, and travel burden. The report highlights national trends, identifies populations most affected, and explores how workforce shortages, hospital closures, and policy changes are reshaping the maternity care landscape.

1 in 3

U.S. counties are
maternity care
deserts (MCDs)

2.4M

women of
reproductive age
live in MCDs

149K

babies born to
women living in
MCDs every year

3X

longer travel
time for those
living in MCDs

Cindy Rahman, MBA

President and Chief Executive Officer

“Every family deserves access to high-quality maternity care, no matter where they live.”

Why it matters

Over half of U.S. counties lack a hospital with labor and delivery services. At the same time, labor and delivery unit closures are continuing nationwide, with nearly 100 recently reported closures. In many affected communities, the closed unit was the only local birthing facility, placing additional strain on families and healthcare systems. Rural communities and under-resourced areas continue to face the greatest challenges.

Maternity care deserts are not naturally occurring, nor are they inevitable. They are the result of policy decisions and longstanding underinvestment in maternity care infrastructure. Individuals in these communities are increasingly required to navigate pregnancy and childbirth with fewer local resources and greater travel burdens.

Our commitment

March of Dimes remains committed to advancing data-driven solutions that address maternity care access challenges nationwide. We will continue working with our partners and communities to improve access for moms and babies. Efforts such as March of Dimes Mom & Baby Mobile Health Centers and PeriStats demonstrate how community-based care delivery and publicly accessible data can help expand access and inform decision-making. Continued investment and action will be critical to ensuring all women can access high-quality maternity care.

Michael Warren, MD MPH FAAP

Chief Medical and Health Officer

“Data helps us see the gaps and drive solutions that bring care closer to families.”

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National support for this report is provided by Ob Hospitalist Group (OBHG).

As the nation’s largest employer of OB-GYNs, OBHG partners with hospitals and community clinicians to expand access to maternal healthcare, building a new standard of care that is connected, equitable, and always within reach. Their sponsorship reflects a shared commitment to improving outcomes for moms and babies nationwide.

Introduction

Too many families in the U.S. continue to face barriers to accessing timely and appropriate maternity care. Maternal and infant outcomes are shaped by systems, policies, and access to care, highlighting the critical need for continued investment in maternity care infrastructure to improve outcomes for moms and babies.

March of Dimes envisions a maternity care system in which trained obstetric clinicians are available, birthing facilities are accessible, and care is high-quality and affordable. Across the U.S., access varies widely, particularly in rural and under-resourced communities facing clinician shortages, labor and delivery unit closures, long travel distances, and financial barriers to care.

“Nowhere to Go: Maternity Care Deserts Across the U.S.” examines access to maternity care across the country, highlighting geographic disparities and recent trends in access to care. The findings are intended to inform public health planning, support policy and systems change, and elevate strategies that improve access and outcomes for moms and babies.

For more information about definitions, data sources, and analytical methods, see our [technical notes](#).

Key findings

1 in 3 U.S. counties (34.6%) are maternity care deserts, with no obstetric clinicians or birthing facilities.

- These counties are home to **2.4 million women** of reproductive age and **149,000 infants** born each year.

An additional **3.4 million women** and **209,000 infants** live in counties with low or moderate access to maternity care.

- In total, **5.8 million women** and **358,000 infants** have limited access to maternity care.

Obstetric clinician shortages are more severe in rural areas, where nearly **58% of counties** lack obstetric clinicians, compared to about **19% of urban counties**.

More than half of U.S. counties lack a hospital with labor and delivery services, affecting nearly **370,000 births** annually.

Labor and delivery unit closures are ongoing nationwide, with at least **96** publicly reported **closures** across 35 states between 2024 and early 2026.

- In nearly **60%** of affected counties, the closed unit was the only local birthing facility.
- Recent closures have **increased travel times** to maternity care by an average of **25 minutes** in affected communities.

Residents of maternity care deserts travel about **3 times longer**, on average, to reach labor and delivery services than residents of full-access counties.

About **1 in 9 women** of reproductive age are uninsured nationally, with the highest rates concentrated in the South, rural areas, and maternity care deserts.

Policies such as **Medicaid expansion** and **postpartum Medicaid extension** have improved access to care, but recent and proposed policy changes threaten to reverse progress.

Access to healthcare means being able to find qualified clinicians and receive timely, appropriate medical services. Maternity care access functions as a structural determinant of maternal and infant health.

Limited access to maternity care is associated with inadequate prenatal care and higher risks of maternal and infant morbidity and mortality.¹⁻³ Barriers to quality maternity care can have cascading effects across the pregnancy journey, contributing to delayed care, unmanaged conditions, and increased risk of complications.

Access to comprehensive maternity care across the pregnancy journey supports:⁴

Reproductive planning	Timely initiation of prenatal care	Postpartum follow-up care
Identification and management of chronic conditions	Recommended screenings and vaccinations	Monitoring for postpartum complications
Mental health screening and treatment	Mental health screening and treatment	Management of chronic conditions
Optimal health before pregnancy begins	Monitoring and management of pregnancy complications	Mental health screening and treatment
	Risk-appropriate care at delivery	Newborn care education

What factors can impact access to maternity care?

Clinician availability: Availability of obstetric and subspecialty clinicians, wait times for appointments, and acceptance of insurance plans

Financial access: Access to health insurance, affordability of transportation and childcare

Birthing facilities: Physical access to services, proximity of hospital labor and delivery units, availability of higher-level care when appropriate

Policy: State, federal, and facility-level policies that shape coverage, access, and care delivery

1 in 3 counties (34.6%) in the U.S. are maternity care deserts, with no obstetric clinicians or birthing facilities.

5.8 million women and 358,000 infants live in counties without full access to care.

In some states, up to 1 in 5 women and infants live in maternity care deserts.

Living in a maternity care desert is associated with elevated risk of infant mortality, pregnancy-associated mortality, and inadequate prenatal care.⁵

From 2016 to 2024, the share of U.S. counties designated as maternity care deserts remained largely unchanged (34.7% to 34.6%).

Definitions for maternity care access designations

March of Dimes defines maternity care access at the county level using three factors: obstetric clinician availability, birthing facility availability, and insurance coverage among women of ages 19 to 54. Counties are classified into four designations: full access, moderate access, low access, or maternity care desert (Table 1).

Table 1. Maternity care access designations

			Full access	
Birthing facilities (hospitals or birth centers)	zero	<2	<2	≥2
Obstetric clinicians per 10,000 births*	zero	<60	<60	≥60
Proportion of women 19-54 without health insurance	any	≥10%	<10%	any

Note: Obstetric clinicians include obstetrician gynecologists (OB-GYNs), certified nurse midwives/certified midwives (CNMs/CMs), and family physicians who reported delivering babies. A county is classified as full access if it meets at least one criterion.

1 in 3 U.S. counties (34.6%) is designated as a maternity care desert, defined as an area with no birthing facilities or obstetric clinicians (Figure 1). These counties are home to more than 2.4 million women of reproductive age (ages 15 to 44), who gave birth to nearly 149,000 infants in 2024 (Figure 2). An additional 3.4 million women and 209,000 infants live in low- and moderate-access counties.

1 in 3 U.S. counties (34.6%) are maternity care deserts, areas with no birthing facilities or obstetric clinicians

Figure 1. Maternity care access designations by county, U.S. and Puerto Rico

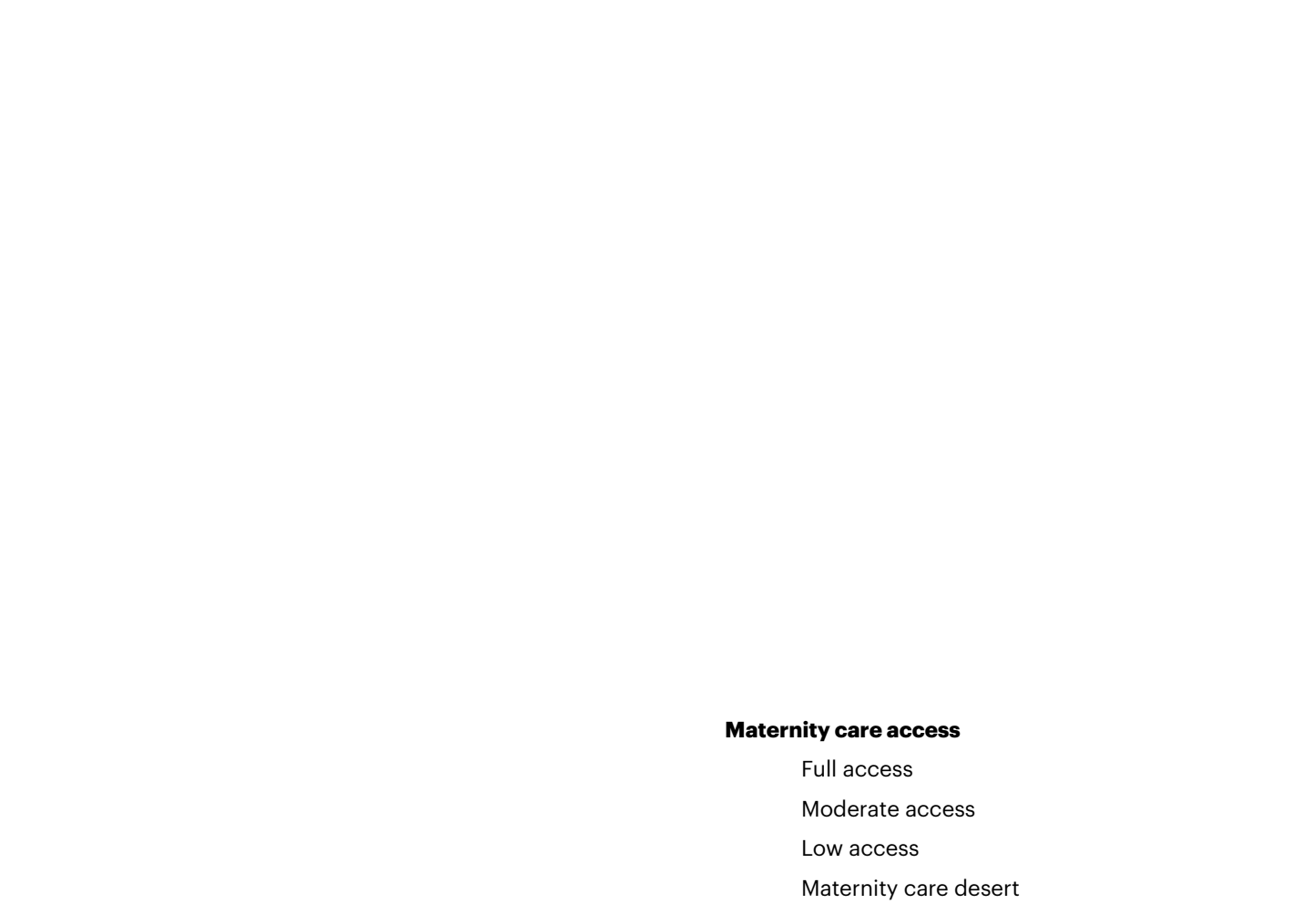
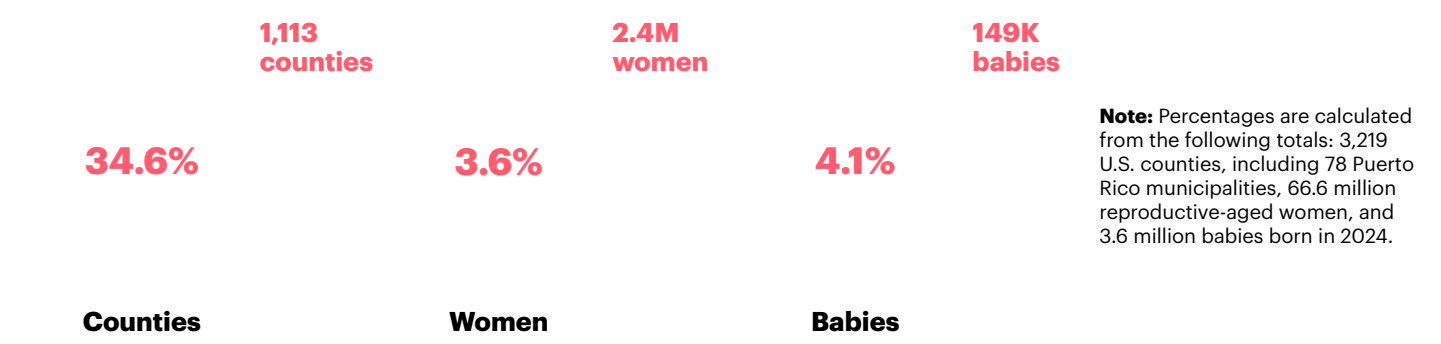


Figure 2. Number and percentage of U.S. counties designated as maternity care deserts and the reproductive-aged women (ages 15 to 44) and babies living in these counties



Sources: U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2024-2025 file; American Board of Family Medicine, 2021-2024; American Association of Birth Centers, 2024; Centers for Medicare and Medicaid Services (CMS), National Plan and Provider Enumeration System (NPPES), November 2024 file; National Center for Health Statistics, 2024 final natality data; U.S. Census Bureau, 2024 American Community Survey 5-Year Estimates; American Hospital Association, 2024; CMS Provider of Services File, 2024.

5.8 million women and 358,000 infants live in counties without full access to care

This translates to:

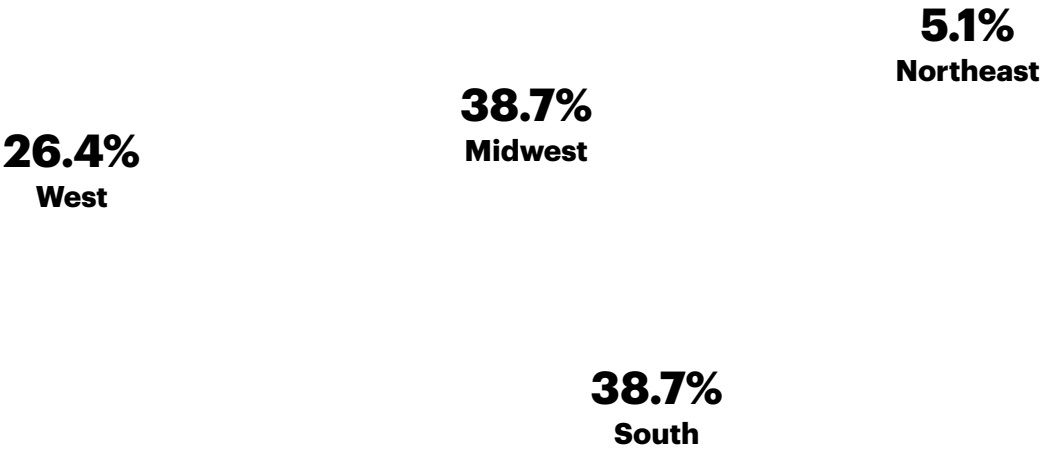
1 in 12 women 1 in 10 infants

Geographic patterns vary across regions. The South and Midwest have the greatest proportion of counties designated as maternity care deserts (38.7%; Figure 3), though a smaller share (5-6%) of women and infants in these regions live in maternity care deserts overall. However, in some states, such as Mississippi, West Virginia, and North Dakota, as many as 1 in 5 women and infants live in maternity care deserts, increasing to 1 in 4 when including low- and moderate-access counties.

States with the largest number of women and infants impacted include North Carolina, Texas, and Tennessee, which together account for more than 1.2 million women and 82,000 infants living in areas with limited access to maternity care.

The South and Midwest regions have a greater proportion of maternity care deserts

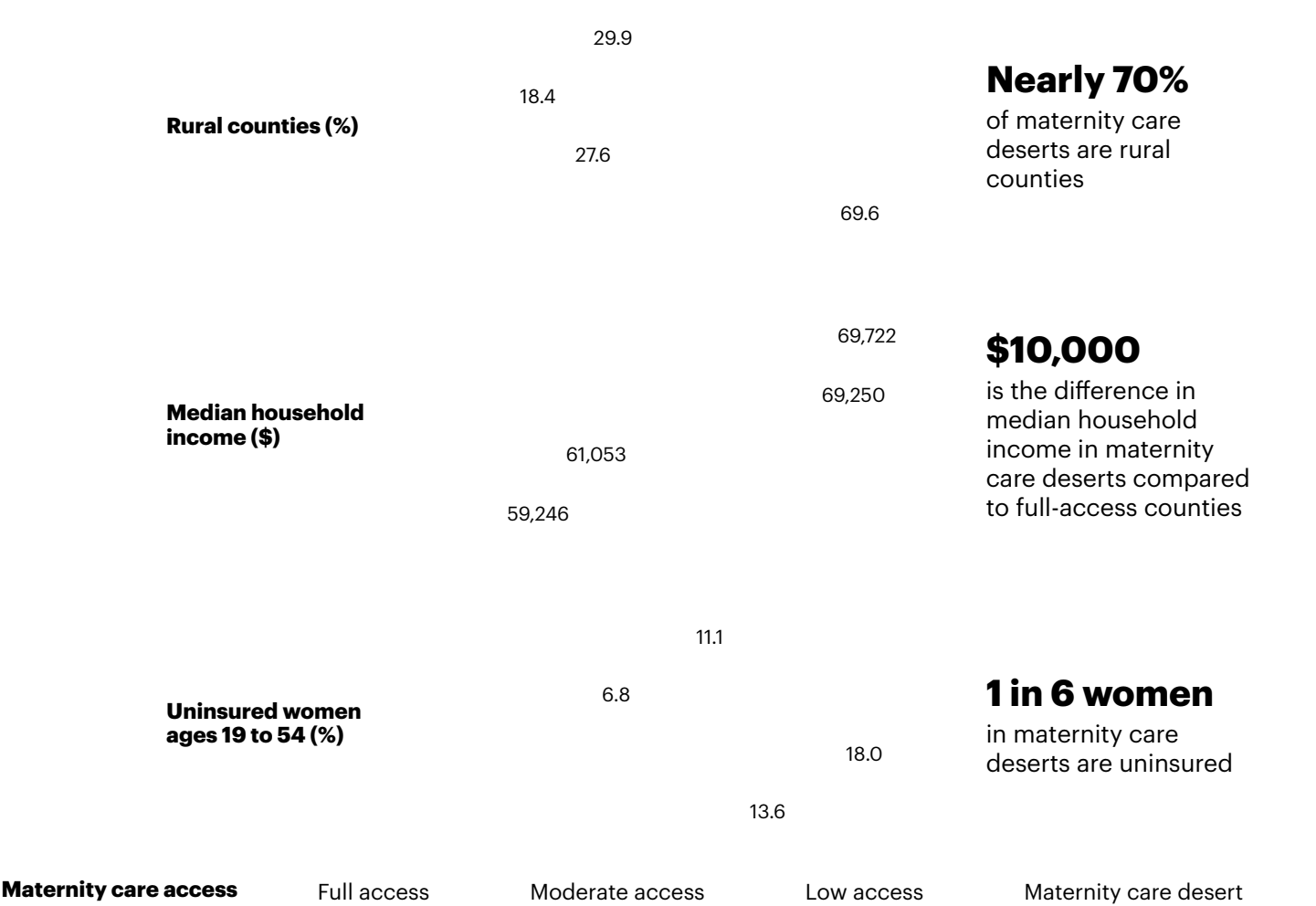
Figure 3. Percentage of counties designated as maternity care deserts, by U.S. region



Maternity care deserts are not only defined by a lack of clinicians and facilities, but they also share demographic and economic characteristics that further limit access to care.

Maternity care deserts are more often rural, have lower median incomes, and higher uninsured rates among women

Figure 4. County demographics by maternity care access designation



Maternity care deserts in the literature

Research consistently shows that living in a maternity care desert is associated with worse outcomes for moms and babies, compared to individuals in full-access counties:

- Infants face a **higher risk** of mortality.⁶
- Women face a **higher risk** of pregnancy-associated mortality.^{5,7}
- Medicaid recipients are **less likely** to receive timely prenatal and postpartum care, and infants are less likely to be vaccinated.⁸
- Have **fewer** mental health clinicians and pediatricians.⁸

Changes in maternity care access, 2016-2024

For nearly a decade, March of Dimes has tracked county-level maternity care access across the U.S. Over time, the measures used have evolved through enhanced data sources, more rigorous methodologies, and expanded metrics. Using current methods, historical designations have been reassessed to measure how access has changed since 2016. Maternity care deserts remained relatively stable from 2016 to 2024, accounting for about one-third of U.S. counties (34.7% in 2016 and 34.6% in 2024). During the same period, the proportion of full access counties increased slightly from 52.0% to 53.2%.

Overall, 372 counties improved in access, resulting in 153 fewer maternity care desert counties nationwide. At the same time, 272 counties experienced a decrease in access, including 150 counties that became new maternity care deserts. Together, these shifts affected nearly 1 in 5 U.S. counties, reflecting a broader transformation in the U.S. maternity care system.

Clinician availability was the primary driver of changing access designations. In counties with increased access, more than 80% experienced a gain of clinicians; in counties with decreased access, more than 90% experienced a loss of clinicians. Between 2016 and 2024, the number of family physicians delivering babies declined by 7.3%, while the supply of doctors of medicine (MD) obstetrician-gynecologists (OB-GYNs) remained relatively stable nationally, but declined in rural areas. In contrast, the number of doctors of osteopathic medicine (DO) OB-GYNs and certified nurse-midwives/certified midwives (CNMs/CMs) increased by 31.8% and 41.8%, respectively, with smaller gains in rural areas.

Among counties that lost access, reductions in birthing facility availability were also a key contributor, reflecting ongoing labor and delivery unit closures and regionalization of maternity services. In contrast, improvements in insurance coverage were more common than declines and contributed to access gains over the same period.

58%

of counties with changes in access designations (n=372) experienced increases over the time period.

644
Counties
total

42%

of counties with changes in access designations (n=272) experienced decreases over the time period.

Factors contributing to changes in access, 2016 to 2024

5.4%

of counties had more birthing facilities

Birthing
facility access

26.8%

of counties had fewer birthing facilities

81.7%

of counties had more obstetric clinicians

Clinician
availability

90.4%

of counties had fewer obstetric clinicians

44.9%

of counties had higher rates of insurance coverage

Insurance
coverage

1.8%

of counties had lower rates of insurance coverage

State-level changes in access, 2016 to 2024

Louisiana showed meaningful gains in access. 6 counties moved out of maternity care desert status.

Nevada demonstrated notable improvements in access. 2 counties moved out of maternity care desert status.

Montana saw rural access recovery in select counties. 5 counties moved out of maternity care desert status.

Texas saw the largest expansion of maternity care deserts. 16 counties became maternity care deserts.

Iowa experienced a steady decline in access. 5 counties became maternity care deserts.

Nebraska also saw measurable declines in access. 5 counties became maternity care deserts.

Collectively, these patterns point to a broader restructuring of the U.S. maternity care system. While some communities have benefited from growth in the maternity care workforce, particularly among DO OB-GYNs and CNMs/CMs, others have experienced labor and delivery unit closures and reductions in the obstetric clinicians, especially family physicians. Consequently, access is increasingly shaped by the intersection of workforce availability, birthing facility access, and insurance coverage. These shifts have occurred unevenly across the country, leaving many rural counties with persistent gaps in both workforce capacity and facility availability.

“We need more places like this model.”

Madison Dickerson, expectant mother and medical assistant, Cahaba Medical Care, Centreville, Alabama

Madison has seen how access to maternity care can transform a community. At Cahaba Medical Care in Centreville, she works alongside a team that provides prenatal care close to home while helping patients overcome barriers to care.

During her current pregnancy, an unexpected finding on an ultrasound meant she would deliver more than an hour away at a higher-level hospital. With prenatal care available in her own community, she was able to build trusted relationships with the providers who guided her pregnancy and recognized when she needed specialized care.

Her experience reflects how investments in clinicians, healthcare infrastructure, and local maternity services can strengthen access while ensuring patients receive the right level of care when complications arise.

“We need more places like this model. If we were maybe a little bit better funded, we would be able to help get these patients more of the help that they need.”

Scan to learn more about Madison's experience in a low-access area.

Over one-third (35.9%) of U.S. counties lack a practicing obstetric clinician.

In rural counties, 57.9% lack an obstetric clinician, compared to 19.4% of urban counties.

More than 1 in 10 counties have only one obstetric clinician.

Comprehensive policy actions in 16 states have expanded midwifery practice, including independent practice, prescribing authority, admitting privileges, and pay parity for CNMs.

The shortage of obstetric clinicians remains a major barrier for equitable maternity care access in the U.S. A 2026 Health Resources and Services Administration (HRSA) report projects that by 2035, all but 6 states will have an inadequate OB-GYN supply, particularly in rural communities.⁹

**Labor and delivery
unit closures**

Fewer clinical
practice sites

**Aging workforce and
clinician burnout^{10,11}**

**Policy and
regulatory barriers**

Restrictions on
midwifery scope
of practice

**Limited training
opportunities and
financial incentives**

for family physicians
and midwives¹²

**Recruitment and
retention challenges**

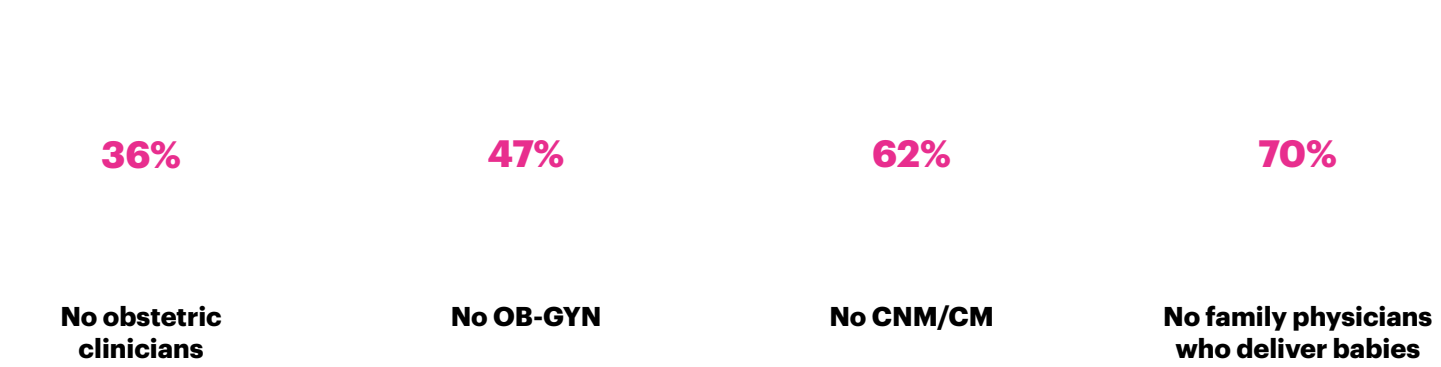
especially in
rural areas¹³

Over one-third (35.9%) of U.S. counties lack an obstetric clinician and over 10% of counties have just one

Figure 5. Distribution of obstetric clinicians by county, U.S. and Puerto Rico



Figure 6. Percentage of counties without obstetric clinicians, by type



Half of U.S. counties lack each major type of obstetric clinician, including OB-GYNs, midwives, and family physicians, with over one-third having none, leaving many communities without access to any consistent source of maternity care.

Sources: U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2024-2025 file; American Board of Family Medicine, 2021-2024; Centers for Medicare and Medicaid Services (CMS), National Plan and Provider Enumeration System (NPPES), November 2024 file.

Challenges for rural communities

Rural communities in the U.S. face significant gaps in access to obstetric care, driven by workforce shortages. In rural counties, 57.9% lack an obstetric clinician, compared to 19.4% of urban counties. Although 5.3% of women of reproductive age live in rural counties, 2.6% of OB-GYNs and 4.8% of CNMs/CMs practice there.

Family physicians play a critical role in addressing these gaps. While they represent just 5.6% of the overall obstetric workforce, they account for 26.8% of obstetric clinicians in rural counties. Family physicians face fewer opportunities for obstetric training during residency and increasing barriers to maintaining obstetric practice. Hospital credentialing requirements further limit their ability to retain privileges, reducing access in communities where alternative clinicians are already scarce.

Recruiting and retaining clinicians in rural areas is further challenged by professional isolation, heavy workloads, frequent on-call demands, and family considerations including limited employment opportunities for spouses, housing availability, and long travel distances.¹³⁻¹⁵ Evidence suggests that medical students who complete rural training are more likely to practice in those settings, especially if they come from rural backgrounds.¹⁶

Strengthening rural training pipelines and recruitment is critical to addressing long-term workforce shortages. Additional strategies include expanding rural training programs, offering loan repayment incentives, and leveraging telehealth to support collaboration and complex care management.

“It’s scary to think that if our clinic were not there, where would they go?”

Dr. Jamie Bishop, family physician,
Cahaba Medical Care, Centreville, Alabama

Dr. Jamie Bishop delivers babies and provides prenatal care in rural Alabama, where maternity services have become increasingly difficult to access. Many of her patients travel long distances for specialty care, struggle with transportation, or face financial barriers that can delay treatment during pregnancy.

A graduate of the Cahaba-UAB Family Medicine Residency, Bishop believes rural training programs are essential to building the workforce communities need. Physicians trained in rural settings gain experience managing complex situations while working with limited resources and fewer specialists nearby.

For Bishop, the issue is personal. She was raised in a rural area herself, a fact she regards as preparation more than coincidence. She sees firsthand what happens when access to care disappears.

“Families in rural communities deserve the same opportunity for healthy pregnancies and healthy babies as anyone else,” she said. “If local maternity care continues to disappear, many patients won’t know where to turn.”

Scan to learn more about
Dr. Bishop’s experience as a
clinician in a low-access area.

Filling the gap: opportunities for midwives

Midwives play a critical role in expanding access to maternity care, particularly in rural and under-resourced communities. Midwifery care is associated with higher rates of spontaneous vaginal delivery and lower use of interventions such as Cesarean delivery, instrumental delivery, and episiotomy. Individuals receiving midwifery care also report higher satisfaction.¹²

Despite these benefits, midwives attend a relatively small share of births in the U.S. In 2024, 11.6% of hospital births were attended by midwives, up from 8.4% in 2016 (Figure 7). While this represents meaningful growth and mirrors the trend of an increasing workforce, access to midwifery care remains uneven across states and communities.

Expanding and fully integrating midwives into the maternity care workforce represents a cost-effective strategy to improve access. However, regulatory and institutional barriers continue to limit their impact. Addressing these barriers, along with supporting the integration of midwives into hospitals and care teams, can strengthen midwives' roles and expand access to care.

Midwives are essential to expanding access to high-quality maternity care, especially in communities with limited access

Sources: National Center for Health Statistics, final natality data, 2016; National Center for Health Statistics, final natality data, 2024.

In 2024, 11.6% of hospital births were attended by midwives, up from 8.4% in 2016

2016	2024
------	------

Example interpretation:

In Delaware, the percentage of births attended by midwives rose from 10.0% in 2016 to 20.2% in 2024, a 102% increase.

Figure 7. Percentage of hospital births attended by midwives, 2016 and 2024

Independent practice:

Remove requirements for physician supervision or contractual agreements, allowing midwives to practice within their full scope of training.

Prescribing authority:

Authorize midwives to prescribe medication to manage patient care directly.

Hospital admitting privileges:

Enable midwives to admit and discharge patients to ensure continuity of care across settings.

Pay parity:

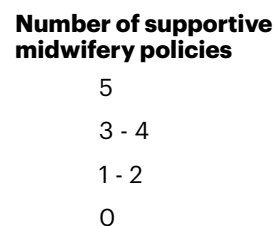
Align reimbursement rates so midwives are paid at 100% of physician rates for comparable services, supporting sustainable practice.

Licensure of CMs:

Expand licensure for CMs, which is currently available in 11 states, to increase workforce capacity.

Colorado, D.C., Maine, and Rhode Island lead in adopting all 5 supportive midwifery policies

Figure 8. Supportive midwifery policies by state, U.S. and Puerto Rico



Source: American College of Nurse Midwives, 2026.

Strengthening access to maternity care will require expanding obstetric training and practice opportunities for family physicians, reducing barriers to midwifery integration, and addressing OB-GYN workforce challenges such as burnout, particularly in rural and under-resourced communities.

It takes a team: the full spectrum of maternity care

This report focuses on clinicians who attend hospital deliveries in the U.S.; however, many professionals support healthy pregnancies and births across the care continuum.

Provide support

Doulas

Community
health workers

Provide medical care

Family physicians trained in obstetrics	CNMs/CMs
OB-GYNs	Women's health nurse practitioner
Maternal fetal medicine specialist	Certified professional midwives (CPMs)

Note: CNMs/CMs, family physicians trained in obstetrics, and OB-GYNs are licensed to deliver babies in hospital settings.

“What gives me hope is that there is a new generation of physicians who want to care for families in rural communities.”

Dr. John Waits, co-founder and CEO,
Cahaba Medical Care, Alabama

For more than 20 years, Dr. John Waits has worked to improve access to maternity care in rural Alabama. When he arrived in Bibb County, the local labor and delivery unit had been closed for more than a decade, forcing families to travel outside their community for care.

Through Cahaba Medical Care and the Cahaba Family Medicine Residency, Waits has helped train physicians for rural practice while building partnerships to strengthen local maternity services. In 2015, those efforts helped reopen the county’s labor and delivery unit, restoring access to care for local families.

His experience demonstrates that addressing maternity care deserts requires long-term investment in workforce development, community collaboration, and sustainable healthcare infrastructure.

Scan to learn more about
Dr. Waits’ experience as a
clinician in a low-access area.

Doulas are trained, non-clinical professionals who provide emotional, physical, and educational support before, during, and after childbirth.¹⁷ Rooted in longstanding cultural and community traditions of birth support, they help individuals navigate pregnancy, childbirth, and the postpartum period.¹⁸ Although they do not provide medical care, doulas play an important role in helping families navigate complex maternity care systems.¹⁹ In communities with limited access to obstetric clinicians or hospital-based maternity services, doulas may also help bridge gaps in care coordination, education, and support.²⁰

Research links continuous doula support to improved maternal and infant outcomes, including lower intervention rates, shorter labor duration, improved patient satisfaction, and reduced risk of preterm birth.^{21,22}

Policy efforts to recognize doulas within the maternity care system have accelerated in recent years, particularly through Medicaid programs.^{23,24} These efforts commonly include reimbursement for prenatal, labor and delivery, and postpartum support, as well as policies allowing doulas to enroll as independent Medicaid providers.

26 states and D.C. allow doulas to enroll as Medicaid providers and bill Medicaid independently

Figure 9. States allowing independent doula practice and billing under Medicaid

Doulas practice and bill independently

No

Yes

Source: National Academy for State Health Policy, 2026.

States are also addressing implementation challenges, including **low reimbursement rates, administrative barriers, and workforce sustainability**

Addressing implementation challenges

Oregon has worked to strengthen Medicaid reimbursement structures and expand provider participation.²⁵

Minnesota has developed standardized certification pathways to support workforce participation and sustainability.²⁶

California and **New Jersey** have advanced community-based doula models that emphasize culturally responsive care and partnerships with community organizations.^{27,28}

In **New York**, recent legislation would require insurance coverage of doula services as part of standard maternity care.²⁹

As efforts to expand access to and reimbursement for doula services continue, doulas are increasingly recognized as a practical strategy to improve continuity of care and support families in communities with limited access to maternity services.

More than half of U.S. counties lack a hospital with a labor and delivery unit, affecting nearly 370,000 births annually.

Residents of maternity care deserts travel three times longer, on average, to reach their nearest labor and delivery hospital.

Out-of-hospital births have increased since 2016, with home birth rates nearly twice as high in maternity care deserts compared to full-access counties.

Access to birth centers remains limited and uneven, shaped by geography, policy environments, and socioeconomic factors.

Access to hospital-based labor and delivery services

More than half of U.S. counties (52.5%) lack a hospital with a labor and delivery unit, limiting care for millions of families, affecting nearly 370,000 births annually (Figure 10).

Geographic disparities are substantial: 70.3% of rural counties lack a hospital with labor and delivery services, compared to 39.2% of urban counties, leaving many families without nearby options for giving birth.

70.3%	Counties without hospital-based labor and delivery services (%)
	39.2%
Rural	Urban

52.5% of all U.S. counties do not have hospital-based labor and delivery services

Figure 10. Hospitals with labor and delivery services by county, U.S. and Puerto Rico, 2024

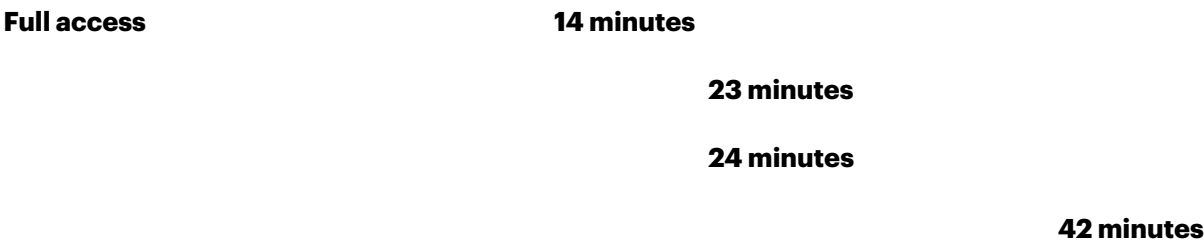
Hospitals with labor and delivery services
none
1 or more

Sources: American Hospital Association, 2024; Centers for Medicare and Medicaid Services Provider of Services File, 2024.

On average, pregnant women travel 16 minutes by car to their nearest labor and delivery unit. However, access varies substantially by location. Geographic disparities are particularly pronounced in rural counties, where average travel time is 33 minutes, more than twice that of urban counties (15 minutes). In several states, including North Dakota, West Virginia, and Montana, average travel times are 25 minutes or more. Residents of maternity care deserts travel an average of 42 minutes to reach labor and delivery services, three times longer than those traveling 14 minutes in full-access counties (Figure 11).

Women living in maternity care deserts travel three times longer, on average, to reach the nearest hospital with labor and delivery services

Figure 11: Travel time by maternity care access designation



Longer travel distances are associated with delayed entry into prenatal care, increased likelihood of unplanned out-of-hospital deliveries, higher rates of maternal morbidity, and greater neonatal intensive care unit (NICU) admissions.^{2,30,31} Longer travel distances also increase indirect costs for families, including transportation, childcare, missed work, and temporary lodging.

“If labor happened, the drive was always on our minds.”

Latasha Bell, RN, maternal mortality prevention professional and mother, Lowndes County, Alabama

For Latasha, living in a maternity care desert meant planning every pregnancy around distance. As a teenager expecting her first child, and years later as a registered nurse preparing to deliver her fourth, the nearest labor and delivery hospital was more than 45 minutes away. Every appointment, every contraction, and every decision began with one question: How long will it take to get there?

Even with health insurance, reliable transportation, and medical knowledge, Latasha understood that geography alone could shape pregnancy outcomes. She knows many families in rural Alabama face even greater barriers, forcing them to delay care or travel long distances for routine prenatal visits, labor and delivery, and emergency care.

“I wish people understood how much access to care matters. Sometimes it's as simple as being able to get to a provider.”

Scan to learn more about Latasha's experience in a low-access area.

Hospital labor and delivery unit closures have accelerated across the U.S. and are associated with negative impacts on maternal and infant health.

96 publicly reported labor and delivery unit closures were identified across 91 counties in 35 states between 2024 to early 2026.

Across all affected counties, unit closures increased travel time by an average of 25.0 minutes, with increases up to 77 additional minutes to reach the nearest labor and delivery unit.

Across the U.S., an increasing number of women of reproductive age are losing access to local birthing facilities. As labor and delivery units close, access to maternity care can shift across entire regions, often requiring families to travel farther for care. Research shows that the loss of local labor and delivery services is associated with longer travel distances, delays in accessing care during emergencies, increased risk of out-of-hospital births, and adverse maternal and infant outcomes, particularly among those living in rural communities.^{2,32-34} For many families, these changes can delay care during pregnancy and childbirth and add stress while navigating already complex health systems. At the same time, some hospitals report that consolidating maternity services can allow remaining facilities to concentrate specialized staff and resources, potentially improving quality and safety in higher-volume centers.^{32,25}

Because national hospital datasets are lagged, we analyzed publicly reported closures occurring between 2024 and early 2026 using Becker's Hospital reviews, data from the Center for Healthcare Quality and Payment Reform, online news reports, and hospital announcements. This approach captures publicly reported closures and may not represent all closures during this period.

During the study period, 96 labor and delivery unit closures were identified across 91 counties in 35 states. Nearly two-thirds of closures occurred in rural hospitals, and more than half involved the county's only birthing facility.

Reported drivers of labor and delivery unit closures included declining birth volume, workforce shortages, and financial pressures. Declining birth volume was the most frequently cited factor, reflecting reduced patient demand that challenges hospitals' ability to sustain staffing, maintain financial viability, and support continuous obstetric services. Workforce shortages were reported in approximately half of closures and most commonly involved shortages of obstetric clinicians, labor and delivery nurses, and anesthesia providers, limiting hospitals' ability to maintain safe, 24-hour coverage. Financial pressures were reported in approximately one-third of closures and included rising operating costs, low Medicaid reimbursement, and persistent financial losses associated with maintaining labor and delivery services.

Reported reasons for closure also differed by hospital location. Rural hospitals more frequently cited workforce shortages as a primary contributing factor, whereas urban hospitals more often reported declining birth volume.

This report is based on publicly reported labor and delivery unit closures and may not capture every closure. Help us keep this resource current by reporting any closures you are aware of through the March of Dimes closure reporting survey: <https://www.marchofdimes.org/L&Dclosure>

Labor and delivery unit closures across the U.S.

96
labor and delivery
unit closures
occurred across
35 states and 91
counties*

*From January 1, 2024, to May 1, 2026

Closure count

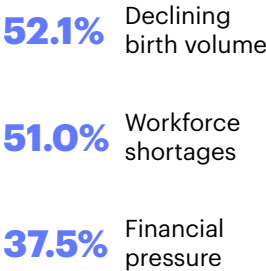
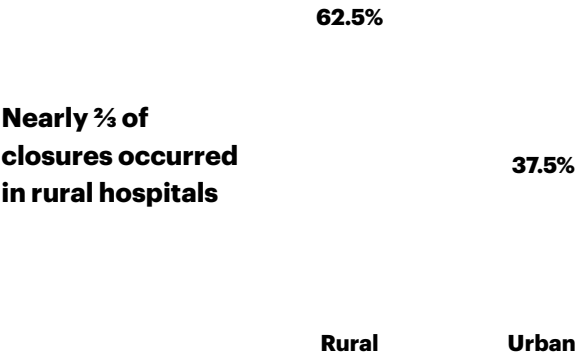
- 0
- 1 - 2
- 3 or more

9.2 million
women of
reproductive age
live in counties with
recent closures.

465K births
occur annually in
these counties,
representing 13% of
live births.

58.3%
of closures were
a county’s sole
birthing facility.

Percentage of closures with reason mentioned

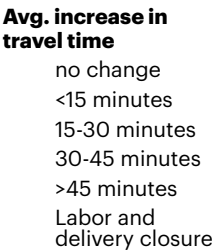


The impact of labor and delivery unit closures on travel time

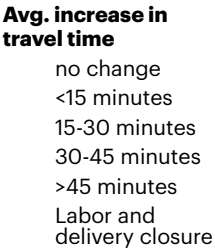
Recent labor and delivery unit closures have increased travel times to maternity care by an average of 25 minutes in affected communities. While some states, including California, Wisconsin, Indiana, and Minnesota, experienced a higher number of closures, the greatest relative increases in travel burden occurred in more rural states, including Wyoming (12.8% increase in travel time), West Virginia (10.6%), Maine (7.4%), and Wisconsin (6.6%).

State spotlight: local impacts of labor and delivery unit closures

While labor and delivery unit closures are occurring nationwide, their impact varies considerably across states. In some areas, closures are concentrated geographically, further limiting already constrained systems. In others, even a single closure can substantially alter access because few alternative facilities exist. West Virginia and Wisconsin demonstrate how quickly access to maternity care can shift when local birthing services are lost.



In Wisconsin, recent closures have further strained maternity care systems, particularly in rural communities. Staffing shortages contributed to multiple labor and delivery unit closures, including in Barron and Taylor counties, where travel times to the nearest unit tripled for residents. The effects also extended into surrounding counties such as Rusk and Price, where travel times were already nearly one hour and increased by 46% and 19%, respectively. While rural communities are disproportionately affected, similar challenges are occurring in metropolitan and suburban areas. In the Milwaukee region, for example, hospital consolidations and labor and delivery service changes have shifted where families seek obstetric care, reflecting broader financial and workforce pressures affecting hospitals across Wisconsin.



In West Virginia, the impact of closures is intensified by a long-standing shortage of birthing facilities. Because the state has one of the lowest densities of labor and delivery hospitals in the country, even a single closure can significantly alter access to care. In Greenbrier County, the closure of the only unit serving several surrounding counties increased travel times across the region, particularly in the Southeast. Families in multiple rural counties now travel two to three times longer to reach obstetric services, with many communities requiring at least one hour of travel after accounting for the increase in travel time due to a nearby closure. Together, the affected counties in southeastern West Virginia are home to more than 17,000 women of reproductive age and over 1,000 births annually, highlighting how the loss of a single facility can quickly create widespread geographic barriers to care.

States and health systems are implementing a range of strategies to mitigate the impact of labor and delivery unit closures. These strategies range from advanced planning requirements to new funding and care delivery models.

Maine

Maine enacted legislation requiring hospitals to provide 120 days' advance notice before closing labor and delivery units or making significant changes to maternity or newborn care services.^{36–38}

California

California SB 669, enacted in 2025, established a new “standby perinatal services” model for rural hospitals unable to sustain traditional 24/7 labor and delivery units.

Oregon

In 2026, Oregon launched a statewide rural stabilization initiative in response to the increasing number of labor and delivery unit closures. The initiative allocated \$25 million to support rural maternity care services.

In communities where maintaining full obstetric services is no longer feasible, hospitals are also strengthening emergency department capacity to respond to obstetric emergencies³⁹ and training emergency medical service personnel to stabilize patients during longer maternal and infant transport times. Continued evaluation will be important to understand which strategies most effectively preserve access while maintaining quality and safety.

Value-based payments: alternative payment methods for maternity care

Traditionally, healthcare providers in the U.S. have been reimbursed through a fee-for-service (FFS) model, in which payment is tied to each individual service delivered. In contrast, value-based payment (VBP) models incentivize high-quality, coordinated, and cost-efficient care.

Efforts to expand VBP in maternity care include pay-for-performance models, episode-based bundles, maternity care homes, population-based models, and total cost of care approaches. Strengthening and scaling value-based maternity care models may improve access, quality, and cost-efficiency. Some value-based models also create opportunities to better integrate midwives, doulas, care coordination, and postpartum support into maternity care systems.

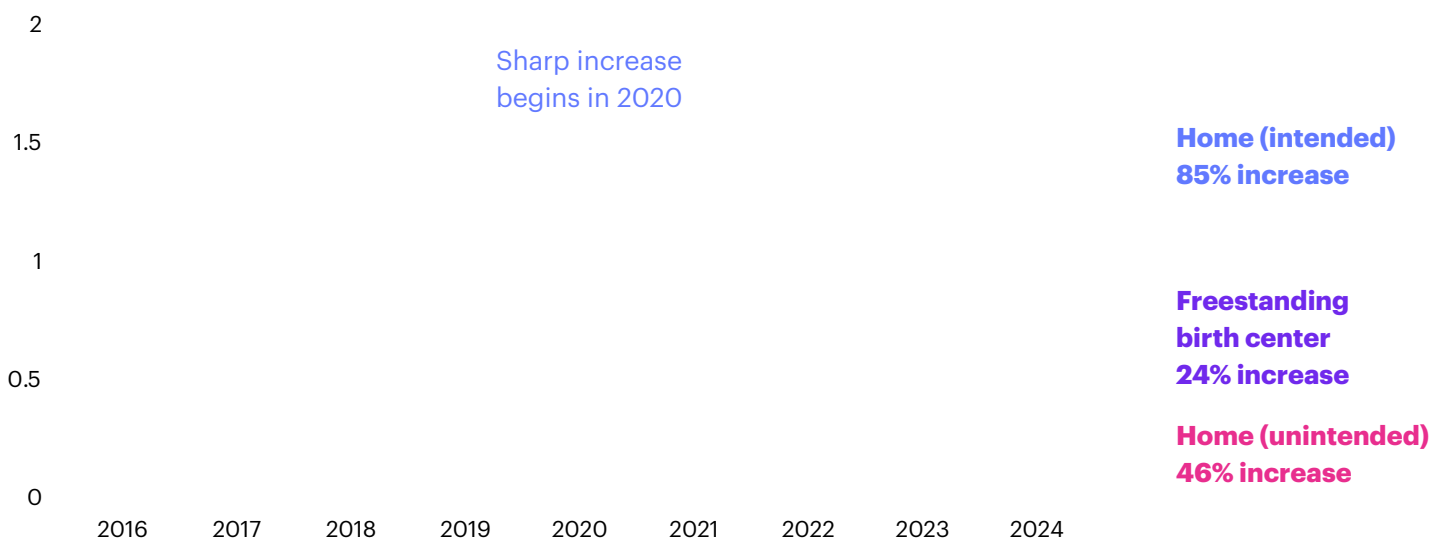
As access to hospital-based labor and delivery care becomes more limited, particularly in counties with long travel times and fewer labor and delivery services, birth patterns are shifting. In these areas, decisions about birth setting may reflect access constraints, with choices shaped in part by the local options available.

Out-of-hospital births increased by 50% since 2016, and home birth rates are 1.9 times higher in maternity care deserts than in full-access counties

While hospitals remain the primary setting for childbirth, accounting for nearly 98% of all births, this pattern is changing. Between 2016 and 2024, the proportion of counties without a labor and delivery hospital increased from 47.5% to 52.5%. Over the same period, births occurring outside hospital settings increased by 50%, reaching 2.3% of all births in 2024.

Home births have increased from 1.0% of all births in 2016 to 1.6% in 2024, a 65.3% relative increase (Figure 12). This trend has been linked to the loss of hospital-based birthing services and is more pronounced in areas with limited or no access to maternity care.⁴⁰ In maternity care deserts, home birth rates are nearly twice as high as in full-access counties. Among home births in maternity care deserts, 92.3% are reported as intended, suggesting birth setting decisions may reflect limited local hospital access.

Figure 12. Percentage of out-of-hospital births by setting, 2024

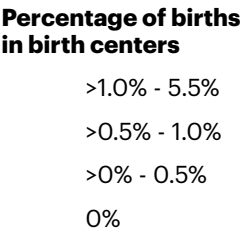


Source: National Center for Health Statistics, final natality data, 2016-2024.

Birth centers offer an alternative to hospital birth, emphasizing the midwifery model of care for low-risk pregnancies.⁴¹ There are 421 birth centers nationwide, yet only 8.4% of counties have at least one. Birth center access remains highly uneven, with just 1.3% of rural counties having one, compared to 13.7% of urban counties. Nearly 70% of all birth centers are concentrated in just 10 states, with the largest shares in Texas, California, Florida, Washington, and Virginia. Birth centers accounted for 0.6% of U.S. births in 2024, up from 0.5% in 2016, a 24.0% relative increase (Figure 13).

Birth centers are associated with improved outcomes and lower-cost, patient-centered care.⁴¹ Low reimbursement rates, administrative burdens, and payment delays create significant operational challenges. In addition, variation in state licensure requirements and the absence of clear pathways in some states further restrict where birth centers can operate and expand.

Figure 13. Percent of total births in birth centers by state, U.S. and Puerto Rico, 2024



Source: National Center for Health Statistics, final natality data, 2024.

Birth centers are not accessed equally

Geography, income, insurance coverage, race, and ethnicity all can shape women’s options and outcomes during pregnancy, childbirth, and the postpartum period.

Birth center utilization by race and ethnicity

Percentage of births that occur in birth centers versus hospitals.

Race and ethnicity	Birth centers	Hospitals
White	74.6%	48.5%
Hispanic	11.9%	27.5%
Black	6.4%	13.2%
Asian	1.9%	6.4%
American Indian/Alaska Native	0.4%	0.7%

The takeaway

Birth center utilization varies substantially by race/ethnicity, education, insurance coverage, and geography. **Addressing these disparities is critical to ensuring equitable access to birth center care.**

Education level	Birth centers	Insurance coverage	Birth centers
Percentage of individuals with at least some college.	73.5%	Percentage of births covered by Medicaid.	17.4%
	Hospitals		Hospitals
	61.5%		40.4%

Expanding access to accredited birth centers is a critical strategy for addressing gaps in maternity care access, particularly in under-resourced and rural communities. Key policy actions include:

Remove regulatory barriers:

Exempt birth centers from certificate of need (CON) requirements that can delay or prevent new facilities from opening.

Improve financial sustainability:

Establish equitable Medicaid reimbursement rates (at 100% of the fee schedule) and reduce administrative burdens, including payment delays.

Standardize quality measures:

Align state regulations with Commission for the Accreditation of Birth Centers (CABC) standards.

Integrate into care systems:

Support standardized coding, contracting mechanisms, and inclusion in provider networks to ensure coordinated care.

Plan for emergencies:

Require transfer agreements and documented protocols for responding to obstetric or neonatal emergencies.

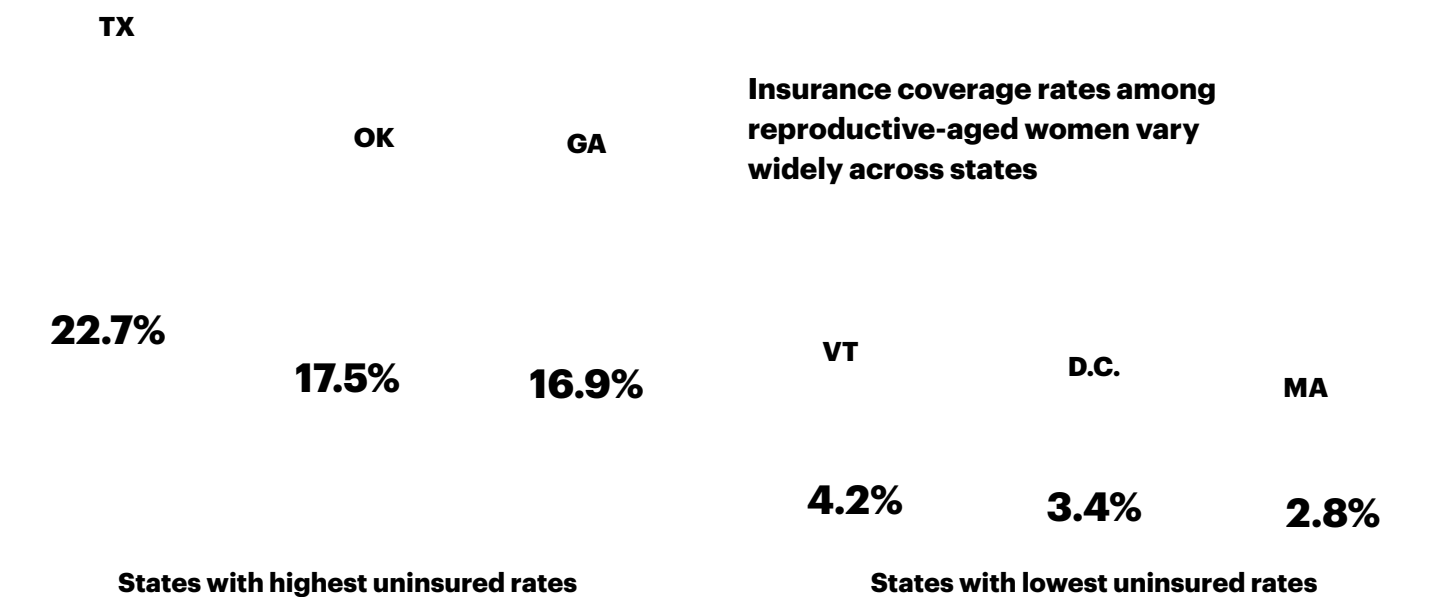
Nationally, about 1 in 9 (10.9%) women ages 19 to 54 were uninsured in 2024, with substantial variation across states and counties.

Since the passing of the Affordable Care Act in 2010, which expanded Medicaid income-eligibility thresholds, uninsured rates among women ages 19 to 54 have decreased 45% nationally, but to a lesser extent (just 35%) in states that have not expanded Medicaid.

Recent federal policy could result in increases in uninsured rates nationwide, leading to decreased financial access to care.

Access to affordable, comprehensive health insurance is critical for healthy pregnancies and positive outcomes for moms and babies.⁴² Without stable coverage, women are more likely to enter pregnancy with unmanaged conditions, delay prenatal care, and face barriers to specialty and high-risk services. Access to care before pregnancy influences maternal and infant outcomes long before prenatal care begins. Coverage gaps increase the risk of delayed prenatal care and preventable complications.

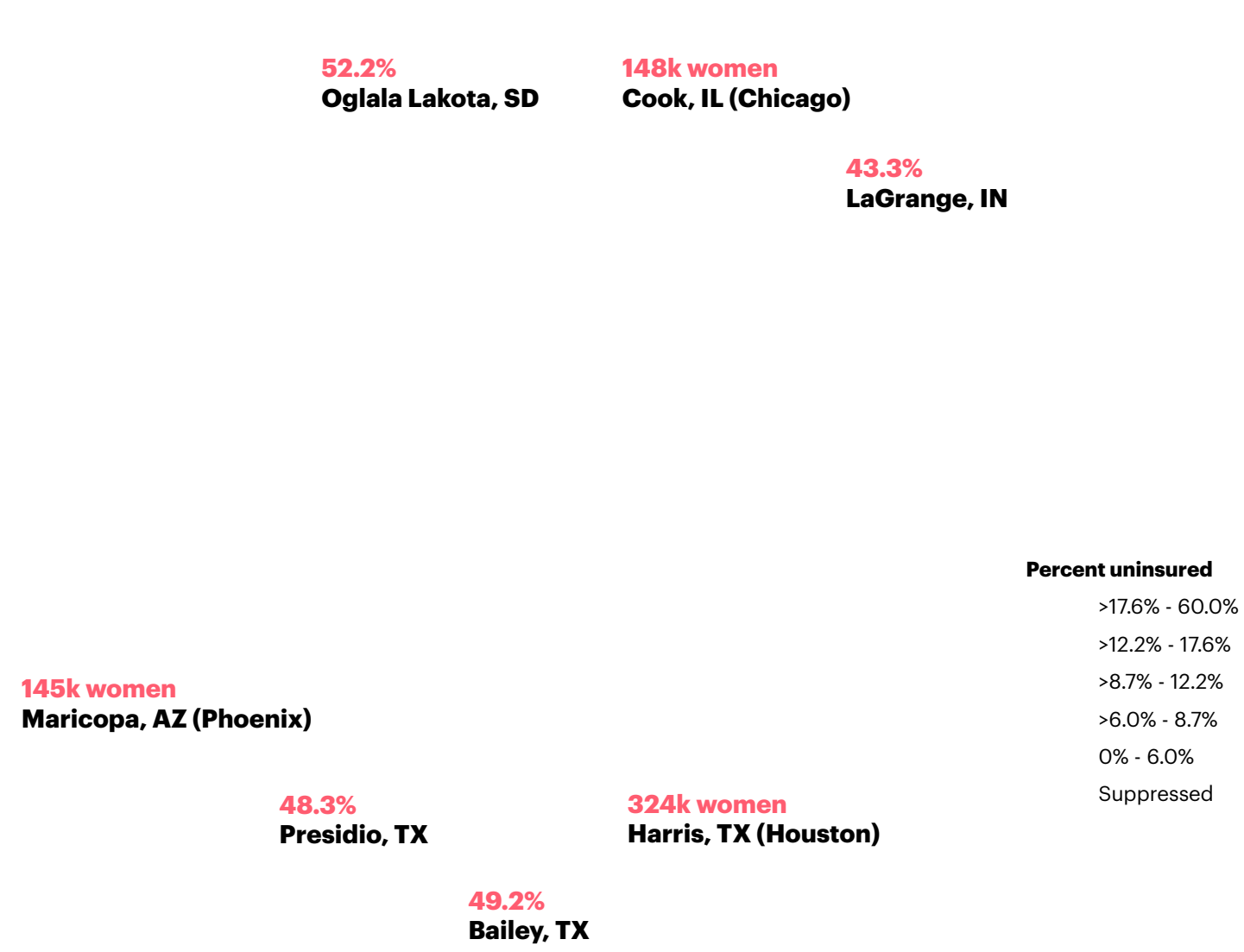
**1 in 9 women
ages 19 to 54 years
are uninsured**



County-level variation in insurance coverage is even more pronounced. In approximately 3% of counties, as many as 1 in every 3 women are uninsured, with clusters in Texas, Georgia, Oklahoma, Alaska, and South Dakota. Uninsured rates are highest in maternity care deserts, as well as in rural, border, and tribal counties, while several large urban counties also experience both high rates and large numbers of uninsured women (Figure 14).

High uninsured rates persist across U.S. counties

Figure 14. Percentage of uninsured women ages 19 to 54 by county, U.S. and Puerto Rico, 2024



Source: U.S. Census Bureau, 2024 American Community Survey 5-Year Estimates.
Note: Individual callouts represent cities or counties with high rates or numbers of uninsured women.

Landmark health insurance policy and changes in access

Access to health insurance and coverage for women and families in the U.S. has been shaped by federal policy since the introduction of Medicaid in 1965. The Affordable Care Act (ACA) marked a major turning point by allowing states to expand Medicaid income eligibility (adopted in all but 10 states as of 2026) and providing insurance premium tax credits.⁴³

Medicaid expansion, implemented in 2014, has led to substantial declines in uninsured rates overall and among women ages 19 to 54. While research on the impacts of Medicaid expansion on overall maternal and infant outcomes is mixed, some studies suggest that expansion may be associated with timely initiation of prenatal care and improved management of high-risk conditions such as hypertensive disorders of pregnancy, progress toward reducing racial and ethnic disparities, and reductions in maternal mortality.⁴⁴⁻⁴⁷

More recent policies, including extension of postpartum Medicaid coverage through 12 months (adopted in 49 states and D.C. as of July 2026),⁴³ have further strengthened access to care. However, proposed or enacted changes following the passage of House Resolution 1 (H.R. 1), also referred to as the One Big Beautiful Bill Act, including Medicaid funding cuts and work requirements, and the expiration of insurance premium tax credits, threaten to reverse these gains and increase the number of uninsured families.

In maternity care deserts, where clinician and facility shortages already limit access, loss of coverage compounds existing barriers to care, making it more difficult for women to receive timely prenatal, delivery, and postpartum services.

Health insurance policy shapes who can access care, when they receive it, and whether coverage is continuous across pregnancy and postpartum

“I had to jump through three hoops with fire on them just to obtain insurance.”

Savannah Yax, mother, Elmore County, Alabama

After moving to Alabama early in her pregnancy, Savannah spent five months navigating the state's Medicaid enrollment process before she could establish prenatal care. Even after gaining coverage, every appointment required a 40-minute trip to the nearest obstetric provider and reliable transportation she often didn't have.

Throughout her pregnancy and postpartum recovery, Savannah faced delays in receiving treatment because of transportation challenges, provider availability, and the limits of her coverage. Now, as her Medicaid eligibility comes to an end, she worries about losing access to the mental healthcare and other services she still needs as a new mother.

Throughout her experience, Savannah learned that getting insurance alone wasn't enough. Finding providers, arranging transportation, and keeping coverage were ongoing challenges that affected every stage of her pregnancy and recovery.

“Make healthcare and prenatal and postpartum care easily accessible for mothers and children all over.”

Scan to learn more about Savannah's experience in a low-access area.

Legislative milestones in health insurance policy for pregnant women and children

Over time, federal policies have expanded eligibility, increased affordability, and improved continuity of coverage for pregnant women and children.⁴⁸⁻⁵¹

Early and Periodic Screening, Diagnosis and Treatment Program

Required all states to provide Medicaid-enrolled infants and children with appropriate and necessary pediatric services.

1967

Pediatric services coverage for children

1965

Medicaid program established

Social Security Act

Required all states, D.C., and U.S. territories to provide health coverage for low-income individuals.

1970

Coverage for family planning

Family Planning Act

Established federal funding and authority for family planning programs, expanding access to contraception and reproductive health services. Required that all services be provided on a voluntary basis.

Deficit Reduction Act of 1984

Required states to provide Medicaid coverage to eligible children under age 5 and income qualifying pregnant women (single parents or single earner households) and granted automatic one-year Medicaid eligibility to infants born to mothers covered by Medicaid.

1984

Medicaid coverage for children under 5

Omnibus Budget Reconciliation Acts

Required Medicaid coverage during pregnancy through 60 days postpartum, regardless of employment or marital status, and gradually broadened eligibility to higher income levels (up to 133% FPL required, with options up to 185% FPL).

1985-1990

Expanded coverage for pregnant women and presumptive eligibility

Introduced presumptive eligibility to allow states the option to provide temporary prenatal care access while formal Medicaid eligibility is determined.

1996

**Limits on Medicaid
for legal non-citizens**

**Personal Responsibility and Work
Opportunity Reconciliation Act**

Restricted Medicaid eligibility
for legal non-citizens, including
pregnant women, during their first 5
years of U.S. residency.

**Children's Health Insurance
Program (CHIP)**

Provided federal funding to expand
coverage for children in low-income
families not eligible for Medicaid.

1997

**Coverage expansion
for children**

2009

**Expanded options
for coverage of
pregnant women**

CHIP Reauthorization Act

Allowed states to cover lawfully
residing pregnant women
through Medicaid without a
5-year waiting period.

**Patient Protection and
Affordable Care Act**

Allowed states to expand Medicaid
income eligibility and required
coverage of essential health
benefits, including maternity and
newborn care and preventative
services for women, infants,
and children. Provided premium
tax credits to subsidize the cost
of insurance and increase the
affordability of coverage.

2010

**Medicaid expansion
and insurance
subsidies**

2021

**Extension for
postpartum coverage
through 12 months**

**American Rescue Plan Act, made
permanent in 2023**

Allowed states to extend Medicaid
coverage to 12 months postpartum,
supporting continuity of care during
a high-risk period.

House Resolution 1

(One Big Beautiful Bill Act)

Reduced funding for Medicaid and
CHIP programs and introduced
work requirements. Did not extend
insurance premium tax credits
provided under the ACA.

2025

**Medicaid funding cuts
and work requirements
introduced**

Why this matters

Health insurance policy directly shapes whether women can
access prenatal care, deliver in safe settings, and receive
postpartum care. Sustaining and expanding coverage is critical
to improving access to care and achieving better outcomes for
moms and babies, particularly in maternity care deserts.

Since the implementation of the ACA, uninsured rates among women ages 19 to 54 have declined nationally, from 19.7% in 2013 to 10.9% in 2024, and across all states and most counties. At the state level, average rates decreased from 18.0% to 9.8%, representing a 45.1% reduction (Figure 15).

Uninsured rates among women decreased across all states, though progress varies

Figure 15. Percentage of uninsured women ages 19 to 54 by U.S. state, 2013 and 2024

Example interpretation:

Louisiana’s uninsured rate fell from 25.2% in 2013 to 9.2% in 2024, a 63% decrease.

Expanded Medicaid

2013 rate 2024 rate

Did not expand Medicaid

2013 rate 2024 rate

Expansion not applicable

2013 rate 2024 rate

Kentucky and Oregon demonstrated the largest improvements, each reducing uninsured rates by 66%.

Even states with the smallest improvements, including Puerto Rico and Texas, achieved reductions of roughly 25%.

Despite state-level progress, about 1 in 20 counties did not experience declines.

The average reduction in states that had expanded Medicaid by 2024 was 48%, compared to just 35% in non-expansion states.

Medicaid expansion and other policies implemented through the passing of the ACA have been one of the strongest drivers of coverage gains among women of reproductive age. States that expanded Medicaid experienced larger reductions in uninsured rates, demonstrating the impact of policy decisions on access to care. Variation across states and counties

highlights the need for targeted strategies and supportive policies to ensure that gains in health insurance coverage are equitable and sustained over time. Maintaining and expanding access to continuous coverage before, during, and after pregnancy will be critical to sustaining gains and preventing further erosion of maternity care access.

Advocacy can help drive meaningful change. Join the [March of Dimes Advocacy Network](#) to support policies that improve access to care for moms and babies.

“We have a lot of work to do because there are so many moms and babies counting on us.”

Sen. Katie Britt, U.S. Senator, Alabama

As Alabama continues to face one of the nation's highest maternal mortality rates, Sen. Katie Britt has made improving maternal health a priority in Congress. Growing up in rural Alabama and raising two children of her own, Britt understands the importance of ensuring families can access quality care before, during, and after pregnancy.

Recognizing that many rural communities are far from labor and delivery services, Britt has championed efforts to better prepare rural hospitals and first responders to care for women experiencing obstetric emergencies. She also supports expanding research into the causes of maternal mortality and improving access to resources that help women navigate pregnancy and early parenthood.

For Britt, improving maternal health requires strengthening both the healthcare system and the support available to families, particularly in rural communities where access to care remains limited.

“We have a lot of work to do. There are many of us rolling up our sleeves because we know there are so many moms and babies counting on us.”

Discover Sen. Katie Britt's work to improve access to maternity care.

Early prenatal care is critical to improving maternal and infant health outcomes. Timely care supports risk identification, chronic disease management, and delivery of recommended preventative services, including mental health screenings, substance use treatment, vaccinations, and infectious disease screening.⁴

More than 1 in 4 women covered by Medicaid during pregnancy reported being uninsured prior to conception, increasing to more than 1 in 3 in non-expansion states.⁵² Gaps in pre-pregnancy coverage can delay prenatal care initiation as women navigate Medicaid enrollment early in pregnancy. Presumptive eligibility (PE) policies help reduce this barrier by allowing immediate access to care while eligibility is determined.

Many states have long-standing PE policies for pregnant women, while recent actions in Alabama and Arkansas expanded PE beginning in 2025.^{53,54} These policies may be particularly impactful in non-expansion states, where women are more likely to be uninsured before pregnancy and experience delays in accessing prenatal care.

Although research suggests PE policies may improve prenatal care initiation, findings have not consistently demonstrated improvements in birth outcomes.^{55,56} These findings suggest that insurance coverage alone does not eliminate barriers to prenatal care.

Additional barriers to prenatal care include:⁵⁷

Socioeconomic and logistical barriers	Health system barriers	Population-specific barriers
Transportation challenges and long travel distances	Understaffed clinics and long wait times	Language barriers
Work, school, childcare, and paid leave constraints	Limited clinician availability or participation in Medicaid and other insurance plans	Immigration-related concerns that may deter seeking care
Limited access to broadband internet and digital tools in rural and under-resourced communities		

In 2024, 1 in 4 women did not receive prenatal care during the first trimester of pregnancy

Rates of early prenatal care are slightly lower among women living in maternity care deserts (74.8%) and low-access counties (71.3%) compared to full-access counties (75.6%).

Evidence-based strategies to improve prenatal care utilization:⁵⁸

- Providing financial incentives
- Expanding telehealth services
- Deploying mobile health clinics in underserved communities

Broader investments in maternity care infrastructure and workforce capacity are also needed to improve timely access to prenatal care in under-resourced areas.

Telehealth, remote patient monitoring (RPM), mobile health applications, and mobile health centers can expand access to maternity care in under-resourced communities by helping overcome geographic, transportation, and workforce barriers. Reliable broadband access is increasingly essential healthcare infrastructure for maternity care access.

Studies suggest that mobile health centers can improve early and adequate prenatal care utilization, increase patient satisfaction, support the identification of maternal hypertension, and reduce preterm birth rates. While not a substitute for sustainable local

maternity care infrastructure, these approaches may be particularly beneficial for high-risk pregnancies and postpartum monitoring, including for hypertensive, cardiac, and mental health conditions.

Postpartum care remains especially important, as most pregnancy-related deaths occur after delivery and the majority are preventable.⁵⁹ Yet many women do not receive the recommended postpartum care.⁶⁰ Mobile health centers and digital tools may help improve timely follow-up care and reduce barriers to accessing postpartum care.

To expand equitable access to technology-enabled maternity care, policymakers should prioritize the following:

Payment and insurance reform:

Establish permanent reimbursement parity for telehealth services across Medicaid and private insurance plans. Expand coverage for RPM tools, including blood pressure cuffs and glucose monitors, and reimburse audio-only visits when video access is not feasible.

Broadband and technology access:

Invest in broadband expansion in rural and under-resourced communities. Support digital literacy initiatives and programs that improve access to smartphones, tablets, and data plans for patients and clinicians.

Licensure and regulatory flexibility:

Expand interstate licensure contracts to allow obstetric clinicians, midwives, doulas, and mental health professionals to provide care across state lines, particularly in areas with limited access to specialty care.

By addressing these policy priorities, digital health technologies may help reduce barriers to care and improve maternal health outcomes, particularly in under-resourced communities.

March of Dimes Mom & Baby Mobile Health Centers

March of Dimes partners with local organizations and healthcare systems to bring maternity care services directly to communities with limited access through the Mom & Baby Mobile Health Centers program. The program currently operates seven mobile health centers across Ohio, New York, Arizona, Washington, D.C., and Texas, with additional sites launching in 2026.⁶¹ These mobile clinics provide services spanning pre-pregnancy, prenatal, postpartum, and newborn care.

AL

AZ

In 2026, new Mom & Baby Mobile Health Centers will launch in:

- Navajo and Apache counties in Arizona, two rural counties
- Lowndes County, Alabama, a maternity care desert

The Rural Health Transformation Program (RHTP), created through H.R. 1, will distribute \$50 billion over 10 years to strengthen healthcare delivery in rural communities. The initiative presents an opportunity for states to modernize health systems, improve access to maternity care, and test innovative models of care delivery.

Because states will implement different strategies and receive varying levels of funding, continued evaluation will be important to identify which approaches most effectively improve access and outcomes.

Promising state initiatives:

Regional care networks

Alabama, California, Pennsylvania, and South Dakota are implementing hub-and-spoke models to expand specialty care access in rural communities.

Addressing labor and delivery unit closures

Indiana is training rural emergency departments to manage obstetric emergencies, Ohio is pursuing policies to expand delivery at birth centers, and Washington is exploring new hospital financing approaches to help sustain maternity services.

Telehealth

Alaska and Maine are expanding behavioral telehealth services, remote fetal monitoring, and cloud-based technologies to support perinatal care in tribal and rural communities.

Workforce development

States including Illinois, Missouri, Nevada, and New Jersey are investing in scholarships and training opportunities for doulas, midwives, family physicians, community health workers, lactation consultants, and home visitors.

Value based payment

Tennessee and Colorado are incorporating maternal health into new rural value-based payment initiatives.

Conclusion

Maternity care deserts are not inevitable.

Every family deserves access to high-quality maternity care—no matter where they live. With coordinated action and sustained investment, we can build a future where all families can access the care and support they need.

The challenge

Access to maternity care in the U.S. remains uneven, with millions of families living in communities facing shortages of obstetric clinicians, limited access to birthing facilities, long travel distances, and financial barriers to care. In many rural and under-resourced communities, these challenges are compounded by hospital labor and delivery unit closures and persistent workforce shortages.

The path forward

Improving access to maternity care will require coordinated action across healthcare systems, policymakers, payors, public health agencies, community organizations, and maternal and child health advocates. The absence of maternity care results from interlocking challenges, which means there is no single solution; it also means there are multiple opportunities for action.

Essential investments

Expanding the maternity care workforce, strengthening hospital and birth center infrastructure, improving insurance coverage, integrating midwives and doulas into care teams, and investing in telehealth and mobile health models are all important strategies to improve access and outcomes for moms and babies.

March of Dimes' role

Organizations like March of Dimes play an important role in advancing data-driven solutions, supporting communities, elevating evidence-based policy and systems change, and bringing partners together to address gaps in care. Continued collaboration and investment will be critical to ensuring all families can access the care and support they need.

Explore the data

To explore additional national, state, and county-level maternal and infant health data, visit March of Dimes [PeriStats](#), a public data resource designed to support research, policy, and community action.

Limitations

This report measures maternity care access at the county level using available national data on obstetric clinicians, birthing facilities, and insurance coverage. County-level designations may not fully reflect local variation in care access, including transportation barriers, appointment availability, or differences in quality of care. In addition, national datasets may contain reporting delays or incomplete information on clinicians and facilities, and the designations do not capture all professionals who support pregnancy and birth, such as doulas or community health workers.

Despite these limitations, these measures provide an important national view of geographic patterns and trends in maternity care access across the U.S.

For more information about definitions, data sources, and methods, see our [technical notes](#).

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Abbreviations and definitions

AABC – American Association of Birth Centers

ABFM – American Board of Family Medicine

ACA – Affordable Care Act

ACNM – American College of Nurse Midwives

ACS – American Community Survey, Census Bureau

AHA – American Hospital Association

AI/AN – American Indian/Alaska Native

CABC – Commission for the Accreditation of Birth Centers

CDC – Centers for Disease Control and Prevention

CHIP – Children’s Health Insurance Program

CM – Certified midwife

CMS – Centers for Medicare & Medicaid Services

CNM – Certified nurse midwife

CON – Certificate of need

DO – Doctor of osteopathic medicine

FPL – Federal poverty level

HRSA – Health Resources and Services Administration

MCD – Maternity care desert

MD – Doctor of medicine

NCHS – National Center for Health Statistics

NICU – Neonatal intensive care unit

NPPES – National Plan and Provider Enumeration System

OB-GYN – Obstetrician-gynecologist

PNC – Prenatal care

Birth center	A healthcare facility that follows the midwifery model of care and provides maternity care to low-risk birthing people.	American Association of Birth Centers
Doula	A non-clinical professional who provides physical, emotional, and informational support before, during, and after childbirth.	National Academy for State Health Policy
Certified nurse midwife	A registered nurse with additional training in midwifery, providing care to women throughout pregnancy, childbirth, and the postpartum period.	Centers for Medicare and Medicaid Services, National Provider Identifier file
Certified midwife	A midwife who meets specific educational and certification requirements to provide care to women during pregnancy, childbirth, and the postpartum period.	Centers for Medicare and Medicaid Services, National Provider Identifier file
Family physician	A doctor trained to care for common and chronic illnesses among both children and adults with an emphasis on person-centered care and general well-being.	American Board of Family Medicine
Federal poverty level	Measure used by the federal government to determine eligibility for certain programs and benefits based on income.	US Census Bureau, American Community Survey
Maternity care desert	A county with no birthing facilities or obstetric clinicians.	March of Dimes
Obstetrician-gynecologist	A physician (MD or DO) specializing in women's health, particularly in pregnancy, childbirth, and disorders of the reproductive system.	Health Resources and Services Administration, Area Health Resources File
Obstetric hospital	A hospital with a dedicated maternity ward or labor and delivery unit.	American Hospital Association, Annual Survey
Prenatal care	Healthcare services provided to pregnant individuals to monitor pregnancy and ensure the health of mom and baby.	National Center for Health Statistics, Natality file

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State of the U.S. Maternal Health Workforce, 2025

December 2025

The United States has a high maternal mortality rate compared to other high-income nations (Gunja et al., 2023). Furthermore, as many as 60,000 U.S. women each year experience severe maternal morbidity, resulting in short- or long-term health problems (Declercq & Zephyrin, 2021). This brief provides data on the maternal health workforce, including information on demographics and comparisons to the female population of childbearing age. The purpose of this data is to assist policymakers and other stakeholders in analyzing the maternal health workforce and developing workforce education, training, and other programs to improve maternal health outcomes.

About the National Center for Health Workforce Analysis

The National Center for Health Workforce Analysis informs public and private sector decision makers on health workforce issues by expanding and improving health workforce data, disseminating workforce data to the public, and improving and updating projections of the supply and demand for health workers.

For more information, visit the [Health Workforce Analysis](#) webpage.

Data

Various datasets were used by the National Center for Health Workforce Analysis (NCHWA) to prepare this brief. Data covers 50 states and Washington, DC, unless otherwise noted. Sources and reference years are noted with each data point. Workforce data are presented as counts of health care providers unless otherwise noted.

Definitions

For this brief, the maternal health workforce includes physicians specializing in family medicine, general internal medicine, obstetrics and gynecology (OBGYN), and neonatology or perinatal health, as well as licensed and employed nurse midwives and registered nurses (RNs) in women's health or with a maternal or perinatal specialization who have patient care responsibilities. While doulas play an important and expanding role in maternal care, data on the number of doulas in the United States is not readily available. As such, doulas are excluded from the discussion of the size of the maternal health workforce below. Similarly, maternal care coordinators are important sources of information about care options and assist women with connecting with maternal health care providers. However, data on the number of care coordinators is also not readily available.

The size and composition of the maternal health workforce

- More than 306,000 physicians (family medicine, general internal medicine, OBGYN, and neonatal and perinatal medicine) and approximately 201,000 nurses (nurse midwives and RNs specializing in gynecology, obstetrics, labor and delivery, or neonatology) are considered part of the maternal health workforce (Table 1).

Table 1. Enumeration of Current Maternal Health Workforce in the United States

Family medicine physicians ^a	124,049 (2023)
General internal medicine physicians ^b	130,483 (2023)
Obstetrics and gynecology (OBGYN) physicians	45,790 (2023)
Neonatal and perinatal physicians	6,463 (2023)
Nurse midwives ^c	14,540 (2024)
Maternal health registered nurses (RNs) ^d	200,733 (2021)

Note. Data for physicians is adapted from the *American Medical Association's (AMA) Physician Professional Data*, 2023. Data includes both MDs and DOs and excludes residents. Data for nurse midwives is adapted from the *2024 Demographic Report*, by the American Midwifery Certification Board (<https://www.amcbmidwife.org/docs/default-source/default-document-library/2024-demographic-report.pdf>). Data for RNs is adapted from the *National Sample Survey of Registered Nurses (NSSRN)*, by the Health Resources and Services Administration, 2022 (<https://data.hrsa.gov/topics/health-workforce/nursing-workforce-survey-data>). ^a Excludes geriatrics subspecialties. ^b Includes all internal medicine subspecialties, except cardiology, endocrinology, gastroenterology, geriatrics, hematology and oncology, infectious disease, nephrology, pulmonology, and rheumatology. ^c Total reflects the number of certified nurse-midwives and certified midwives. ^d Consists of employed and licensed nurse midwives and RNs specializing in gynecology, obstetrics, labor and delivery, or neonatology with patient care responsibilities. RNs include advanced practice registered nurses (APRNs), which are nurse practitioners, certified nurse midwives, clinical nurse specialists, and nurse anesthetists.

- While the maternal health workforce is expected to grow over the next decade, there is projected to be a shortage of physicians in family medicine and general internal medicine in primary care as well as OBGYN physicians in women's health in 2038, based on current utilization patterns (Table 2). Assuming current patterns of care use continue in the future, there is a projected surplus in nurse midwives, nurse practitioners, and physician assistants in women's health services, after accounting for anticipated demographic changes.
- Meanwhile, the number of women of childbearing age is projected to grow from 76.5 million in 2023 to 77.9 million in 2038, an increase of 1.4 million (Table 3).

Table 2. Projected Surplus or Shortage for the Maternal Health Workforce, 2038

Family medicine physicians (primary care)	(39,060)	76%
General internal medicine physicians (primary care)	(20,660)	83%
Obstetrics and gynecology (OBGYN) physicians (women's health)	(7,660)	86%
Nurse midwives (women's health)	4,610	140%
Nurse practitioners (women's health)	9,260	205%
Physician assistants (women's health)	3,250	196%

Note. Adapted from the *National Center for Health Workforce Analysis (NCHWA)'s Workforce projections, Primary care and women's health*, by the Health Resources and Services Administration, 2025 (<https://data.hrsa.gov/topics/health-workforce/workforce-projections>). Projections reflect the impact of the COVID-19 pandemic. Demand and supply estimates and projections are in full-time equivalents (FTEs), defined as working 40 hours a week. Percent adequacy is calculated as projected supply divided by projected demand.

Table 3. Women of Childbearing Age (15-49 Years Old) in the United States, Selected Years

2023	76,533,440
2030 (projected)	77,811,406
2038 (projected)	77,939,248

Note. Adapted from the *Annual estimates of the resident population for selected age groups by sex for the United States: April 1, 2020 to July 1, 2024*, by the U.S. Census Bureau, 2025 (<https://www.census.gov/data/tables/time-series/demo/popest/2020s-national-detail.html>) and the *2023 national population projections datasets: Projected population by single year of age, sex, race, and Hispanic origin for the United States: 2022 to 2100, Main series*, by the U.S. Census Bureau, various years (<https://www.census.gov/data/datasets/2023/demo/popproj/2023-popproj.html>).

The geographic distribution of the maternal workforce

- In 2023, 10,139,368 women lived in U.S. counties with no OBGYN physicians, 4,043,632 of whom are of childbearing age (15-49 years old). This accounts for 6.0% of all women and 5.3% of women of childbearing age in the United States (AMA, 2023; Census, 2025).
- Maternal health physicians tend to be more concentrated in large and medium metropolitan areas than the female population of childbearing age (Table 4). As of 2023, 3.6% of internal medicine physicians and 4.1% of OBGYNs were located in micropolitan and noncore areas (i.e., areas with a population less than 50,000), compared to 10.2% of females ages 15-49. In contrast, the percent of family medicine physicians in micropolitan and noncore areas was similar to the percent of the female childbearing population within those areas. However, family medicine is a broad specialization that includes maternal health as well as other types of health care.
- In 2038, the supply of OBGYN physicians in metro areas is projected to meet 89% of demand. For nonmetro areas, that figure is 54% (HRSA, 2025).
- Analysis of 2014-2019 data from the National Plan and Provider Enumeration System (NPPES) and the American Board of Family Medicine finds there are 12.8 family physicians providing obstetrical services per 100,000 women of childbearing age across the U.S. This ratio is higher for family physicians practicing in nonmetropolitan areas (34.4), particularly noncore areas (49.0), than for their peers practicing in metropolitan areas (9.8) (WWAMI Rural Health Research Center, 2020).

Table 4. Rurality of Maternal Health Physicians Compared to Female Population of Childbearing Age (15-49 Years Old), 2023

Large metropolitan area	27.2%	38.5%	37.0%	40.9%	30.9%
Medium metropolitan area	37.5%	42.1%	41.6%	45.4%	36.5%
Small metropolitan area	24.4%	15.9%	17.3%	12.3%	22.4%
Micropolitan area	9.6%	3.4%	4.0%	1.3%	9.2%
Noncore area	1.2%	0.2%	0.1%	0.05%	1.0%

Note. Adapted from the American Medical Association's (AMA) *Physician Professional Data*, 2023, and the *Annual county and Puerto Rico municipio resident population estimates by selected age groups and sex: April 1, 2020 to July 1, 2024*, by the U.S. Census Bureau, 2025 (<https://www.census.gov/data/tables/time-series/demo/popest/2020s-counties-detail.html>). Data includes both MDs and DOs and excludes residents. Numbers may not add to 100% due to rounding. Rurality based on the National Center for Health Statistics' Urban-Rural Classification Scheme. Large metropolitan areas are counties with a population of 1,000,000 or more. Medium metropolitan areas are counties with a population between 250,000 and 999,999. Small metropolitan areas are counties with a population between 50,000 and 249,999. Micropolitan areas are counties with a population between 10,000 and 49,999. Noncore areas are counties with a population less than 10,000. Rurality designations for Connecticut counties in the AMA Physician Professional Data used 2021 U.S. Census resident county estimates, due to the adoption of Connecticut's nine planning regions within the U.S. Census resident county estimates starting in 2022.

Patient care time among maternal health registered nurses

- Maternal health RNs generally spend a greater percentage of their time on patient care than RNs with other specialties. In 2021, licensed and employed RNs and APRNs with a maternal health specialty spent an average of 70.0% of their time on patient care, compared to an average across all RNs with patient care responsibilities of 63.7% (HRSA, 2022). In fact, the maternal specialties (gynecology, obstetrics, labor and delivery, and neonatology) are among the top five clinical specialties in terms of the average percent of time spent on patient care (Table 5a).

Table 5a. Registered Nurse Clinical Specialties with Highest Percent of Time Spent on Patient Care, 2021

Labor and delivery or neonatology	70.7%
Gastrointestinal	70.5%
Surgery, preoperative, postoperative, post-anesthesia care unit (PACU) or anesthesia	70.0%
Obstetrics and gynecology (OBGYN)	69.1%
Critical care or intensive care	67.1%

Note. Adapted from the *National Sample Survey of Registered Nurses (NSSRN)*, by the Health Resources and Services Administration, 2022 (<https://data.hrsa.gov/topics/health-workforce/nursing-workforce-survey-data>). Data consists of employed and licensed RNs with patient care responsibilities, including advanced practice registered nurses (APRNs), which are nurse practitioners, certified nurse midwives, clinical nurse specialists, and nurse anesthetists.

Table 5b. Registered Nurse Clinical Specialties with Lowest Percent of Time Spent on Patient Care, 2021

Assisted living or nursing home	40.1%
Infectious or communicable disease	41.7%
Long term care	43.7%
Gerontology	45.5%
Occupational health	47.8%

Note. Adapted from the *National Sample Survey of Registered Nurses (NSSRN)*, by the Health Resources and Services Administration, 2022 (<https://data.hrsa.gov/topics/health-workforce/nursing-workforce-survey-data>). Data consists of employed and licensed RNs with patient care responsibilities, including advanced practice registered nurses (APRNs), which are nurse practitioners, certified nurse midwives, clinical nurse specialists, and nurse anesthetists.

Conclusion

While the maternal health workforce is expected to grow over the next decade, there is projected to be a shortage of physicians in family medicine and general internal medicine in primary care as well as OBGYN physicians in women's health in 2038. Maternal health physicians tend to be more concentrated in large and medium metropolitan areas than the female population of childbearing age. As such, shortages are projected to be larger in rural areas.

Given the projected shortages in maternal health physicians and the maldistribution of the maternal health workforce across states and counties, it is important to focus on workforce issues, such as recruitment, placement, and retention, as well as ways to encourage maternal health care providers to locate to under-resourced areas.

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MEMORANDUM

TO: Colleen McCarthy Reid, Principal Analyst, Office of Policy and Legal Analysis

FROM: Kristina Lunner, Deputy Commissioner, Department of Professional & Financial Regulation (DPFR)

CC: Penny Vaillancourt, Director, Office of Professional and Occupational Regulation
Tim Terranova, Executive Director, Board of Licensure in Medicine
Amanda Boulay, Assistant Executive Director, Board of Nursing

DATE: August 25, 2026

RE: Licensing Information re: Maternal Health Care

We appreciate the Committee's interest in obtaining information from the Department of Professional and Financial Regulation (DPFR) on whether there are any licensing or other regulatory barriers within the jurisdiction of DPFR's licensing boards that prevent licensed health professionals from providing maternal labor and delivery services in hospital settings.

We have attached information from the three relevant DPFR licensing boards. Two of the licensing boards, the Board of Licensure in Medicine (BOLIM)¹ and the Board of Nursing (BON), are "affiliated" with the Department. The Board of Complementary Health Care Providers is one of 37 licensing entities within the Office of Professional and Occupational Regulations (OPOR).

Penny Vaillancourt, Director of OPOR, Tim Terranova, Executive Director of BOLIM, and Amanda Boulay, Assistant Executive Director of BON, and I will be attending the Committee's Interim Meeting on Thursday, August 27th in person if you or the HCIFS Committee has any questions or additional requests for information.

¹ Information for the Board of Osteopathic Licensure is included in the information from the Board of Licensure in Medicine

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
& FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION

Janet T. Mills
Governor

Joan F. Cohen
Commissioner

Board of Complementary Health Care Providers

Fact Sheet

The Board of Complementary Health Care Providers (Board) issues licenses to qualified applicants seeking to practice as a certified midwife and as a certified professional midwife. Below is licensure data, qualifications for licensure, scopes of practice, and other relevant information.

a. Licensing Data

1 – actively licensed Certified Midwife (Maine address)

44 – actively licensed Certified Professional Midwives (33 Maine addresses)

b. Licensing Qualifications

License Type	Education	National Certification
Certified Midwife	Completion of a graduate program in midwifery that is accredited by the Accreditation Commission for Midwifery Education (ACME) Link: https://theacme.org/	Current certification from the National Midwifery Certification Board as a certified midwife. Link: https://www.amcbmidwife.org/
Certified Professional Midwife²	Completion of a formal midwifery education and training program this is accredited by the Midwifery Education Accreditation Council (MEAC) Link: https://www.meacschools.org/	Current certification from the North American Registry of Midwives (formerly the National Reigstry of Midwives) Link: https://narm.org/

² For applicants who were nationally certified prior to January 1, 2020 and who completed a program that was not accredited may qualify with evidence of a midwifery bridge certificate issued by the North American Registry of Midwives. Link: <https://narm.org/>

c. Definitions and Scope of Practice

Midwifery means “providing primary health or maternity care to women and infants. Midwifery includes consultation with or referral to medical and other health care providers when indicated by client health care needs.” 32 M.R.S. § 12501 (6-C).

- Certified Midwives scope pursuant to 32 M.R.S. § 12537
 - Standards – must follow national standards and those set by the Board
 - Order and interpret medical laboratory tests, perform ultrasound scanning and other equipment supplies for safe practice
 - Prescriptive authority except Schedule II drugs
 - Subject to Board Rules Chapter 6-B
 - Certified midwives primarily practice in hospitals, clinics, and offices, and may practice in birth centers, homes, and emergency care settings. Certified midwives may consult, refer, or transfer to licensed allopathic or osteopathic physicians, or other licensed health professionals as necessary for the client’s health or safety in accordance with professional judgment.
- Certified Professional Midwives pursuant to 32 M.R.S. § 12535:
 - Standards – must follow national standards and those set by the Board
 - Order and interpret medical laboratory tests, perform ultrasound scanning and other equipment supplies for safe practice
 - Administrative drug authority: drug formulary set by Board rule. Cannot include Schedule II, III or IV drugs.
 - Subject to Board Rules Chapter 6-A
 - Certified professional midwives primarily practice in homes, birth centers, clinics, and offices, and may also practice in hospitals, and emergency care settings. Certified professional midwives may consult, refer, or transfer to licensed allopathic or osteopathic physicians, or other licensed health professionals as necessary for the client’s health or safety in accordance with professional judgment.

d. Reporting Forms

Pursuant to 32 M.R.S. § 12539, all licensed midwives are required to report annually information regarding cases in which the midwife assisted during the previous calendar year when the intended place of birth at the onset of care was an out of hospital setting.

e. Other

At its October 14, 2026 meeting, the Board has tentatively scheduled an informational session with Amy Belisle, MD, MBA, MPH, Chief Child Health Officer, who is working with the Office of MaineCare Services on an initiative entitled “Perinatal Transitions in Maine: Data, Gaps, and Solutions” which is part of advancing the Transforming Maternal Health (TMaH) Model. Link: <https://www.maine.gov/dhhs/oms/about-us/tmah-model>

The Board of Licensure in Medicine

Fact Sheet

The Board of Licensure in Medicine (BOLIM) was asked to provide information regarding the licensure and training of physicians with the ability to provide labor and delivery services. BOLIM licenses allopathic physicians (MD) and grants a license to practice medicine. It does not issue specialty specific licenses. Physicians normally choose an area of medicine they wish to pursue and complete a residency in that area following graduation from medical school.

The following information contains current licensure statistics and some basic information regarding training.

- Current Licensees who have designated their specialty as Obstetrics and Gynecology (Please note that not all these licensees may be practicing obstetrics.)
 - Allopathic
 - 306 active licensees
 - 166 with a Maine address
 - Osteopathic (Numbers from the Board of Osteopathic Licensure)
 - 77 active licensees
 - 43 with a Maine address
 - Total
 - 383 active licenses
 - 209 with a Maine address
- Specialties that are generally considered able to deliver as part of their scope of practice
 - Obstetrics and Gynecology
 - Family Practice
 - Issues that may impact the decision to participate in labor and delivery include
 - Liability
 - On call duties
 - Work/life balance
 - Additional stress
- Education
 - Medical School (MD)
 - Every student does a rotation (4 weeks) through Obstetrics and Gynecology

Office Location: 161 Capitol Street Augusta, ME 04330
Mailing Address: 137 State House Station, Augusta, Maine 04333
www.maine.gov/md

- Graduate Medical Education
 - Three pathways that may include Obstetrics and Gynecology training
 - 1st year transitional or intern year
 - Can include an Obstetrics and Gynecology rotation
 - Family Practice
 - Includes rotations in Obstetrics and Gynecology
 - Obstetrics and Gynecology
 - Other specialties are not likely to have rotations in OBGYN
 - Pediatrics may “stand by” but are not normally part of the delivery process.

STATE OF MAINE
BOARD OF NURSING
158 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0158

JANET T. MILLS
GOVERNOR

KIM ESQUIBEL, PHD, M.S.N., R.N.
EXECUTIVE DIRECTOR

Board of Nursing

Fact Sheet

The State Board of Nursing is the state regulatory agency charged with protection of the public health and welfare in the area of nursing service.

The board issues, renews, reinstates and reactivates licenses. The Board issues the following types of licenses:

- Registered Nurses (28,985 Active licensees)
- Licensed Practical Nurses (1,546 Active licensees)
- Advanced Practice Registered Nurses: (Total – 5,829 Active Licenses)
 - Certified Nurse Practitioners (4,960 Active licensees)
 - Certified Nurse Midwives (132 Active licensees)
 - Certified Registered Nurse Anesthetists (685 Active licensees)
 - Clinical Nurse Specialists (52 Active licensees)

Total Active Licensees: **36,360 Active Licenses**

a. Licensing Data

- Total CNP licenses: 4,960
 - Certified Nurse Midwife
 - 132 Active licenses
 - 102 with Maine address
 - Family Nurse Practitioner
 - 3280 Active Licenses
 - 1554 with Maine address
 - Women's Health Nurse Practitioner
 - 93 Active Licenses
 - 55 with Maine address
 - Other unrelated specialties:
 - Psychiatric Mental Health Nurse Practitioner
 - Adult Certified Nurse Practitioner
 - Pediatric Nurse Practitioner

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OFFICES LOCATED AT: 161 CAPITOL ST., AUGUSTA, ME
www.maine.gov/boardofnursing

- Neonatal Nurse Practitioner
- Clinical Nurse Specialist

b. Definitions and Scope of Practice (Board Rules Chapter 8)

Certified Nurse Practitioner (CNP) is a registered professional nurse who has received post-graduate education designed to prepare the nurse for advanced practice registered nursing in a practice category that has a defined scope of practice and has been certified in the clinical specialty by a national certifying organization acceptable to the Board.

The certified nurse practitioner shall provide only those health care services for which the certified nurse practitioner is educationally and clinically prepared, and for which competency has been maintained. Such health care services, for which the certified nurse practitioner is independently responsible and accountable, include:

- (1) obtaining a complete health database that includes a health history, physical examination, and screening and diagnostic evaluation;
- (2) interpreting health data by identifying wellness and risk factors and variations from norms;
- (3) diagnosing and treating common diseases and human responses to actual and potential health problems;
- (4) counseling individuals and families;
- (5) consulting and/or collaborating with other health care providers and community resources; and
- (6) referring clients to other health care providers and community resources

Concerns with working outside of formal education include liability and patient risk.

Certified Nurse Midwife (CNMs) is formally educated and certified to provide care during pregnancy, childbirth and the postpartum period.

A CNM is a registered professional nurse who has received post-graduate education in a nurse-midwifery program approved by the American College of Nurse-Midwives and who has passed the national certification examination administered by the American Midwifery Certification Board or its successors, the former American College of Nurse- Midwives or the American College of Nurse-Midwives Certification Council, Inc. (ACC).

A CNM may provide only those health care services for which the CNM is educationally and clinically prepared and for which competency has been maintained. The CNM is authorized to function to the full extent of the midwife education, training and competency within the population focus and scope of practice. Such health care services for which the CNM is independently responsible and accountable include:

- (1) primary health care services for women from adolescence to beyond menopause;
- (2) primary health care of the newborn up to age 28 days;
- (3) primary maternity care, including preconception care, and care during pregnancy, childbirth and the postpartum period; and
- (4) provision of gynecological and family planning services, and treatment of sexually transmitted diseases in male and female patient contacts.

Family Nurse Practitioner (FNP) is educationally prepared, certified, and licensed to provide primary care services, in all settings, to individuals and families, from birth to end of life. They also offer basic preventive and wellness screenings including that can screen for early pregnancy and coordinate primary care.

Women's Health Nurse Practitioner (WHNP) practice as primary care nurse practitioners (NPs), caring for women starting at menarche and continuing through the lifespan as well as providing reproductive health care for men. The emphasis of their role includes care delivery including "wellness promotion, care of women's common primary care nongynecological problems, gynecologic care, male sexual and reproductive health, and normal and high risk prenatal and postpartum care." The scope of practice for these NPs excludes care during childbirth.

Licensed Practical Nurse and Registered Nurse licensure is generalized and allows practice on maternity wards.

Licensed Practical Nurse (LPN) - The practice of "practical nursing" means performing tasks and responsibilities, by a licensed practical nurse, for compensation within a structured health care setting, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician, podiatrist or dentist. [32 M.R.S. § 2102\(3\)](#)

Registered Nurse (RN) - The practice of "professional nursing" means the performance by a registered professional nurse for compensation of professional services defined as follows:

- A. Diagnosis and treatment of human responses to actual or potential physical and emotional health problems through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being and execution of the medical regimen as prescribed by a legally authorized licensed professional acting within the scope of the licensed professional's authority to prescribe medications, substances or devices or otherwise legally authorized individual acting under the delegated authority of a legally authorized licensed professional acting within the scope of the licensed professional's authority to prescribe medications, substances or devices:
 - (1) "Diagnosis" in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. This diagnostic privilege is distinct from medical diagnosis;
 - (2) "Human responses" means those signs, symptoms and processes that denote the individual's health needs or reaction to an actual or potential health problem; and
 - (3) "Treatment" means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen;
- B. Delegation of selected nursing services to licensed practical nurses when the services use standardized protocols and procedures leading to predictable

outcomes in the observation and care of the ill, injured and infirm; in the maintenance of health; in action to safeguard life and health; and in the administration of medications and treatments prescribed by an individual authorized by state law to prescribe.

- C. Delegation of selected nursing services to assistants to nurses who have completed or are currently enrolled in a course sponsored by a state-approved facility or a facility licensed by the Department of Health and Human Services. This course must include a curriculum approved by the board. The board shall issue such rules concerning delegation as it considers necessary to ensure quality of health care to the patient;
- D. Supervision and teaching of nursing personnel;
- E. Administration of medications and treatment as prescribed by a legally authorized individual. Nothing in this section may be construed as limiting the administration of medication by licensed or unlicensed personnel as provided in other laws;
- F. Teaching activities of daily living to care providers designated by the patient and family; and
- G. Delegation of specific nursing activities and tasks to be provided by unlicensed assistive personnel. This paragraph may not be construed to require a nurse to delegate or permit a person to coerce a nurse into delegating, specific nursing activities and tasks in any care setting against the nurse's professional judgment or to prohibit a nurse in the exercise of the nurse's professional judgment from refusing to delegate specific nursing activities and tasks in any care setting. [32 M.R.S. § 2102\(2\)](#)

**132nd LEGISLATURE
JOINT STANDING COMMITTEE ON HEALTH
COVERAGE, INSURANCE AND FINANCIAL SERVICES**

August 27th Interim Committee Meeting

**Written Comments Submitted Prior To Meeting
(as of 8am 8/27/26)**

August 24, 2026
Joint Standing Committee on Health Coverage, Insurance, and Financial Services
Maine State Legislature
Re: Birthing unit closures

Dear Joint Standing Committee on Health Coverage, Insurance and Financial Services,

For the past 6 years, numerous organizations in Maine have collaborated to understand and address the challenges in sustaining obstetrics units. To date, there have been at least 21 recent reports focused on improving maternal health and healthcare access in our state. Many of these have been produced as part of comprehensive maternal health programs, including the RMOMs initiative, the State Maternal Health Innovations grant, and PCQ4ME. We write as public health professionals to share a summary of these reports and highlight key recommendations we believe may be useful to the committee.

We encourage the legislature to consider developing a plan for maintaining access to obstetric care services within 30 minutes for most and 60 minutes for almost all Maine residents, an evidence-based benchmark for ensuring safety. This will require substantial support to grow the workforce and advance new models of care.

Below we offer 8 recommendations that appear in at least two of the reports and which support this vision of access. At the end, we provide a reference list of the 21 existing reports as well as two national reports on obstetric unit sustainability. We believe this demonstrates the breadth of work that has already been conducted and encourages policymakers to enact actionable, impactful legislation.

We also want to alert you that our group of public health professionals is collaborating on a policy brief that explores these recommendations more deeply, including how the legislature can more specifically support these recommendations. We are in the early stages of this work and look forward to sharing it with you when it is complete this fall.

Common recommendations across existing Maine reports, 2020-2026:

- **Support rural hospitals in partnering with Federally Qualified Health Centers to staff obstetrics units and provide prenatal care.** Providers at FQHCs get malpractice coverage, and patient visits are reimbursed at a higher federal rate. FQHCs are also located across the state, including in rural communities.
- **Expand the workforce of trained family medicine doctors who can perform C-Sections** by supporting fellowships in Maine and establishing a formal, standardized credentialing process across all hospitals.
- **Expand the workforce of Certified Nurse-Midwives**, and ensure they are able to practice to the full extent of their scope at every Maine hospital.
- **Establish programs for OB nurses** from small, low-birth-volume hospitals to participate in clinical immersions at Maine's busiest obstetrics units so they get hands-on practice with serious complications that occur rarely at smaller hospitals.

- **Create a Maine-based, traveling-provider program and/or regional ‘float pool’** to cover staffing gaps at rural hospitals on a short-term basis. Providers in the pool would receive extra pay and lodging and return to the same hospitals on a regular basis, enhancing continuity of care and decreasing burnout among regular providers.
- **Expand phone/video access for rural providers to high-risk pregnancy and newborn specialists;** allocate funding to ensure sustainability and reach to all hospitals.
- **Require hospitals that are closing a maternity unit to write a formal transition plan** that includes how patients will be transitioned to other providers, and how the hospital will train and prepare for any deliveries that may arrive at their doors.
- **Negotiate with Maine's dominant malpractice insurance company (Medical Mutual) to revisit rules regarding** trial of labor and vaginal birth after a prior C-section [TOLAC/VBAC], and family doctors performing C-sections. Currently, malpractice insurance rates for these delivery options are restrictive for rural hospitals.
- **Ensure that emergency room staff at hospitals without obstetrics units and paramedics serving these areas receive regular training,** practice drills, phone/video access to specialists, and clear step-by-step instructions for handling birth emergencies.

We look forward to sharing details about legislative strategies for implementing these recommendations, and welcome open discussion to further identify evidence-backed solutions. A summary of Maine-based reports is attached.

Sincerely,

Gianna DeJoy, PhD, MSSW
 Brianna Keefe-Oates, PhD, MPH
 Kristen Kinchla, MPH
 Katherine Simmonds, PhD, MPH, RN, WHNP-BC, FAAN
 Louisa Smith, PhD
 Sarah Tewhey, MPHc

Maine & Regional Obstetric Access and Maternal Health Reports 2020-2026

A summary of Maine-based reports and feasibility studies focused on maternal health, relevant to rural obstetric unit closures in Maine. Titles link to reports.

Workforce/healthcare system assessments:

1. **Rural to Referral: Assessing the Obstetric Workforce Landscape in the State of Maine** (2025)
Keefe-Oates, Simmonds, Smith & Stollow, Roux Institute (Northeastern University)/MaineHealth/RMOMS Network
Examines Maine's rural obstetric workforce landscape through 15 interviews at 6 major referral hospitals and 8 key informant interviews with staff at 3 hospitals that recently closed their OB units. Provides recommendations for care coordination and referrals, workforce training strategies, and a formal closure-consultation process.
2. **Maine's Rural Maternity Crisis: A Policy Agenda** (2025)
Dora Anne Mills, published in Maine Policy Review
Synthesizes Maine state data and national research literature. Provides recommendations across 7 policy domains including financial stability, workforce diversification, and telehealth.
3. **Certified Nurse Midwifery Training in Maine: A Feasibility Study** (2025)
Sally Weiss, Maine Hospital Association (Funded through the Maine RMOMS grant)
Assesses the feasibility of a new CNM training program through 3 stakeholder convenings and a survey of 14 Maine birthing hospitals (79% response rate).
4. **Feasibility Study: Rural Nurse Immersion Program in Obstetrics** (2025)
Sally Weiss, Maine Hospital Association (Funded through the Maine RMOMS grant)
Assesses the feasibility of a nurse immersion training program through surveys of low-volume and high-volume Maine birthing hospitals, and provides a ready to implement two-track training model with a template hospital affiliation agreement.
5. **Needs Assessment of the Obstetric Workforce in Maine's Rural Hospitals** (2024)
Roux Institute (Northeastern University) / MaineHealth / Maine RMOMS Network
Assesses obstetric workforce sustainability at Maine's 15 rural birthing hospitals through key informant interviews with hospital administrators/staff and analysis of workforce and community data. Provides recommendations for interventions at the provider, hospital, and state levels.
6. **Building Maine's Perinatal System of Care: Table of Roadmap Findings and Actions Currently Underway or For Future Consideration** (2024) (Follow up to report below)
PQC4ME / Maine Medical Association Center for Quality Improvement
Tracks progress on findings in the 2023 Roadmap through a statewide survey. Provides updated recommendations across access, workforce, data, and policy, including a proposal to require a formal patient transition plan before an OB unit closure.
7. **Building Maine's Perinatal System of Care: A Roadmap for the Future** (2023)
Perinatal Quality Collaborative for Maine (PQC4ME) / Maine Medical Association Center for Quality Improvement

Assesses the current state of Maine's perinatal system of care. Provides recommendations for strengthening regional coordination, workforce, telehealth, and rural hospital financial stability.

8. **Understanding and Addressing the Drivers of Infant Mortality in Maine** (2020)

Qualidigm (lead author Katherine Flaherty)

Examines the drivers of Maine's rising infant mortality rate through analysis of Vital Statistics and PRAMS data plus 34 key informant interviews. Provides recommendations across 7 strategic areas including workforce, perinatal regionalization and program coordination, and access to care in areas affected by OB unit closures.

Patient experiences, assessments, and recommendations to improve patient care:

9. **Experiences with Perinatal Mental Health in Maine: Themes and Recommendations around Education, Screening, Referrals, and Treatment** (2026)

PQC4ME, funded via HRSA/Maine Maternal Health Innovation Fund

Examines perinatal mental health screening and referral experiences through 13 individual interviews and 2 language-specific focus groups with 28 immigrant and rural Maine residents (Sept-Dec 2025), and provides 28 recommendations across screening practices, provider training, and interpreter access.

10. **Perinatal Mental Health in Maine** (2025)

Maine Center for Disease Control and Prevention (Maine CDC)

Reviews perinatal mental health prevalence, disparities, and access to care through analysis of PRAMS, MFIMR case reviews, BRFSS, and hospital discharge (MHDO) data, and provides 8 recommendations including universal screening and a maternal psychiatric consultation line for providers.

11. **Using Maps to Visualize the Impact of Obstetric Unit Closures Across Maine's Counties (MPHA Conference Poster)** (2025)

Andrea Lenartz & Fleur Hopper, Maine CDC / University of Southern Maine

Maps county-level changes in drive-time access to obstetric units through GIS analysis of Census population data and Maine birth certificate records (2015 vs. 2025 comparison), identifying Waldo, Washington, Aroostook, and Oxford Counties as the hardest-hit.

12. **Mothers' Experiences and Ideas for Improving Perinatal Care in Maine** (2023)

Elizabeth Winterbauer, PQC4ME / Maine Medical Association Center for Quality Improvement

Gathers perinatal care experiences and patient-education feedback through focus groups and interviews with 40 pregnant/postpartum mothers across 4 community partner organizations, and provides recommendations for standardizing hypertension education and improving EMS/perinatal system coordination.

13. **2023 Maine Perinatal Health Disparities Needs Assessment** (2024)

Market Decisions Research/Maine Center for Disease Control and Prevention

Examines perinatal health disparities in Maine through interviews, a quantitative analysis of perinatal health indicators, a workforce capacity evaluation, and community landscape mapping. Finds persistent disparities affecting Black/African American and American Indian populations. Recommends expanding doula and community health worker services, improving interpretation access, adding patient advocacy programs, increasing midwife availability, strengthening statewide data collection.

14. **Racial Disparities in Prenatal Access in Maine (2022)**

Permanent Commission on the Status of Racial, Indigenous, and Tribal Populations (PCRITP)

Explores the effects that racism, structural barriers, the social determinants of health, and community and cultural norms have in creating barriers to maternal health.

Recommends supporting community-led data gathering, investing in relational care and addressing structural inequities.

The following reports (15-21) are produced by Maine's Center for Disease Control and Prevention on a yearly basis to examine maternal and infant deaths and make recommendations to reduce mortality. These statutorily required reports are based on reviews and recommendations by the Maternal, Fetal, and Infant Mortality Review Panel (MFIMR):

15. **Maine's Maternal, Fetal, and Infant Mortality Review Panel 2024 Annual Report (2025)**

2025 recommendations included supporting mental health programs, substance abuse support programs, and addressing social determinants of health.

16. **MFIMR Panel Recommendations to the Public, July 2023-December 2024 (2024)**

Compiles findings from the MFIMR Review Panel's clinical case review of 22 maternal/fetal/infant deaths (July 2023-Dec 2024), and provides 97 recommendations across 21 themes, prioritizing mental health, substance use, and cultural/linguistic support. Also recommends improving funding for EMS response and training.

17. **Maine's Maternal, Fetal, and Infant Mortality Review Panel 2024 Annual Report (2024)**

Recommendations cluster around three themes: mental health (universal prenatal screening, safety plans with warm handoffs), substance use (universal screening, naloxone distribution, more rural rehab access), and cultural/linguistic support (statewide peer navigators, culturally appropriate mental health services) and a cross-cutting push to reduce healthcare stigma through staff training and patient advisory councils.

18. **Maternal, Fetal, and Infant Mortality Review Panel 2023 Annual Report (2023)**

Issues 43 recommendations covering safe care plans, family support networks, provider education, and panel composition.

19. **Maine Maternal, Fetal, and Infant Mortality Review Panel 2022 Annual Report (2022)**

Based on four completed case reviews, it recommends expanded substance use treatment access, safe sleep initiatives, improved care coordination, and better fetal-death data collection.

20. **Maine Maternal, Fetal and Infant Mortality Review Panel 2021 Annual Report (2021)**

Recommends greater maternal-fetal medicine involvement, stronger provider coordination, expanded substance use treatment access, and a peer review process for home births.

21. **Maine Maternal, Fetal and Infant Mortality Review Panel Annual Report, 2020** (2020)

Sets FY2021 priorities including a national FIMR data-registry agreement, expanded home-interview and bereavement-referral programs, coordination with the Child Death and Serious Injury Review Panel, and broader Panel Coordinator access to records (including EMS, mental health, and substance use treatment records).

The following two are national reports focused on sustaining maternity care that provide valuable solutions:

22. **Sustaining Rural Labor & Delivery Programs: Strategies for Financial Analyses and Considerations for Maintaining Services** (2025)

Eric Shell, Dahlia McGrath, Jeff Sommer, Kristie Thompson, Megan Lahr & Kristin Reiter, Flex Monitoring Team (University of Minnesota / UNC Chapel Hill / University of Southern Maine)

Develops a financial-analysis guide from real hospital case studies drawn from prior consulting engagements, informed by a 2024 Rural Maternity Innovation Summit, and recommends correcting Medicare cost report allocations before deciding to close obstetric services.

23. **Stopping the Loss of Rural Maternity Care (December 2025 update)** (2025)

Center for Healthcare Quality and Payment Reform (CHQPR)

Analyzes 2024 hospital cost report data for rural labor & delivery hospitals nationwide, ranking Maine as having the 2nd-highest closure rate of any state since 2020, and recommends standby capacity payments and reformed delivery-fee structures.

Written Testimony to the Joint Standing Committee on Health Coverage, Insurance and Financial Services

August 27, 2026

Re: Legislative Opportunities to Preserve and Strengthen Rural Maternity Care in Maine

Senator Bailey, Representative Mathieson, and Members of the Committee:

On behalf of the **Maine Section of the American College of Obstetricians and Gynecologists (ACOG)**, thank you for the opportunity to provide written comments as the Committee considers what Maine can do to prevent further loss of maternity services and preserve access to safe maternity care across the state.

Maine does not need to start from the beginning.

Over the past several years, considerable work has already been done to understand the challenges facing rural maternal and perinatal care in Maine. This includes the *Needs Assessment of the Obstetrical Workforce in Maine's Rural Hospitals* and subsequent *Rural to Referral* work, *Building Maine's Perinatal System of Care: A Roadmap for the Future*, the *Maine Perinatal Health Disparities Needs Assessment*, work addressing maternal and neonatal transport, and the Maternal, Fetal and Infant Mortality Review process.

These efforts have identified many of the same challenges: workforce shortages, financial instability of low-volume services, increasing travel distances, difficulties with recruitment and retention, the need for regional systems of care, transportation and transfer challenges, and the importance of maintaining access to prenatal and postpartum care.

We therefore believe that the next phase of this work should increasingly focus on **implementation**.

At the same time, Maine has an unusual opportunity. Significant state and federal resources are currently being directed toward rural health and maternal health transformation. These investments provide opportunities to develop new workforce models, regional partnerships, telehealth infrastructure and alternative approaches to financing care.

Legislation can help ensure that these efforts become part of a durable statewide system.

We offer the following areas for consideration as the Committee begins thinking about potential legislation.

1. Establish an Early-Warning, Stabilization and Recovery Process

Maine's advance notice requirement for maternity service closures is important. However, by the time a hospital formally decides to close a birthing unit, many opportunities to preserve that service may already have been lost.

Maine should develop a system that identifies vulnerable maternity services **well before closure is imminent**.

Hospitals and health systems could be required or strongly encouraged to notify DHHS or an appropriate statewide collaborative body when significant indicators suggest that a birthing unit may become unsustainable within the following 12–24 months.

Warning signs could include persistent workforce vacancies, difficulty maintaining call coverage, increasing dependence on temporary staffing, declining volume, loss of anesthesia or other essential supporting services, financial instability, recurring service interruptions, or the anticipated departure of clinicians essential to maintaining the service.

This process should be designed to encourage early disclosure rather than punish it.

Hospitals need a **safe and appropriately confidential mechanism for saying, “We are worried about the future of this service and need help,” without that request itself creating fear in the community, causing patients to leave, or making recruitment and retention even more difficult.**

Early notification could trigger a multidisciplinary stabilization process involving the hospital, the state, regional partners and practicing clinicians. Together they could evaluate the specific reasons the service is vulnerable and identify potential solutions, including temporary workforce assistance, shared staffing or call arrangements, FP-OB or midwifery models, regional anesthesia solutions, telehealth support, recruitment assistance and temporary stabilization funding.

The existing 120-day notice should therefore become the **final safeguard rather than the beginning of the problem-solving process**.

If closure ultimately cannot be prevented, the process should also require a **continuity and recovery plan**. That plan should address preservation of prenatal and postpartum care, emergency obstetric readiness, EMS and transfer relationships, and the conditions that would need to change for delivery services to become viable again.

Where reasonably possible, hospitals should avoid dismantling infrastructure in ways that make future restoration of maternity services unnecessarily difficult.

A temporary workforce or financial crisis should not automatically result in the permanent loss of maternity care from a community.

2. Establish a Rural Maternity Care Stabilization Program

Low-volume obstetric services face a fundamental financial problem: the cost of maintaining the capacity to safely deliver a baby 24 hours a day does not disappear simply because fewer babies are delivered.

Hospitals must maintain trained staff, emergency surgical capability, anesthesia availability, neonatal resuscitation capability, equipment and other resources regardless of delivery volume.

Traditional volume-based reimbursement does not adequately recognize the cost of maintaining this essential readiness.

The Legislature could establish a **Rural Maternity Care Stabilization Program** providing targeted support to geographically essential maternity services.

Eligibility could take into account distance and travel time to the next birthing hospital, financial vulnerability, regional need and the consequences of closure for patients, EMS, surrounding hospitals and communities.

Funding could be tied to participation in regional planning and a willingness to explore collaborative staffing, alternative workforce models and other approaches to maintaining safe care.

This could provide immediate support while Maine continues to develop longer-term and more sustainable approaches to financing rural maternity care.

3. Strengthen Maine's Rural Maternity Workforce — Including FP-OBs

Maine cannot preserve rural maternity care without addressing the current issues with workforce shortages. Recruitment incentives, loan repayment, tuition support and retention programs can all help. But simply producing or recruiting more clinicians is not sufficient if appropriately trained clinicians subsequently encounter barriers that prevent them from practicing the skills for which they have been trained.

This is particularly important for **family physicians with enhanced obstetric training (FP-OBs)**.

Family physicians have historically been an important part of the rural maternity workforce. In many rural communities, maintaining an exclusively OB/GYN-based workforce may simply not be realistic. Appropriately trained family physicians can provide prenatal care and deliveries and, with additional training and demonstrated competency, cesarean delivery and other obstetric services.

Yet FP-OBs **do encounter significant barriers** in obtaining hospital credentials and privileges.

Credentialing requirements can vary considerably among hospitals and health systems. Requirements based upon specialty designation, procedure volume or training pathway can effectively exclude a family physician despite additional obstetric training and demonstrated competency.

There can also be cultural and professional bias regarding whether family physicians "should" provide obstetric care, particularly cesarean delivery.

This deserves explicit attention.

The American College of Obstetricians and Gynecologists and the American Academy of Family Physicians have jointly stated that hospital privileges should be based on training, experience and demonstrated current competence and that physicians should be held to the same standards regardless of specialty. Their joint policy specifically addresses obstetric care and cesarean delivery.

Maine should examine whether its credentialing and privileging environment reflects that principle.

The Legislature could direct the appropriate state agencies, licensing boards, hospitals, health systems and professional organizations to develop a **consistent, transparent and competency-based framework for obstetric credentialing and privileging**.

Hospitals must retain responsibility for credentialing and patient safety. But the fundamental principle should be straightforward:

Privileges should be based upon a clinician's education, training, experience and demonstrated competency, not simply based on the specialty through which that clinician was trained.

This is particularly important as Maine invests in programs designed to train family physicians for rural obstetric practice. There is little value in investing public and institutional resources in creating an FP-OB workforce if those physicians subsequently cannot obtain the privileges necessary to use those skills.

This is not about replacing OB/GYNs with family physicians. ACOG is acutely aware that workforce needs vary considerably across hospitals and regions. Larger referral centers and well-staffed obstetric practices may have different staffing models and may not rely on FP-OB physicians in the same way that smaller rural hospitals do. The goal is not to promote a single model of maternity care for every setting, but rather to ensure that communities have access to the workforce model that best meets local needs.

Maine needs OB/GYNs, family physicians, midwives, anesthesia professionals, nurses, pediatric clinicians and other professionals working together.

It is about ensuring that **every appropriately trained clinician who can safely contribute to rural maternity care is able to do so.**

4. Sustain Emergency Obstetric Readiness and Training in Rural and Low-Volume Settings

Maine is already doing important work to improve readiness for obstetric emergencies in rural hospitals, emergency departments and low-volume birthing units. This includes simulation training, emergency preparedness, skills maintenance and efforts to strengthen the ability of clinicians and teams to respond when an obstetric or neonatal emergency occurs.

The issue is not simply creating more programs. It is **sustaining the good work that is already being done.**

Many of these efforts have been developed or expanded through time-limited grant funding. Yet simulation and skills maintenance are not one-time interventions. Staff change, skills deteriorate when they are infrequently used, and hospitals without birthing units must remain prepared for obstetric emergencies indefinitely.

The Legislature should consider mechanisms to provide **ongoing, sustainable funding for successful obstetric and neonatal emergency-readiness programs after current grant funding ends.**

ACOG specifically recommends frequent multidisciplinary drills and simulation in rural and low-volume settings, periodic clinical experience at higher-volume regional facilities, ready access to consultation and strong regional referral and transport relationships.

Rather than repeatedly developing successful programs with short-term grants and allowing them to disappear when the funding ends, Maine should identify which programs are working and establish mechanisms to sustain them.

Emergency obstetric readiness is not a temporary project. It is an ongoing responsibility of a regional maternity system.

5. Build a Statewide Real-Time Emergency TeleOB Consultation System

Maine already has important telehealth programs supporting maternal and neonatal care.

These include remote blood-pressure monitoring, nutritional and gestational diabetes support, expanding maternal mental health services, and access to maternal-fetal medicine consultation. These programs are important and should continue to be supported and expanded.

However, the program we are proposing addresses a different need: **real-time, emergent TeleOB consultation.**

As distances to maternity services increase, clinicians caring for pregnant patients need rapid access to obstetric expertise when an unexpected or potentially serious obstetric situation occurs.

A statewide emergency TeleOB system should **never be viewed as replacing an obstetric clinician at the bedside**, nor should it be used as justification for removing local obstetric services.

Its purpose would be to provide immediate support to an **emergency physician caring for an obstetric patient in a hospital without obstetric services**, or to clinicians in a struggling rural birthing unit that is temporarily on diversion or does not have its usual obstetric resources immediately available.

Real-time consultation with an obstetric clinician could assist with assessment, medical management and stabilization, clinical decision-making, and determining whether transfer is necessary and what level of care is required.

Just as importantly, expert consultation may help determine when transfer is not necessary and a patient can safely remain in the local community.

Teleconsultation can never replace the OB clinician at the bedside. It can, however, provide critical support to the ER physician or rural clinician faced with an obstetric emergency without immediate access to obstetric expertise.

Maine also does not need to build all of the necessary infrastructure from the ground up.

There is already important experience and infrastructure through Maine's neonatal **MedNet** program, which allows real-time neonatal consultation with clinicians caring for newborns in community hospitals. This can help determine which newborns may need a transfer to a higher level of neonatal care and which babies can safely remain in their local hospital, thus avoiding the significant disruption and expense associated with transfer and tertiary hospitalization.

A maternal emergency consultation system could build upon the infrastructure and lessons of this existing neonatal model to create a complementary maternal capability.

Real-time emergency obstetric teleconsultation is also not an untested concept. Programs elsewhere have demonstrated how specialists at tertiary centers can use real-time telemedicine to support clinicians caring for obstetric patients in rural and community settings. The Mayo Clinic has been among the institutions developing and using telemedicine approaches to extend obstetric expertise beyond the walls of the tertiary medical center.

Maine has an opportunity to build on what is already working here and elsewhere to create a **24/7 statewide emergency TeleOB resource**.

The goal is straightforward: when an emergency physician or rural maternity clinician is faced with a difficult obstetric situation, **expert obstetric support should be immediately available regardless of geography**.

6. Strengthen Maternal Transport and Transfer

Regionalization only works if patients can reliably reach the appropriate level of care.

Maine has already done considerable work addressing maternal and neonatal transport. The next step should be ensuring that the resulting system functions consistently across the state.

Legislation could support a coordinated maternal transport framework with clear regional transfer relationships, rapid access to accepting facilities, appropriate EMS training and reimbursement, and mechanisms for consultation during difficult transfer decisions.

A clinician caring for an unstable pregnant patient in a rural emergency department should not have to spend critical time making repeated telephone calls trying to find a hospital willing and able to accept that patient.

Transport should be considered an integral component of Maine's maternity system—not something that begins only after local care has failed.

7. Preserve Prenatal and Postpartum Care Close to Home

Loss of a birthing unit should not automatically mean loss of maternity care from an entire community.

Even when delivery must occur at a regional hospital, **prenatal and postpartum care should remain available locally whenever possible.**

This is particularly important for patients who would otherwise need to travel more than an hour—or in some parts of Maine considerably farther—for routine prenatal visits.

Requiring patients to make those trips repeatedly throughout pregnancy creates a significant barrier to care. Transportation, weather, work, child care and the cost of repeated long-distance travel can all make it less likely that patients receive adequate prenatal care.

Ensuring access to prenatal care close to home makes it more likely that patients will receive appropriate and consistent care throughout pregnancy, which in turn contributes to better maternal and infant outcomes.

Legislation could support enhanced reimbursement, grants or alternative payment models allowing **FQHCs, rural health clinics, family medicine practices, certified nurse-midwives, visiting obstetric clinicians and telehealth-supported practices** to provide prenatal and postpartum care locally while maintaining a formal clinical relationship with the hospital where delivery will occur.

The goal should be to ensure that **distance from a delivery hospital does not also become distance from prenatal care.**

Local prenatal care also provides an important opportunity for **risk assessment and advance planning**.

The local prenatal provider, working collaboratively with the hospital where delivery is planned, can identify patients who may require a higher level of care, determine when earlier transfer of care or relocation closer to the delivery hospital may be appropriate, and develop individualized plans for patients who face particularly long travel times.

Planning should also recognize the reality that some patients may go into labor or experience an obstetric emergency before they can reach the planned delivery hospital.

For patients living substantial distances from a birthing hospital, the prenatal provider could help develop an individualized emergency plan. Depending upon the patient's circumstances and geography, this might include identifying the closest emergency department, when to call EMS, where to go if travel to the planned delivery hospital is no longer safe, and providing appropriate emergency supplies or a delivery kit when clinically indicated.

These plans could be developed collaboratively among the patient, the local prenatal provider, the planned delivery hospital and, when appropriate, local EMS or the nearest emergency department.

Preserving prenatal care close to home therefore does more than reduce travel. It improves access to care while allowing patients and clinicians to plan thoughtfully and safely for delivery when the birthing hospital is a significant distance away.

8. Strengthen Community-Based Maternal Services

A sustainable maternity system extends beyond the walls of a birthing hospital.

Maine's previous perinatal work has identified needs involving home visiting, maternal mental health, community-based support, care coordination and access to services.

Legislation can strengthen these supports through sustainable funding for home visiting, doulas and community health workers; improved access to perinatal behavioral health services; and better connections between community providers and clinical maternity care.

These services become even more important as hospital-based maternity services become increasingly regionalized.

9. Build a Durable Regional Perinatal System of Care

Ultimately, Maine cannot solve the rural maternity crisis hospital by hospital.

A sustainable system needs to connect birthing hospitals, hospitals without birthing units, tertiary referral centers, OB/GYNs, FP-OBs, midwives, FQHCs, pediatric and neonatal services, anesthesia, EMS, home visiting, behavioral health and community-based services.

Regional planning should also include the clinicians actually providing care. Practicing physicians, midwives, nurses, EMS professionals and other frontline clinicians need meaningful involvement early in decisions affecting how care will be delivered.

Importantly, **this regional work is already being developed through Maine's Transforming Maternal Health (TMAH) initiative**. Rather than creating a separate or competing structure, legislation should support and strengthen this work and help establish the sustainable infrastructure necessary for it to continue.

The Legislature can help create a durable framework for this regional system while allowing the clinical details to be developed by those providing and receiving care.

The goal should be to ensure that this regional infrastructure **remains after individual grant programs end**.

Moving From Assessment to Implementation

These proposals will require further development, fiscal analysis and collaboration among DHHS, hospitals, health systems, clinicians, EMS and communities.

But Maine does not need another broad assessment simply to establish that rural maternity care is under strain.

The work already done gives us a foundation from which to act.

We encourage the Committee to consider **these overarching legislative priorities**:

1. Identify vulnerable birthing units early and prevent avoidable closures.

Create an early-warning system, intervene before closure becomes inevitable, provide stabilization resources and preserve the possibility of restoring services when closure cannot be avoided.

2. Address the financial vulnerability of rural maternity care.

Develop financing mechanisms that recognize the cost of maintaining essential 24/7 maternity capacity in geographically important low-volume hospitals.

3. Build and fully utilize Maine's rural maternity workforce.

Recruit and retain clinicians while addressing credentialing and privileging barriers that prevent appropriately trained FP-OBs and other professionals from practicing to their demonstrated capabilities.

4. Sustain safe care and emergency readiness in rural communities.

Provide sustainable funding for successful simulation, skills-maintenance and emergency-readiness programs rather than allowing essential infrastructure to disappear when individual grants end.

5. Make regionalization safe.

Build on existing infrastructure to provide real-time emergency maternal teleconsultation, EMS and maternal transport systems appropriate to increasing distances from birthing hospitals.

6. Preserve maternity care close to home.

Maintain prenatal, postpartum, behavioral health and community-based services locally even when delivery must occur elsewhere.

7. Build a durable regional system.

Strengthen the regional work already underway through TMaH and create a structure in which hospitals, clinicians, EMS, community providers and the state identify problems and develop solutions together.

The Legislature does not need to determine the clinical details of Maine's maternity system. Those decisions should be developed collaboratively by clinicians, communities, hospitals, health systems, DHHS and other stakeholders.

The Legislature can, however, create the **financial, regulatory and organizational infrastructure necessary to allow those solutions to succeed.**

Maine has spent years identifying the challenges facing rural maternity care.

The next phase should be implementation.

Thank you for your consideration and for your attention to the future of maternity care in Maine.

Respectfully submitted,

Maine Section American College of Obstetrics & Gynecology

Shannon L. Carr MD MS, Chair

Rebecca Hunt MD, Vice Chair

Anne Marie van Hengel MD, Secretary-Treasurer

Comments from Ashlynn Ward, RN
Health Care, Insurance, and Financial Services Committee Interim meeting
August 27, 2026

Good morning members of the committee,

My name is Ashlynn Ward. I am a registered nurse, and I work in Labor and Delivery at Northern Light Eastern Maine Medical Center in Bangor and I'm a member of the Maine State Nurses Association. I am here today not only as a nurse, but as someone who sees firsthand what happens when access to maternity care disappears. I have lived and worked in Maine for just three and a half years and have seen four Labor and Delivery units in Maine close in that short period of time. Four closures in that short amount of time is not a trend we should see as inevitable, but one we see as a warning. One community loses its unit, then another, and another. Every time a hospital closes its doors to laboring patients, the remaining hospitals are expected to absorb those patients, those births, and those emergencies.

We cannot continue to treat these closures as isolated decisions made by individual hospitals. They are not isolated. When a Labor and Delivery unit closes in one part of Maine, it changes the entire maternal health system. Maine has lost 11 birthing units in the past decade, and we are continuing to see closures and proposed closures. The given reasons for the closures are all the same excuses: low birth volume, difficulty recruiting and retaining staff, financial pressures, and the inability to maintain 24/7 coverage.

But I want this committee to understand something from the perspective of a nurse working in one of the hospitals that remains open. When one hospital closes its birthing unit, the problem does not just disappear. That problem just gets moved somewhere else. At Eastern Maine Medical Center, we care for patients from across a huge geographic area. We are a referral center. We care for complicated pregnancies and emergencies, but we also care for people who simply need a safe place to have their baby. As more communities lose their local Labor and Delivery services, more patients are traveling to hospitals like EMMC. That means longer drives for pregnant patients. It means delivering outside of their community and safety net. It means patients arriving farther into their labor. It means more people who may not have easy access to transportation, childcare, time off from work, or the financial ability to travel hours for prenatal and postpartum care. And it means more pressure on the nurses, physicians, midwives, anesthesiologists, neonatal teams, and support staff who are already stretched.

We cannot solve a perceived workforce and financial problem by continually concentrating patients into fewer hospitals. At some point, the hospitals that remain open will reach their own limits. And as a nurse, that concerns me deeply. Shutting down Labor and Delivery services in a community is not like closing a clinic. A patient can walk through the doors with a completely normal pregnancy and, within minutes, develop a hemorrhage, experience placental abruption, have a baby in distress, or require an emergency cesarean section. You cannot schedule an emergency. That is why having trained staff, anesthesia,

operating rooms, newborn care, and emergency services available before the emergency happens matters.

Maine LD 2189, "An Act to Require Prior Notification of Closures of Labor and Delivery Units and Changes in Maternity or Newborn Care Services by Hospitals" requires hospitals to provide at least 120 days advance notice before closing a birthing unit. But notification is not the same thing as protection. Telling the community that a hospital is closing its Labor and Delivery unit does not prevent the closure. It does not protect the patient. It does not protect the baby. It does not create a nurse. It does not create an obstetrician. It does not create capacity at a hospital further down the road.

We need to be asking, "What would it take to keep these units open?" This should not be up to the individual communities, this should be a statewide strategy and fight. We need meaningful investment in obstetric trained physicians and nurses, midwives, anesthesia providers, and pediatric providers. We need to look at reimbursement and recognize that maintaining a 24/7 emergency maternity service has fixed costs that cannot be supported simply by counting the number of deliveries. We need regional models that allow smaller hospitals to share resources, provide backup coverage, develop stronger transfer systems, and support our rural providers. Most importantly, we need to stop looking at Labor and Delivery as a service that should survive only if it can make enough money. Compassion may not pay the bills, but it can save a life. When we reduce maternity care to a balance sheet, we lose sight of what that balance sheet really represents. The balance is made up of mothers, babies, families and communities.

Until Maine gets all of those strategies in place to protect labor and delivery units, we ask that you institute a moratorium on labor and delivery unit closures, combined with funding to support hospitals in genuine financial need to keep their labor and delivery units open. We also ask that any state funds that go to support hospitals include a condition requiring that the hospital keep their labor and delivery unit open.

No one ever asks whether a fire department puts out enough fires to justify keeping it open. We don't ask whether an emergency department sees enough trauma patients to justify having one. It's understood that those services must exist because when you need them, you need them immediately. That is exactly how we should think about emergency maternity care. Maternity care is not a luxury service. It is essential healthcare.

I ask this committee to not just study the prior closures. I ask that they study how to prevent the next one. And most importantly, fund it.

Thank you,
Ashlynn Ward

McCarthyReid, Colleen

From: Anne Fanelli <anne.fanelli630@gmail.com>
Sent: Tuesday, August 25, 2026 10:59 AM
To: McCarthyReid, Colleen
Subject: Comments on Labor and Delivery Closures

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This message originates from outside the Maine Legislature.

Hello,

My name is Anne Fanelli Bailey and I am currently an OB nurse at Lincoln Hospital, formerly known as Miles. I have been an OB nurse at Miles for over 2 years.

I wanted to provide some insight to the maternity closure crisis in Maine as someone on the front lines. Unfortunately, I am not able to speak in person on this issue as I am working on August 27th.

I could discuss public health statistics, best practice guidelines from AWHONN, ACOG, ACNM, and the AAP, and evidence about the economic ramifications of closing birthing centers, but I am positive the Miles Delivers Action Coalition has already provided you with this information.

I could provide you with Miles maternity's exemplary quality and safety reports which are some of the best, if not the best in the entire MaineHealth system. Additionally, we have the highest patient satisfaction scores of any OB unit in the MaineHealth system.

I want to discuss my experience as a young professional in Maine. My husband grew up in Newcastle and as long as we have been together he has wanted to move back to Maine and raise our family in the Midcoast. In order to achieve that goal, I earned my Masters in Nursing from Johns Hopkins University where I tailored my education to become an OB nurse with the hopes of becoming a Certified Nurse Midwife (CNM) at some point in my career. In my final semester of nursing school I received job offers from the labor and delivery units at Johns Hopkins Hospital in Baltimore and Holy Cross Hospital in DC. I turned these offers down to work at Miles. Not only did I want to put roots down in Maine, but I believe the care provided at Miles is exceptional and has the potential to be a blueprint for rural maternity care throughout the country. The closure at Miles has made me stop any efforts to continue my OB education or become a CNM as my job prospects continue to dwindle. Closing OB units due to staffing shortages will only perpetuate these staffing shortages.

There is constant discussion about a labor shortage in Maine but this is not because young people do not want to live and work in Maine. My husband and I are proof of that. There are plenty of medical providers who would love to come work in midcoast Maine. I believe alternative staffing solutions and models were not thoroughly investigated by administrators in MaineHealth because their ultimate goal was to close maternity services in favor of services that have higher reimbursement rates. I believe MaineHealth created our "staffing problem" as reason to close the maternity unit without admitting their financial reasonings. Additionally, since I have started at Miles 2 years ago our nursing staffing has been stable.

Let me be clear, labor and delivery units will continue to close in favor of more profitable service lines until legislation is put in place requiring non-profit hospital to offer these services.

On a personal note, as a woman in my reproductive years living in Lincoln County the closure of Miles maternity is absolutely devastating. I recently found out I am pregnant and the next closest hospital to me is unable to see me for an initial prenatal appointment until I am approximately 14 weeks pregnant due to their increase in patient volume. The standard of care for an OB intake visit is 8-10 weeks per ACOG. Not only will I have delayed initiation of prenatal care, my commute to the closest delivering hospital went from 18 minutes to 40 minutes. In what should be an exciting time for my husband and I, I am not only losing my job but my access to timely OB care. I am scared for my personal health, the health of my child, and the health of those in my community.

While it may be too late for Miles, I urge the legislature to prevent further closure in our state for the safety and health of all in Mainers.

Sincerely,
Anne Fanelli Bailey, MSN, RN, CLC

Committee on Health Coverage, Insurance and Financial Service

Interim Committee Meeting 8/27/26 at 10 am

Dale J Gordon
Caribou, Maine
8/24/26

Dear Senator Bailey, Representative Mathieson and Honorable Members of the Committee on Health Coverage, Insurance and Financial Service:

My name is Dale Gordon and I am a family and emergency nurse practitioner with 45 years of practice in the central Aroostook area. It is with alarm that I have seen obstetrical and maternal health services at Fort Kent, Houlton and now, Lincoln, eliminated. That results in women having an hour or more drive or Lifeflight for services. Emergencies in obstetrics, like hemorrhages, happen quickly resulting in dangerous deliveries on the roadside, in cars or in emergency rooms without 24 /7 access to anesthesia, OR or OB services. Already Maine has an infant mortality of 5.7/1000 (66 infants) births, highest in NE and a maternal mortality between 56-81/10,000 births.

I recognize the difficulty recruiting obstetricians and the negative financial impact facing rural hospitals already straining under the Big Beautiful Bill. The fact is that ER, OB, and pediatrics will never be profit making centers for any hospital but remain vitally important for the community. Certain services must be mandated (ER is) to protect the health and wellness of the community in spite of running in the red. I strongly support universal health care but, in the meantime, providing and funding these services is of the utmost importance, before a tragedy and lawsuit highlight the need.

Finally, as you know our aging demographics indicate Maine needs to retain and recruit young families to meet our employment needs and grow our economy. It will be impossible to recruit or entice young families to rural Maine in the absence of safe OB and pediatric care.

Thank you for the opportunity to share my perspective with the committee.

Dale J Gordon, ENP-BC, FNP- BC
Emergency and Family Nurse Practitioner
BA, MSc(A) CAS

McCarthyReid, Colleen

From: nicole flores <nicoleflores@hotmail.com>
Sent: Tuesday, August 25, 2026 5:48 PM
To: McCarthyReid, Colleen
Subject: L&D closures

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This message originates from outside the Maine Legislature.

Dear Ms. McCarthy Reid,

I am writing to ask politicians to stay out of this issue and to NOT demand a moratorium. It makes great press to demand that they not close, but far better is to stop and fully understand the issue and the consequences. Miles Hospital hasn't had an OB/GYN in 5 years. This is not safe for delivering mothers. Filling this position with per diem or traveling physicians is incredibly expensive and does not ensure consistent care or a person who knows the community and its patients. How is demanding that a hospital keep a unit open, okay when they can't staff it, when the staff practices their skills so infrequently that they lose those skills or haven't seen certain situations in a long time, a safe option? I lost a wonderful OB/GYN in my community because it wasn't feasible for her to raise children where she was on call every 4 days, and this is in a busier area. Instead, she has chosen to go elsewhere, with a larger practice and community where she is on call every 13 days. This is the challenge in recruiting and keeping OB/GYNs - they don't want to put in so many "on call" days, or they want to use their skills and practice more. I don't consider a 40 minute drive tragic for great care. I drove at least that far, on highways in NJ to deliver each of my children. Do the women demanding this L&D unit stay open understand the risks they face in a facility that isn't busy or using skills frequently? I find all of this short sided and selfish - a moratorium on these expensive units will cost everyone else and even jeopardize other types of care. What other specialties will be cut to fund the one you have demanded stay open? Please take a look at the data and facts and beyond emotion with this issue.

Yours,
Nicole Flores

McCarthyReid, Colleen

From: Stephanie Nelson <stephanie@heliakos.com>
Sent: Wednesday, August 26, 2026 3:38 PM
To: McCarthyReid, Colleen
Subject: Moratorium on Labor and Delivery closures in Maine

ALERT This email looks suspicious and may have been automatically generated. Be careful as this is likely spam. If you disagree, mark as Safe/Phishing using the Outlook Add-In. Powered by CyberSentriq.

This message originates from outside the Maine Legislature.

To the Colleen McCarthy Reid and the Committee on Health Coverage,

I'm writing in support of an immediate moratorium on Labor and Delivery closures in Maine hospitals, including the planned closure at Miles campus in Damariscotta. Maine cannot afford to have one more labor and delivery unit close. Health outcomes for local mothers and babies will suffer if our Miles Campus labor and delivery closes.

I live in Newcastle, just across the river from Miles Campus. I would like my children to be able to have their babies close to home in the safest possible way. .

Our state's aging population depends on families being able to stay in Maine and other young people being able to move to here. Labor and delivery closures affect the entire community, not just young families. Dismantling Labor and Delivery, dismantles the community.

It's more important than ever to safeguard women's health given the cuts in federal funding and the attacks on women's health care all over the country. Let's keep Maine "the way life should be" and keep mothers and babies safe here at home.

Stephanie Nelson
10 Pleasant St.
Newcastle, ME 04553
207-563-1849



Sustaining Inpatient Obstetric Services

August 26, 2026

Dear Honorable Members of the Health Coverage, Insurance and Financial Services Committee,

We are writing to express concern and provide testimony to diminish the chances of any additional rural hospital obstetric (OB) unit closures. We are the leadership team of the Northern New England Perinatal Quality Improvement Network (NNEPQIN). NNEPQIN's mission, since our founding in 2003, has been to collaboratively improve perinatal health across Maine, New Hampshire and Vermont in partnership with our 37 member hospital sites. This collaborative model encourages dissemination of best clinical practices and collective problem solving on regional challenges such as OB closures. This work provides us a unique lens on the challenges facing smaller rural OB services. While we understand that small rural hospitals face significant financial pressures, it is crucial to understand the importance of sustaining a geographically diverse, high quality system of rural OB care. We recognize that involved organizations do not make these decisions lightly. We want to ensure accurate consideration of the essential nature of these services along with the immediate and long-term effects such a closure decision will have on the viability of a health care facility and the communities left without access to OB care.

Quality of Care

Concerns regarding the quality of care in low-volume OB units are understandable, but the number of births at an institution does not determine the level of quality. Quality care depends on several factors, including staffing, continuing education, active participation in quality improvement efforts and integration with a system of care supporting appropriate consultation and transfers. Data referencing specific volume varies widely in the criteria applied and lack of exploring a system level approach – making it impossible to surmise a specific, “magical number”. From what we know, the teams across Maine including midwives, obstetricians, nurses, and other staff, work diligently to meet state and regional quality metrics. Teams are engaged in quality improvement work through multiple state and regional initiatives that create a collaborative responsibility and provide technical assistance such as education and clinical simulation training. Additional funding and policy to support these efforts across the state could be part of a multi-tiered approach to sustain quality at lower volume sites.

Following the closure of an OB department, pregnant patients will continue to seek urgent care in the emergency department or other areas of the facility given the burden of an extended drive time exceeding 30 minutes for many families. It's impossible to fully eliminate the need for urgent OB services in an isolated, rural community. The Emergency Department is not an appropriate option for any routine care. The absence of specialized inpatient OB services places additional pressure on remaining staff to handle obstetric emergencies, which can compromise the quality of care. The ripple effect on remaining staff is unpredictable and often leads to moral injury then burnout and potentially dangerous situations which undermines the core principles of patient-centered care. Another supportive policy option would be to ensure already isolated Emergency Department services have access to on demand telemedicine consult support if an OB case presents at their site.

The Value of Maintaining an OB Service

While it's often assumed that OB services are financially burdensome, it's important to recognize the broader financial impact these services have on a hospital. The value of maintaining an OB unit extends far beyond the revenue generated from childbirths. OB services provide a range of ancillary benefits and support, including access to prenatal care, pediatric services, and postnatal support, all of which generate revenue for a hospital. Most importantly, an obstetric service helps build strong, lasting relationships with patients and their families, creating a "healthcare home" that encourages them to seek out all of their healthcare needs at a facility for years to come. The potential closure of the OB unit would disrupt this relationship, risking the loss of future patient visits and a long-term, sustainable patient base.

Economic and Social Impact of Closing OB Services

Research consistently shows that the closure of obstetric services in rural hospitals has a negative long-term impact on the local economy. A key consequence is the decline in young families choosing to settle in the area, which reduces the influx of new residents and limits the community's growth potential. For a rural community to thrive, it needs a steady population of young families, many of whom make healthcare decisions based on the availability of local OB services. Without these services, families are likely to seek care in more urban centers, which ultimately undermines the local economy and long-term sustainability of the region. The closure of this essential service not only jeopardizes the health of the community, but could have far-reaching social and economic consequences, especially as younger families choose to move elsewhere.

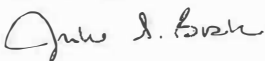
Conclusion

The potential closure of an obstetric unit has significant consequences for both the hospital and the community. The financial, social, and health-related impacts should not be underestimated. Preserving the OB unit is not just about maintaining an individual service—it's about ensuring the health of women and children in Maine's communities, the long-term sustainability of community hospitals and the financial future of rural communities. Thinking holistically about the context and policy that supports a robust system of care, while prioritizing these essential services, creates an opportunity for innovative approaches.

NNEPQIN has been working across our membership in the three Northern New England states to collaboratively prevent more closures. Multiple pro-active policy approaches are being explored that would provide additional financial support to lower volume hospitals located in crucial rural locations. Our Rural OB Access page on the website captures policy and research on this national issue. There are several resources that might be immediately relevant for addressing the financial challenges such as content from Maine Health colleagues on accurately capturing OB inpatient billing and a free financial and strategic consultation service provided through the National Rural Health Association focused on sustaining rural hospital services.

Thank you for your time and thoughtful consideration. We hope you will take the necessary steps to ensure that these essential services remain across Maine's healthcare system.

Sincerely,



Julie S. Bosak, DrPH, CNM, MSN
Executive Director, NNEPQIN



Emily Brayton, RN, BSN
Director of Operations, NNEPQIN



Ella Damiano, MD
Medical Director, NNEPQIN



Steve Ringer, MD, PhD
Medical Director, NNEPQIN

Aliza Wyman
Bridgton, ME
August 26th, 2026

Thank you for the opportunity to speak today.

My name is Aliza Wyman, I am the mother of two beautiful boys. I love them, however there is not a day that I wake up and don't think that that love has cost me everything. I would like to present to the committee a list of things I lost when I became a mother at twenty-three; the ability to leave the house for a year, the ability to make eye contact with people, my sense of well-being, the ability to write for two years. The ability to name my emotions. The ability to express my emotions honestly. The ability to walk into my own home without feeling like I need to take a shower before touching anything. My relationship with my college friends. The ability to sleep through the night. The ability to control anger. My self-esteem. The ability to walk into a grocery store without having a panic attack. The ability to make decisions for myself. The ability to transfer clothes from the washer to the dryer. My own sense of identity. I lost twelve weeks of pay when my second child was born because my job did not at that time provide for maternity leave. I lost my hope in my own future. Since I became a mother, I no longer think I am a good person.

While I was pregnant with my first son, I dreamed of snuggling an adorable infant. The reality of living with a newborn while my husband was at work all day was different. The reality was a bone-deep fear that wouldn't leave me be. Rather than being overwhelmed with love, I woke up each day, worried that he would die, that something I did would accidentally kill him and then I would have to swiftly dispatch my own suicide, because how could I live without him now that I had known him? By the time I had my second son two years later, I was so tired that

bonding with him was difficult. I felt completely burnt out and asked my husband multiple times if we could put him up for adoption (a request, he thankfully denied me).

As mothers, we are not encouraged to be honest. We are told to be grateful. We are told that whatever we get is our own fault because we chose to be mothers.

After seven years of independent searching, I have finally found a therapist. In becoming a mother I have gained anxiety, PTSD and depression. I am lucky, I have insurance, I have sitters I can leave my children with so I can go get the help I need. Not all women are so blessed.

The mothers of Maine should not have to wait seven years to get help when they feel something is not right. This is a waste of our humanity, this is a waste of Maine's human resources. Maternal mental health care should be readily available to those who need it.

Thank you for your time and consideration.

PROTECTING ACCESS TO PERINATAL CARE:

Policy Solutions for the Closure of Maine's Rural Birthing Units



Summary

Across the United States, birthing units continue to close at an alarming rate, limiting access to obstetric care for millions. Although unique in its rural geographic susceptibility, Maine is not the only state experiencing a rapid increase in the number of birthing units closing. Closures, both in Maine and nationwide, are most commonly cited as a consequence of declining birth rates, lack of obstetric providers, and hospital financial pressure.¹ When birthing units close and families are forced to drive further distances to deliver, there is a significant increase in adverse maternal outcomes and NICU admissions.²

The state of Maine has closed 12 birthing units since 2015.³ From 2014 to 2023, the average distance traveled to a birthing unit in Maine doubled when local birthing units closed. Overall, the average distance to a birthing unit in Maine increased by 138% from 9.3 miles to 22.2 miles in that same period.⁴ With more units threatening to close, there are no signs of headway being made to prevent continued closures.

The ongoing loss of rural birthing units in Maine not only threatens where babies can be delivered, but it also disrupts access to perinatal care, creates undue strain on nearby hospitals to accommodate an influx of deliveries, and threatens the health of Maine's rural families. The state of Maine must adopt policies to improve access to obstetric care for rural counties alongside mitigating the impact of closures when they do occur. This policy brief highlights several evidence-based policy recommendations to help strengthen and preserve access to perinatal care in Maine.

Recommendations

1. Expand Obstetric Training Through Funding from the State

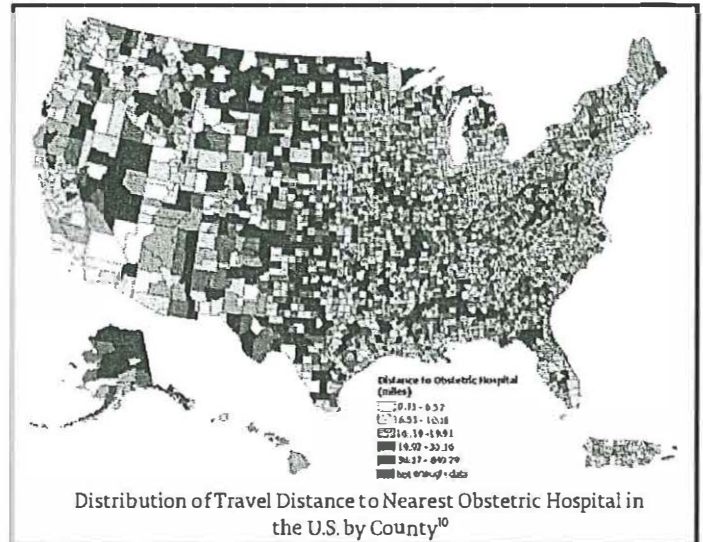
- Losing hospital-based obstetric services is linked to worse birth outcomes in rural areas^{11,12}
- The state could provide funding to rural hospitals for obstetric training opportunities for physicians with potential for longitudinal incentives (both financial and non-financial) to work in rural Maine after their training
- Increasing the number of obstetric training opportunities (i.e. family medicine obstetrics fellowship or dedicated rural Ob/Gyn residency tracks) can help keep obstetric services available closer to the patients' homes, it can reduce travel times, and can improve care for mothers and babies¹⁰
- This would help build a stronger workforce and improve access to care for pregnant patients across a largely rural state⁷
- Doctors who train in rural areas are better trained to meet the needs of rural communities and can continue to work in these areas after their fellowship, especially Family Medicine
- Those in rural areas face greater barriers to receiving maternity care and may have higher risks of poorer health outcomes¹³
- State funding could help cover the training costs of a fellowship along with housing or loan repayment for the doctors who are willing to commit to working in rural Maine after their fellowship





2. Expand Telehealth Coverage for Perinatal Services

- Rural families must travel longer distances than urban counterparts to reach obstetric units, therefore, when birthing units close, the burden to receive care increases⁷
- Long travel times can make it more difficult for people to receive needed care and may increase health risks for the individual and the baby⁸
- Maine legislators should require Medicaid and private health plans to cover telehealth visits for certain perinatal services
- Prenatal checkups, postpartum visits, mental health support, lactation support, and consultations with doctors and specialists are all examples of appointments that could be telehealth⁹
- Expanding telehealth could help people receive care sooner and stay connected with their health team
- Can help reduce the burden of long travel while improving access to care for mothers and babies¹⁰



Considerations

- Barriers to Implementation
 - It is generally difficult to plan and implement changes in the maternal healthcare landscape due to shortages in OB-trained physicians (Family Medicine and OB/Gyn) and because of limited state funding
 - Increasing MaineCare reimbursement rates and funding rural OB-GYN training programs would require long-term financial commitment
 - Telehealth expansion can be limited by internet access and technology costs
 - Keeping units from closing should be paramount, but safety and quality of birthing units should also be a priority when implementing solutions
- Key next steps
 - Identify rural hospitals that are at the highest risk of losing obstetric services, and what reasonable alternatives would look like for the communities
 - Cost will need to be estimated for each policy, including establishing long-term funding solutions as opposed to one-time funding
 - MaineCare, private insurers, hospitals, medical schools, and rural communities need to be involved in strategic planning
- Research Gaps
 - Which policies are most effective at preventing birth unit closures in Maine specifically?
 - Limited evidence on the long-term effects of state-funded rural OB-GYN training and how telehealth can safely replace in-person perinatal care
 - Expansion of cause/affect analysis data for the state of Maine's perinatal landscape over the past 5-10 years in the setting of an uptrend in closures

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McCarthyReid, Colleen

From: Mia Branco <miajbranco@gmail.com>
Sent: Wednesday, August 26, 2026 9:18 PM
To: McCarthyReid, Colleen
Subject: Regarding Labor & Delivery Unit Closures

ALERT This email looks suspicious and may have been automatically generated. Be careful as this is likely spam. If you disagree, mark as Safe/Phishing using the Outlook Add-In. Powered by CyberSentry.

This message originates from outside the Maine Legislature.

To Whom It May Concern,

Please don't let Labor & Delivery Units continue to close in our state. Having access to Labor & Delivery units is essential to the growth and well-being of our communities. It was certainly essential to my community. Now having MaineHealth vote to close our local Labor & Delivery unit at Miles Hospital, women in our community are having to consider that living here and choosing to have a baby, may be a Life & Death decision. This closure is a disastrous decision that will be felt for generations.

I had my first child, a son, at Miles Hospital in Damariscotta in July 2022. He was stillborn. I arrived at the hospital concerned that I had not felt him move for most of a day, and we were informed that we had lost him. Had there not been a local unit to stop into and receive assessment, we may have not known about this loss in a timely manner resulting in further issues to an already painful situation. When MaineHealth argued for closing Miles Labor & Delivery, it was cited that the maximum additional travel time to the next closest L&D unit would be 18 minutes. This is simply not true. Our commute would go from 15 minutes to 45 (with no traffic). It would have been difficult for me to justify taking off of work and driving 90 minutes round trip because of a concern that could have turned out to be nothing.

Our next child, our daughter, was born in August 2023. We were so lucky to be able to once again deliver at Miles Hospital surrounded by staff who knew our whole story and treated us with the tenderness and encouragement that we needed as we welcomed our daughter and still mourned for our son. I have no doubt that had we delivered at another hospital in Maine, the medical care we received would have been just as good. But we weren't just needing medical care, we were needing to be seen for the full circumstances and experience that growing our family had entailed.

The L&D unit at Miles is not just about numbers of babies born. It is about the relationships between doctors and women in what we hope will turn out to be the happiest moment of our lives but can also be the toughest journey to get there. It is essential to have this personalized care that is easy to access. For the well being of the parents, siblings, and all of our precious new babies, it is vital that these services remain available at Miles.

In just my case alone, having Miles meant that we learned of the loss of our son in a timely and humane manner. Having doctors, midwives, and L&D nurses who had gone through that loss with us meant that we had the best support possible for the emotionally and medically complicated

subsequent pregnancy and birth of our daughter. These relationships were essential to my family's health & well-being.

And now, after two miscarriages in 2025, I just gave birth to identical twins this past June also at Miles L&D. If I had not had close proximity to a hospital with a birthing center, my family would have to move somewhere else as it was essential that I was close to a facility during this pregnancy for the safety of the twins and myself.

Once again, delivering at a local facility with practitioners who knew me was an essential part of our babies well-being. The ultrasound tech who I had seen many times throughout my pregnancy heard I was upstairs laboring. She was leaving for the day and called up to L&D to see if a scan would be helpful before she left, as she knew that one of the babies had often been changing position during the pregnancy. Sure enough when she came up and did the scan, she found that Baby B had indeed spun around during my labor and become breech. Having this information allowed us to consider our options and change course to a c-section in a way that was controlled and non emergent.

I am just one story, and I know there are many other women in Maine with similar stories illustrating the value of close proximity to care as well as the importance of relationships within that care. Without a local option, lives will be in danger.

The above arguments alone should be enough to warrant intervention to keep L&D Units open, but there are also economic arguments to be made. If we do not have health care options for young families to safely grow their families, then this becomes a less desirable place for young families to take root. Our economy here is not sustainable without the influx of new families. If we make this area inhospitable to young families, it is a self-fulfilling prophecy. We will continue to be an aging demographic with struggling economic prospects.

These closures leave me fearful and feeling enormously devalued as a woman. Our local L&D unit has been so important to my family and its closure is very distressing. I recognize that these are tough times for rural hospitals, and tough decisions have to be made. But a service like an L&D unit where those in need of care are often needing time sensitive attention and a personal touch at a very scary and vulnerable time, proximity is key. It is essential to the community. What better investment is there than in the well-being of a baby being born?

In addition to the latest closure of Miles Hospital's Labor & Delivery unit being a devastating blow to the community that it served, it is another data point in a dangerous trend taking hold in this state. In a state that has made great efforts to appeal to young families and encourage them to build their lives in Maine, closing L&D units does nothing to help this.

In the case of our L&D unit closing, it was repeatedly stated that the closure was not due to finances but because regionalizing services would better serve the community and address chronic staffing issues. Regionalizing L&D services may make things easier and more streamlined for MaineHealth but it does not make things better for their patients. This is clearly a decision of convenience not of care and they should be ashamed. It is essential that legislators intervene and right this wrong.

We look back proudly at the citizens, administrators, and physicians who worked to establish L&D units across the state. Please don't let us be the generation responsible for closing them. We all know that once they are gone, these essential services will not return. We watch storms erode our shorelines - These closures are an erosion of our communities. We can't choose whether a storm

comes our way, we can choose whether or not we close Labor & Delivery units. Without local Labor & Delivery, having a baby in Maine becomes an issue of Life & Death.

Our local unit has been an essential part of growing our family here in the Midcoast. Please do what you can to keep these services available to all who want to grow their family safely in Maine.

Thank you,

Mia Branco

A proud & grateful Miles Labor & Delivery family (2022, 2023, and 2026)

August 27th, 2026

To the members of the Committee:

Thank you for calling this hearing in order to delve into the deeply concerning pattern of L&D closures across rural Maine. My name is Caryn Howell and I live in Wiscasset. I'm a mom of 2, and my second baby, my daughter, was born at Miles 3 years ago. I have served this summer as a volunteer member of the steering committee of the Miles Delivers Action Coalition. I'd like to share some of my personal experience delivering at Miles, as well as some of what I've learned through my work with the coalition.

I grew up in central, rural Maine but my first pregnancy and birthing experience was in Boston, a city renowned for the quality of health care and hospitals. I moved back to Maine when my first-born was only 13 days old, and 2 years later, we were expecting our second child and chose Miles. Throughout the process of MaineHealth's assessment of LincolnHealth's maternity care, they have often stated that women prefer to deliver at bigger hospitals. I did not personally find this to be true. My husband and I agree that hands down, our experience at Miles was superior to our experience in a big-city high-delivery volume hospital. Every nurse, midwife, and OB I saw was supportive, knowledgeable, caring, and hugely competent. This should not be a surprise as Miles was the first hospital in Maine designated baby friendly by the WHO, and the fifth in the nation. Lincoln county deserves to hold on to this high quality care.

I was lucky to have a healthy and uneventful pregnancy. I was also lucky to live just 20 minutes from Miles. Labor came on fast and my daughter was born barely an hour after we checked into Miles. Had I needed to drive even an additional 15 minutes to Midcoast in Brunswick, with labor quickly progressing, I may have been calling an ambulance on the side of the road. Laboring in Lincoln county should not turn into an emergency; not for those like me with easy access to route 1, and not for those families down on one of the peninsulas where the drive to Midcoast or Pen Bay is an hour on a good day, before summer traffic or winter weather come in to play. In our coalition alone, amongst a small sample of local women, there have been precipitous births, an emergency C-section due to placental abruption, and an emergency breech delivery, all within the past 2-3 years. Closing LincolnHealth's L&D will not eliminate these scenarios, it will only make them more dangerous.

I would urge the committee to look more into MaineHealth's drive time analysis. They have cited an average increase of 18 minutes of drive time for Lincoln County women. They have not shared how they have reached these numbers. They have also failed to even acknowledge that some women live outside of that average increase and will face at the bare minimum an hour drive to give labor. This is double the amount of time that is optimal for maternal and infant outcomes. Maine already has the longest drive time to L&D out of all New England states. And in their own Community Health Needs Assessment, MaineHealth cites transportation as a top 3 concern for families in Lincoln County: "In the Maine Shared CHNA survey, 62.6% of respondents said "transportation needs" negatively impact them, a loved one, and/or their community." Yet, after the decision was made to close Miles L&D, MaineHealth has provided literally no resources or support for expecting women in Lincoln County. Pregnant patients were notified via phone calls from admin, but were pushed off the phone when they began asking

questions and were told “ask your provider.” Then, providers shared with us that they have very little information to share with patients. MaineHealth has made no offers to connect patients with resources related to transportation or otherwise, yet they acknowledge that this is a burden for many families here. Throughout this process, the community has not been centered. Closure of this vital local resource will be a burden on the community.

I would urge the committee to ask the following questions of MaineHealth:

- How did you calculate drive time analysis? Do you think it is safe and acceptable for women on the peninsulas to drive 60+ minutes in labor? What resources do you plan to offer for women whose drive times to give birth just doubled?
- Why are diversions a bigger safety concern than doubled drive times and no availability of emergency C-section care for the entire county?
- How is acceptable to announce closure of a vital community service with no resources prepared to share with pregnant patients? If this decision is “improving” health care for women in the region, where is the evidence of that?
- Have you ever assessed a rural L&D unit and NOT closed it?
- What is your 5 year plan for maternity care across the state of Maine?

Finally, I want to share three reasons that stand out to me as a local parent and community member as to why the pause on L&D closures must be implemented BEFORE December and before LincolnHealth’s maternity unit is forced to close down:

First, the timing for a pause on this decision is right. Births have been ~130 at Miles the past two years, and they have been consistently growing for the past 5 years; they’re up 43%. And, the percent of women of childbearing age is up 9% in Lincoln County, which is 3x the overall population growth. Young families are moving in, and they are delivering at Miles. And, Miles has recently hired two new providers in OBGYN. The addition of these providers should help to solve the staffing and call schedule difficulties. With new staff coming in, a pause should be taken to see if these changes put staffing in a more sustainable place.

Secondly, staff at Miles largely oppose closure of the L&D. More than 50 providers signed a letter of support for keeping L&D open. Providers in OB have shared that they have ideas about staffing and scheduling that either have not been heard or have not been tried. These are folks who know the staffing reality there, who work the call schedule themselves, and they believe there are solutions. Staff have called for more transparency and for more inclusion in the assessment process; since the assessment was only announced in May, this has not been enough time for these qualified and respected staff members to meaningfully participate in this process and offer creative solutions. Please also demand from MaineHealth: why are these ideas not being heard? Why are multiple staff members sharing that there are alternative staffing models that have not been considered while leadership are saying that they have tried everything? We owe it to these dedicated providers and to the community members who need local care to examine and entertain every possible solution.

Finally, closing Miles at the end of this year would not be safe. First because of the increased travel times-- again the hour drive (in perfect traffic conditions) from the peninsulas to

Brunswick or Rockport is double the 30 minute drive time that research has shown is optimal for maternal and infant outcomes. But also because there is not a solid transition plan in place. This came to light when members of our coalition met again with hospital leadership including Cindy Wade and Dr. Tim Fox (ER doc and board member). Perhaps the most disturbing detail from this meeting was the plan for how the hospital will handle emergency C-sections in the ER: they will not be performing them. This means that if a mother somewhere in Lincoln County is in labor, and decides to go to Miles *knowing* that there is no longer an L&D there, she is going to Miles because she has decided she can't make it to Pen Bay or Midcoast. If that same mother then needs an emergency C-section, she then faces an ambulance or LifeFlight ride. This is not the reality we want for expectant mothers in Lincoln county or anywhere in rural Maine. From working on this campaign to save Miles maternity, we have heard countless stories from families who were saved from dangerous or life-threatening outcomes because Miles was there. Stories in which local care is paramount are not outliers. MaineHealth leadership has shared numerous times that patient safety is a key factor in this assessment; at this time the safe path forward is to postpone closure and to explore alternative solutions.

LincolnHealth has the opportunity to have the premier rural L&D in the state. Last year, the unit had the lowest rate of C-sections and inductions across all MaineHealth hospitals. They were the first maternity unit designated baby-friendly by the WHO, and the fifth in the United States. With the growth from the last 5 years, the willingness of staff to problem solve, billing changes coming in 2027-- the timing is right to preserve this unit and to choose solutions over closure. MaineHealth has been on a tear closing L&Ds across the state. They owe it to the communities they serve, to the people of Maine, to prove that they know how to sustain a rural maternity unit. Maine is a rural state. We need smaller, rural hospitals that offer all of the vital services a community needs. It's a wonderful place to live and to raise a family. Let's keep it that way.

Thank you very much for your time.

Caryn Howell
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Valerie Donohue, MD — Family Medicine / Obstetrics

Ryan Donohue, MD — Pediatrics

6 Cooper Way, Walpole ME

8/26/2026

RE: Urgent Request for a Legislative Moratorium on Closures of Rural Labor and Delivery Units

Dear Members of the Committee,

We are writing to you as physicians who practice in coastal Maine — one of us a family physician providing obstetric and primary care, the other a pediatrician and as residents of Lincoln County, one of the communities most recently affected by the collapse of rural maternity services in our state in light of MaineHealth's board recently voting to close the Lincoln Hospital Family Birth Center later this year on December 18. We are writing to urge you to enact an immediate legislative moratorium on all further closures of hospital-based labor and delivery units in Maine, and to use that pause to build the workforce, reimbursement, and staffing solutions our state urgently needs.

In the last decade, Maine has lost twelve hospital-based birthing units, with nine of those closures occurring in just the past several years. Fewer than twenty of the state's hospitals still offer labor and delivery services at all. Our own community is the most recent casualty: despite rising birth volumes, strong provider support, and sustained community opposition, MaineHealth's Board of Trustees voted this summer to end labor and delivery services at Lincoln Hospital's Miles Campus in Damariscotta, leaving Lincoln county without a single operating birthing unit. Gubernatorial candidates across the political spectrum, our own governor Janet Mills, and members of Maine's congressional delegation have all called on MaineHealth to reconsider or delay — unsuccessfully. The Legislature has both the authority and the obligation to act now, rather than leaving the question of whether mothers and babies have access to safe pregnancy and delivery care to the discretion of hospital boards.

Hospital administrators frequently describe these closures as workforce or safety decisions rather than financial ones. Even where that is sincerely believed, it does not change the underlying problem: obstetric units are being treated as line items that must independently "pencil out," rather than as an essential public service that a community is entitled to regardless of volume. To quote Harold Miller, president and chief executive of the Center for Healthcare Quality and Payment Reform, "We don't fund fire departments based on how many fires there are every year." Labor and delivery is the same kind of standby service — it must be staffed and ready before it is needed, not built retroactively once an emergency is underway.

If the economics of running a labor and delivery unit are genuinely the obstacle, that is an indictment of how maternity care is financed in this country, not a justification for abandoning rural families. Many of the hospital systems closing these units, including Maine's largest, are

nominally nonprofit. But the commercial insurance carriers that reimburse the great majority of deliveries in this state are not tax-exempt, mission-driven organizations — they are for-profit corporations whose reimbursement decisions directly shape whether a rural unit survives.

MaineCare, Maine's Medicaid program, reimburses more generously than many other states' Medicaid programs, yet it still pays only a fraction of what commercial insurers pay for the same delivery. According to a 2025 article in the Portland Press Herald, roughly \$4,607 for a vaginal birth and \$6,847 for a cesarean section under MaineCare, compared with roughly \$14,630 and \$23,595, respectively, from private insurers in Maine. Nearly half of all Maine births are covered by MaineCare. When the payer covering close to half of a unit's patients reimburses at a third of the commercial rate, no amount of "efficiency" will keep that unit financially self-sufficient — the shortfall has to be made up somewhere, or the service disappears. That is a policy failure the Legislature can and should address directly, including through MaineCare rate reform and standby-capacity payment models that fund fixed staffing costs rather than per-delivery volume.

The consequences of these closures are measurable and are already occurring in Maine. Out-of-hospital births in Maine rose 41 percent between 2018 and 2023, from 228 to 321 per year, even though hospital births still make up the large majority of deliveries. Maine already has one of the highest home-birth rates in the country. Rural Mainers whose nearest hospital no longer delivers babies now drive an average of 45 minutes one-way to reach a birthing hospital — the longest average drive time in New England — and considerably longer for high-risk patients who must be routed to Bangor or Portland. In Houlton, Aroostook County, and elsewhere, EMS crews and local fire departments have publicly described the strain of handling obstetric transports and unplanned deliveries in ambulances, on top of their existing emergency call volume.

The clinical literature bears out why this matters. A large cohort study of rural deliveries found that rural patients who bypass their local hospital to deliver at a distant, non-local hospital face the highest risk of severe maternal morbidity and mortality in the year following delivery, even after adjusting for other maternal and hospital factors (Hung P et al JAMA 2025). Rural obstetric closures are not a neutral administrative matter; they are a direct contributor to a maternal mortality trend that is already moving in the wrong direction.

Longer travel time does not affect all patients equally. Lower-income patients are the least likely to have flexible work schedules, childcare, or reliable transportation to make repeated prenatal visits an hour or more away. Patients with mental health conditions or substance use disorders — populations already at elevated risk in pregnancy and already less likely to receive consistent prenatal care — are disproportionately likely to miss appointments entirely once the nearest obstetric provider is no longer local. As these units close, we should also expect the volume of remaining births to concentrate at fewer regional hospitals; several of those receiving hospitals are already operating near capacity, and there has been little public accounting of whether they can safely absorb the incoming volume.

One of us, a family physician who has provided obstetric care, has direct, personal experience with how difficult it is for family medicine physicians to find a path into rural obstetrics in this state. Outside of residency training itself, opportunities for family physicians to maintain an obstetrics practice (with or without surgical privileges) are scarce in New England. In 2020, this

co-author inquired directly with 2 coastal Maine hospitals about incorporating obstetric care into a family medicine practice and was told, in both cases, that there was no interest in even discussing the possibility of hiring a family physician for that role.

This experience is consistent with a broader, observable pattern across Maine's hospital systems. Northern Light Health and Maine Health have both cited difficulty with recruiting OB-GYNs as a primary reason for closure of rural obstetric units. In our experience, neither has adequately explored the possibility of staffing their units with obstetric trained family medicine providers.

This pattern matters because family medicine physicians represent an underused pipeline for sustaining rural obstetric coverage, though there are functioning models of care that can incorporate these providers. Family medicine/obstetric physicians without surgical training can provide "first call" coverage in a role similar to a midwife, managing the lower risk vaginal births and triaging all patients, while a "second call" provider (either an OB/GYN or fellowship trained family medicine/obstetrics physician with surgical training) is called to attend any higher risk or complicated births. This "first call/second call" model helps decrease the burden of call on any one provider by appropriately triaging and sharing the care, which is particularly important in rural medicine. The issue with recruitment of OB/GYNs is real, and one of the cited reasons for less interest in rural care for providers is the often more frequent call requirements. It is also true, however, that call frequency is not the only factor that matters – volume of work and location of work are also contributors. When the volume of work is lower and shared, and work is close to home (not necessitating that a provider live in a call room in the hospital even when there are no patients), many providers (ourselves included) find call burden is not as high as it may seem on paper when it is listed on recruitment as "1:4" or every fourth night, for instance.

A second, related issue is the underutilization (and lack of recruiting for) family medicine/obstetrics providers who have completed a surgical obstetrics fellowship and have training in performing cesarean births and managing higher risk pregnancies and deliveries. These physicians exist and have been providing care in our country, predominantly in the western United States, however they are few and far between in New England. Knowing several personally, we know this is not due to lack of interest in living and working in our rural communities, but due to discrimination by hospital systems and lack of job opportunities.

A hospital system's openness to credentialing family physicians for surgical and non-surgical obstetric care is a meaningful lever that state workforce policy could actively encourage — for example, through malpractice insurance support, loan forgiveness tied to rural obstetric practice, funding for additional obstetric training during family medicine residency, or providing incentives for larger hospital systems to host an obstetric fellowship for family medicine doctors (no such program currently exists in New England).

As physicians who together provide obstetric and pediatric care, we want to emphasize an aspect of these closures that receives far less attention: the loss of a hospital's obstetric unit is also a major loss of the community's newborn care team. When a labor and delivery unit closes, the nurses skilled in newborn assessment, breastfeeding support, and recognition of early postpartum complications leave with it. Families whose newborns develop common problems —

poor weight gain, significant jaundice, feeding difficulty — either receive less support from the remaining outpatient pediatrics services or must travel a significant distance for hospital-level pediatric services.

The same loss of local, experienced staff also means fewer trained eyes on at-risk mothers in the weeks after delivery. Losing local obstetric nursing and lactation expertise reduces the number of professionals positioned to notice the early warning signs of postpartum preeclampsia or postpartum mood disorders, both conditions that, when not appropriately identified and treated, can escalate quickly. Postpartum psychosis affects an estimated 1 to 2 of every 1,000 births and carries a well-documented risk of suicide and, in the most severe untreated cases, infanticide — which is precisely why continuity of local obstetric and pediatric contact in the weeks after delivery is not a convenience but a clinical safeguard. Even where a hospital system pledges to preserve outpatient prenatal and postpartum visits after closing its inpatient birthing unit, that model typically asks local physicians and midwives to take call at a distant hospital rather than their own community. In practice, this is more likely to drive experienced local providers to leave for other employment than to preserve meaningful local coverage, further eroding the very safety net these closures claim to preserve.

Requested Action

We respectfully urge the Committee to:

- Enact an immediate statutory moratorium on further hospital-based labor and delivery unit closures in Maine, pending a comprehensive legislative review of the workforce, reimbursement, and access failures driving these closures;
- Direct a review of MaineCare obstetric reimbursement rates, including consideration of standby-capacity payments that fund fixed staffing costs rather than per-delivery volume, so that low-volume rural units are not structurally penalized for their location;
- Require hospital systems seeking to close or restructure obstetric services to publicly disclose the capacity analysis showing that receiving hospitals can safely absorb the added volume; and
- Fund workforce initiatives — including loan forgiveness, malpractice-insurance support, expanded obstetric training in family medicine residency and/or fellowships, and hospital recruitment for family medicine providers with obstetric training — that make it easier, not harder, for family physicians to sustain obstetric practices in rural Maine communities.

The 120-day closure-notice law the Legislature passed last year was a meaningful first step, but notice alone does not keep a birthing unit open — it only tells a community how much time it has left before losing one. Mainers deserve a Legislature that treats the ability to safely deliver a baby close to home as a guaranteed public service, not a line item subject to a hospital board's quarterly review. We would welcome the opportunity to speak with the Committee or provide additional clinical perspective as you consider this issue.

Thank you for your time and attention to this urgent matter.

Respectfully,

Valerie Lynne Donohue, MD
Family Medicine / Obstetrics

Ryan Thomas Donohue, MD
Pediatrics

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McCarthyReid, Colleen

From: Kerri Van Kirk <kerri@kaylocreative.com>
Sent: Thursday, August 27, 2026 12:01 AM
To: McCarthyReid, Colleen
Subject: Statement on Labor & Delivery Closures

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This message originates from outside the Maine Legislature.

Hello,

I'm sorry I couldn't be there in person today, but I want to share how much the Miles Labor and Delivery closure at the end of the year has impacted me, as well as inspired me to get involved with this effort to stop the reduction of maternity and women's healthcare services in Maine.

I am a 36 year old woman who moved to Maine at the end of 2020 and was so excited to find out that a well-respected birthing center connected to a hospital was just 15 minutes from my house. It made me feel incredibly safe to give birth and the glowing recommendations I had heard from my friends who had given birth there made me feel even more safe, and honestly, loved and taken care of as part of the community. It felt like something I could count on, when even getting an appointment with my primary care doctor was difficult. (I have one, but have never met him! I generally go to urgent care for any issues because I can actually get in and know how much it will cost.)

With labor and delivery closing, it makes me feel nervous and uncertain about receiving the care I need, the recommended hospital being an hour away from my home (and over the Wiscasset bridge, no less!) It makes me sad for all of the women who will endure more fear and stress vs. feeling taken care of by their community and the downstream effects that not having a birthing center in Lincoln county will have on families moving to the area.

I am encouraged by the broad community response to this closure and that this meeting today is happening. Maine needs to turn this trend of L&D units closing around and take care of women and families.

Hannah Pingree mentioned that one federal pathway could be to lift the 15% cap on using rural hospital funding for staff (as I understand it, currently the vast majority of funding is earmarked for technology and infrastructure, which is not Maine's biggest problem when it comes to providing maternity services). It seems that many of the closures, including Miles, are about staffing and rural hospitals should be able to use that federal money in ways that serve their particular problems and keep birthing centers open and running. I hope this pathway, alongside state solutions, will be explored.

Thank you,
Kerri Van Kirk

Kerri Van Kirk

Leadership Coach, Advisor

For Democratic Politicians, Deep Thinkers, Creatives

www.kerrivankirk.com

Senator Bailey, Representative Mathieson, and distinguished members of the committee: thank you for allowing the public an opportunity to provide testimony about the ongoing maternal healthcare crisis in Maine.

My name is Alex Beaudet, I live in Bristol, and I own and operate a commercial vegetable farm. My partner is a registered nurse who has previously worked in labor and delivery. She is 38 weeks pregnant with our first child and is due to give birth at MaineHealth Lincoln Hospital, also known as Miles, within the next few weeks.

We are all undoubtedly concerned about the ongoing maternal healthcare crisis affecting communities throughout Maine, and the closures of labor and delivery units like the one at our local hospital. Being an expectant parent who is experiencing an active closure firsthand, I've learned a lot about the challenges of rural maternal healthcare by speaking to current and former providers – doctors, midwives, and nurses – and community advocates who are on the front lines of the crisis. We've also heard from MaineHealth executives, who have given a series of excuses for closure – inconsistent staffing, declining birth rates, and demographic changes – that lack substantiation by empirical evidence and do not match our lived experience. Ultimately, while a maternal healthcare crisis certainly exists, and the issues are multifactorial, I believe it's largely being caused by the unchecked corporate greed and monopolization of our healthcare by organizations like MaineHealth.

I think it's important to give some context to the unjust timeline that has brought us all here, particularly those of us in Lincoln County. In 2025, the Legislature began making incremental steps toward addressing Maine's maternal healthcare crisis, including passage of LD 2189 requiring 120 days of notice prior to closure of labor and delivery units. While not going nearly far enough, it was a start. The Legislature even considered bills such as *LD 1578: An Act to Require the Department of Health and Human Services to Review Disruption to or Removal of Health Services*, which was "brought forward following the closure of labor and delivery units at hospitals in rural areas of the State."¹ Rather than put any actual restrictions on hospitals, this bill was amended to instead establish a commission "to evaluate the scope of regulatory review and oversight over healthcare transactions that impact the delivery of healthcare services in the State." While the amendment was good news in the short term for healthcare organizations like MaineHealth, it appears that they understood what might be coming. On April 29th of 2026 the Maine Legislature adjourned its 132nd session. The very next month, in May, MaineHealth announced that they were considering the closure of yet another labor and delivery unit, at Miles in Damariscotta. Despite an incredible amount of community

¹ Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State (<https://www.legislature.maine.gov/doc/12215>)

organizing, presentation of reasonable solutions, and desperate requests for a delay, MaineHealth voted for closure in August, with a final date of service to come just after the convening of the next legislative session. Convenient timing on their part, to say the least.

Throughout the entire process, MaineHealth has tried to gaslight our community into believing this is not a financial decision, instead blaming low birth volumes and staffing difficulties. In reality, I can't imagine having more consistent or higher quality care than what the Miles Labor & Delivery team currently provides – if you speak to their providers and patients, they will all tell you the same thing. At the same time, births at Miles have increased 43% since 2019, while births at nearby hospitals have decreased substantially in that same period.

If the evidence doesn't support MaineHealth's claims, then you might wonder why they're actually closing units like Miles Labor & Delivery. I think the explanation is relatively simple – money. MaineHealth has indicated plans to funnel deliveries to Mid Coast Hospital in Brunswick, which they also own, where births are declining. Mid Coast has a much larger and more costly birthing center, currently operating well below its designed capacity, and empty beds aren't profitable. If they can force patients to another MaineHealth hospital, they reduce their costs while maintaining revenues. MaineHealth acknowledged in their own whitepaper² that having fewer birthing centers means longer drive times for women in Lincoln County, which has proven to carry significantly higher risks. But for MaineHealth, it also means increased profit. Which, would it seem, do they care about more?

When MaineHealth started gobbling up local hospitals in the late 90s, they claimed it would lead to improved patient outcomes and lower costs. In reality, MaineHealth's consolidation efforts and regional monopoly have led to increased rural closures and some of the highest healthcare costs in the country, exceeding national averages by 25%³. Sadly, this is what happens when you mix capitalism and healthcare. When healthcare is a privilege for those who can afford it and not a human right. A multi-billion dollar "not for profit" hospital, whose executives are paid millions of dollars, and whose assets are in the billions of dollars⁴, can simply take it away. This needs to end.

² MaineHealth Lincoln Hospital OB Whitepaper

(<https://assets.mainehealth.io/s3fs-public/2026-07/MHLHOBWhitePaper.pdf>)

³ <https://www.thirdway.org/report/fixing-maines-broken-hospitals-a-case-study>

⁴ MAINEHEALTH SYSTEM Consolidated Financial Documents

(<https://assets.mainehealth.io/s3fs-public/2026-02/MaineHealth%20Audited%20Financial%20Statements%202024-2025.pdf>)

Some impacts of the Miles Labor & Delivery closure will be immediate like longer drive times, worsening patient outcomes, and the loss of family medicine doctors in our community. Others will take more time, like fewer young families moving to our area, a declining workforce, and the erosion of other essential services at the hospital. But have no doubt that the selfish actions of these organizations are going to have wide ranging and acute negative impacts for Mainers across the state. Our community showed an incredible amount of solidarity, working in good faith with MaineHealth to save labor and delivery services at Miles. It wasn't enough. Just like it wasn't enough for Houlton, MDI, Waldo, and the other units that have been recently closed. This is where we need the help of the people we elected to protect our healthcare access.

Here are some suggestions for your committee to consider:

1. In a recent letter to patients, after the closure of the Miles Labor & Delivery unit, MaineHealth CEO Dr. Andy Mueller stated: *"We are calling on Maine's next Governor and Legislature to make rural maternity care a statewide priority and work alongside hospitals, clinicians, educators, payers and communities to address the workforce, reimbursement and demographic realities threatening these services. MaineHealth will be an active partner."*

Do not make MaineHealth an active partner. Pardon the farming reference, but that's like asking the fox to build the henhouse. They've had decades to be active partners with their communities, and they've chosen consolidation and financial growth over our wellbeing every time. Instead, make the providers your partners. The amazing doctors, nurses, and midwives who are on the frontlines in Maine know what our communities need for access to safe maternal healthcare. Make educators and community advocacy groups your partners. Make your constituents – of all backgrounds and income levels – your partners. Voters have elected you to make decisions that are best for Mainers, not the bottom line of multi-billion dollar healthcare organizations.

2. Impose a moratorium of labor and delivery closures for the next 5 years. After the vote to close labor and delivery services at Miles, MaineHealth stated that they will voluntarily pause any additional closures for 2 years. That's not good enough. They've insisted closures wouldn't happen before, and done it anyway – ask the folks in Boothbay about St. Andrews. Maine has lost 12 maternity wards in the last decade, and we cannot afford to lose any more.

3. Revive legislation to allow DHHS to review disruptions to services, including, but not limited to, changing Certificate of Need criteria to include the closure of labor and delivery units.
4. Increase the required length of notification of closure of labor and delivery units from 120 days to 300 days. This would ensure that women are able to receive full-term care with the providers of their choosing and not risk having to transfer care partway through a pregnancy.
5. Organizations like MaineHealth – who just recently acquired York Hospital – are monopolizing regional healthcare, which is leading to increased cost of care and consolidation resulting in real, tangible, life threatening risks to Mainers. The Attorney General should utilize existing antitrust laws to limit these mergers and break up these monopolies, and the legislature should support these actions with the appropriate laws as needed.
6. Empower municipalities to collect property taxes from hospitals who do not provide all essential healthcare services, including labor and delivery. Maine taxpayers subsidize MaineHealth to the tune of several million dollars annually in property taxes alone on the presumption of being a “charitable organization,” despite less than 1% of expenses going towards charitable cases⁵. If taxpayers can have their access to essential healthcare services taken away, they should be empowered to withhold these subsidies.
7. Cap CEO and executive pay at not-for-profit healthcare organizations who receive any local, state, or federal subsidies at 5:1 when compared to the lowest paid full-time employee of the company. Research suggests that consumers believe an ideal, fair ratio for CEO pay, relative to an unskilled worker, is 4.6:1.⁶

It is not good enough to simply treat the symptoms of this crisis. We must cure the underlying disease of the unchecked greed of corporatized healthcare in Maine. You have the tools and authority to do so, and I simply ask that you make use of them.

Thank you for your time.

Respectfully,
Alex Beaudet
Bristol

⁵ <https://www.thirdway.org/report/fixing-maines-broken-hospitals-a-case-study>

⁶ <https://dash.harvard.edu/server/api/core/bitstreams/7312037d-7596-6bd4-e053-0100007fdf3b/content>

McCarthyReid, Colleen

From: Tim Goltz <ttgoltz@gmail.com>
Sent: Thursday, August 27, 2026 7:58 AM
To: McCarthyReid, Colleen
Subject: Testimony opposing closure of labor and delivery in Damariscotta

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This message originates from outside the Maine Legislature.

As a family physician who has practiced in Damariscotta for over 28 years, I am strongly opposed to MaineHealth's plan to stop providing labor and delivery services in Damariscotta. Abundant studies show that when women need to travel further to deliver their babies, the outcomes both for mothers and the babies are worse.

I strongly suspect that the decision by MaineHealth is primarily driven by financial reasons. While MaineHealth states that its vision is "Working together, so our communities are the healthiest in America", stopping labor and delivery would have negative impacts not only on the health of individuals, but also on the health of our whole community. If women lose the opportunity to deliver babies in Lincoln County, our county will become a less desirable place for young families to live in. Please help to preserve this vital service for our community.

Sincerely, Timothy T Goltz, MD

LeAnne Dunham
Columbia, Maine
August 27, 2026

Dear Committee,

Thank you for taking time to hold this special meeting and hear input from the public on the very concerning issue of maternal health care and labor and delivery unit closures. My name is LeAnne Dunham. I am a doula, childbirth educator, and mom to four from Columbia, Washington County.

In my role as a doula, I am a non-clinical care provider. I work with families during their pregnancy, birth, and postpartum time to provide emotional, physical, and educational support. During my time doing this work, I have supported birthing families in homes, hospitals, and birthing centers all over Washington, Hancock, and Penobscot counties.

The challenges of rural healthcare are not necessarily unique to obstetrics. However, given the standard of care (often at least 8-10 appointments in the third trimester, for a low-risk pregnancy) and not knowing exactly when babies will arrive, having to drive far for care is immensely difficult for the families I work with. This reality is also compounded by other challenges such as transportation and lack of childcare. Families are often having to take full days off of work in order to go to appointments. All of this means appointments will be missed, and when that happens, the risk of maternal and infant death increases.

In my childbirth classes, I sit with over 100 expecting parents a year, and the anxiety over hospital closures, and the ensuing long drives to receive care, is a frequent conversation and cause for much stress. We talk through all the scenarios of when to leave for the hospital, how weather can impact that decision, what to have in the car in case the baby arrives en route. The current maternal healthcare landscape asks patients to be overly prepared and reliable for all scenarios, since the healthcare system is not a steady presence.

In the past year alone, I have worked with families who have:

- driven from Baileyville to Bangor in labor in February. Then drove back home, down Route 9 in the winter, with their two day old baby.
- navigated how to drive from MDI to Bangor in the height of seasonal, July traffic.

-driven from Millinocket to Bangor for an induction, only to have to stay overnight elsewhere in Bangor, while they waited for a bed to be available.

In September of last year, a family from Lubec delivered their baby on the side of the road, in the middle of the night, with no cell phone service. I was with this family on Black Woods Road when their baby arrived. While the baby and mom were healthy, the reality of this unexpected delivery took a lot of time to process. What if something had gone wrong? This family planned to deliver at a birth center in Machias, but their provider wasn't available. Down East Community Hospital in Machias was on diversion (meaning no laboring patients can deliver there because the required staff is not available), and so they were forced to attempt to drive two hours while in labor; from Lubec to Ellsworth.

All of these stories highlight the impact of hospital closures across northern and eastern Maine in the last decade.

Doulas are one evidence-based way to mitigate the impacts of hospital closure, and starting in 2028, MaineCare will cover doula services. However, in a system where closures are happening at such a rate, there has to be large scale movements and solutions.

Thank you for the opportunity to share my experience, and I am happy to talk further at any time.

1. Carvalho OMC, Junior ABV, Augusto MCC, Leite AJM, Nobre RA, Bessa OAAC, de Castro ECM, Lopes FNB, Carvalho FHC. Delays in obstetric care increase the risk of neonatal near-miss morbidity events and death: a case-control study. BMC Pregnancy Childbirth. 2020 Jul 29;20(1):437. doi: 10.1186/s12884-020-03128-y. PMID: 32727418; PMCID: PMC7391531.

McCarthyReid, Colleen

From: KATE REYNOLDS <katereynolds@bellsouth.net>
Sent: Thursday, August 27, 2026 1:29 AM
To: McCarthyReid, Colleen
Subject: Hearing on Birthing Center Closure

This message originates from outside the Maine Legislature.

Ms McCarthy Reid,

I am writing to express my profound disappointment with the MaineHealth corporation's decision to close the Lincoln Hospital award winning birthing center. Throughout this process, it felt like there was no genuine good-faith effort to explore any option beyond outright closure. The community's wishes, thoughtful and well researched proposals to preserve services, and creative solutions from residents and providers all seemed to be largely dismissed. The lack of transparency around this decision has eroded trust and left many feeling disregarded.

Thousands of residents, civic groups, medical professionals, elected officials, our governor, and bipartisan candidates for public office voiced clear opposition. Those voices deserved a serious response. Adding to the concern, when MaineHealth announced the closure, it pledged to pause any additional labor and delivery closures at other facilities for two years. Yet Lincoln Hospital was excluded from that commitment. If a pause was warranted elsewhere, why not here? That inconsistency is hard to justify.

As a nonprofit institution, MaineHealth's mission is to serve the community. The Board of Trustees has fallen short of that responsibility. Personally, I don't need maternity care at my age, but I know communities thrive only when young families choose to live, work, and raise children there. Removing essential services for those families threatens our long-term vitality.

I understand that maternity care deserts are a statewide and national challenge, but that reality calls for innovation, not retreat. Our community offered thoughtful recommendations and showed a willingness to collaborate. We could have been a model for creative, community-based solutions. Instead, MaineHealth chose the simplest option, not the wisest one. This decision is short-sighted, seemed pre-determined, and harmful to our region's future. As a nonprofit health system, MaineHealth must be held to the highest standards of accountability and stewardship. The people of Lincoln County, the people of Maine, deserve nothing less.

Sincerely,

Kate Reynolds, Ph.D
76 Upper Round Pond Rd.
Bristol, ME 04539

To Members of the The Health Coverage, Insurance and Financial Services Committee:

I encourage you to support continuation of birthing services at Lincoln Hospital in Damariscotta, using the site and current community momentum as an opportunity to investigate innovative solutions for providing maternity care in rural settings across Maine and the country.

In 1984, I moved to Maine and started working as a registered nurse on OB in Damariscotta. I had two years of experience in maternity nursing, but those years were at the high volume University of Rochester Medical Center in Rochester, New York. Needless to say, the change in practice was dramatic. What I discovered, however, was a unique model of care that put women, their babies, and families first. The quality of care was outstanding. As a nurse, I had both independence and responsibilities that were exciting, despite the much lower volume. I never looked back and never wanted to work anywhere else.

In the 40 years I worked at Miles the organization had a number of different iterations:

Miles Memorial Hospital
Miles Health Care Center
Lincoln County Health Care
LincolnHealth
MaineHealth Lincoln Campus

But names and organizational structures don't really matter to patients. Care does. For most of my 40 years our team helped between 160 and 225 mothers give birth. We won national awards for safety (Consumer Reports) and for patient satisfaction (Avatar 1st in the U.S). We became the 5th hospital in the United States to be recognized as Baby-Friendly by the World Health Organization - a designation for excellence in breastfeeding education and support. When as manager I was first required to report quality statistics to Anthem, their quality team did not believe me, our numbers were that good!

Then 15 years ago a consultant recommended closing OB. There was a very public discussion about the potential closure. After three years of discussion, the board decided to keep us open, but by that time many providers had left and our numbers dropped.

I believe that Miles remains one of the best places in Maine, and indeed the country, to give birth. Birth volume has gradually increased and is expected to near 150-160 again this year. There are challenges, for sure, and the unit is small, but that makes it nimble, and an excellent lab for developing strategies to reverse the tide of closures.

There is a common misconception that busier departments in larger hospitals give better care. The service at Miles has a track record of innovation, excellence, and high rates of patient satisfaction. In my 14 years as department manager (2004-2018), I received endless compliments regarding the proficiency and caring of both the nursing and medical staff. "They didn't just take good care of her, they took care of her like she was their sister," one patient's mother remarked.

Supporting maternity services in small hospitals is essential for the continued vibrance of rural life. Local birth services support local pediatricians and a range of other medical services important to the community. Young families feel welcome in town. In contrast, the message given when maternity services are eliminated is that young families, their needs and safety are no longer valued.

I retired in 2024, and I have largely stayed on the sidelines of this controversy. The folks in Damariscotta know me, and know my love of the unit and I felt that it was best for the next generation of voices to lead this effort. There is energy there to find solutions. Please give them the chance to succeed.

Lynn Plumb, retired nurse
Nobleboro, Maine

**132nd LEGISLATURE
JOINT STANDING COMMITTEE ON HEALTH
COVERAGE, INSURANCE AND FINANCIAL SERVICES**

August 27th Interim Committee Meeting

**Written Comments Submitted To Committee
(after 8am 8/27/26)**

August 27, 2026

To the Maine State Legislature:

My name is Cecilia Ackerman and I live in Alna, Lincoln County. I am currently a pregnant patient at Lincoln Hospital in Damariscotta. Between May 2026 and the present date, my experience of the proposed—and now planned—closure at Lincoln Hospital has been marked by MaineHealth’s lack of care toward pregnant patients caught in the middle of the “assessment” and closure process, demonstrated through inconsistent messaging, lack of support for patients trying to plan for different eventualities, and intimidating actions taken by MaineHealth opposite pregnant people attempting to peacefully participate in the decision-making process as community members. I am asking lawmakers to enact legislation that will protect pregnant patients from disruptions to their care and birth plan choices due to proposed or determined closures of these essential services, and support communities asking healthcare corporations for time to engage in finding and implementing solutions.

I first learned about the proposed closure of labor and delivery at Lincoln Hospital in mid-May at a town hall meeting in Alna. A local member of the Lincoln Hospital board remarked, “we are about to become a maternity care desert in this area.” I was startled and concerned, having heard nothing from my providers. I sent a message to my medical team asking if I needed to seek care elsewhere. They had to ask for guidance from the hospital president, Cindy Wade, to answer my question, but confirmed they would be able to deliver my baby in October.

At my next appointment on May 19, I was informed that while no official decision had been made by MaineHealth, patients with due dates in December and later would need to seek labor and delivery services elsewhere. I asked whether “no official decision” meant there was still a chance the unit could remain open. My provider responded that it was extremely unlikely. When I asked whether the proposed closure would affect retention of labor and delivery staff this fall, I was told that nursing staff had already been provided stipends so that they would stay on through the closure date, and had also been told they would not be offered positions at other MaineHealth hospitals until after the closure.

Following these initial discussions with my providers, I attended a public forum held by MaineHealth on June 2 in Damariscotta. At that meeting, Cindy Wade told the public that the unit was still under assessment and that no formal decision had been made regarding closure. To me, this series of statements meant that the hospital system had communicated a *de facto* decision to staff that was not being communicated to patients and the community.

Unclear communication, along with the inability to adequately plan for birth, has caused additional stress and anxiety to every currently pregnant patient at Lincoln Hospital that I know. At or soon after the community forum meetings hosted by MaineHealth, Cindy Wade told the public that Lincoln Hospital intended to maintain prenatal care services. One of my pregnant friends due in January asked whether she could meet providers at Midcoast Hospital—anyone who would likely be in the room at the birth of her child. She was told that she could not meet any providers at Midcoast unless she transferred her care in its entirety, including prenatal care. This MaineHealth policy during the “assessment” period demonstrates a lack of understanding

that pregnant patients need to plan for birth, not only to maintain continuity of care for the sake of better maternal health outcomes, but also for their mental health.

From the time when closure plans became public, MaineHealth positioned itself antagonistically toward the Lincoln County community, hiring security guards who walked the hallways at Great Salt Bay Elementary School at the June 2 forum; a place where women already had to face an intimidating board of hospital officials and share some of the most vulnerable moments of their lives in their pleas to keep the unit open. Hospital officials refused to answer questions or comment in person. Despite MaineHealth's rhetoric to the contrary, this was the extent of its "dialogue" with the Lincoln County community. Lincoln Hospital subsequently published FAQs loosely based on questions posed by the public that were filled with data that was either incorrect, misleading, or incomplete.

MaineHealth security was also called in on the day of the MaineHealth Board of Trustees vote. The Miles Delivers Action Coalition, a group mainly composed of mothers, several of whom, like me, are pregnant and active patients at Lincoln Hospital, gathered on a strip of lawn across from the hospital to present our providers with care packages we had made. We knew this would likely be a difficult day for them. MaineHealth again hired additional security personnel to make sure we didn't set foot on hospital property. One of our leaders was escorted out of the hospital while trying to deliver flowers. How can patients feel safe receiving care at a hospital where security is hired to intimidate them?

The Coalition attempted to engage with MaineHealth in myriad ways, presenting solution after solution as the hospital system's rationale for closure continued to change, morphing from low birth rate and staffing, to finances, and finally, after the Board of Trustees vote, to patient safety. It became obvious that MaineHealth was not interested in engaging with the community of Lincoln County in any meaningful way.

The manner in which MaineHealth has conducted itself in relation to patients and community members has eroded trust in Lincoln Hospital. I know many people who are seeking to transfer all their outpatient care from MaineHealth to independent providers. I have decided to hire a home birth midwife so that I have another option should I need it. Those patients I know who are due after closure have been provided no specific guidance on transitioning their care to another hospital; there is no plan in place to accommodate the patients from Lincoln Hospital with any care for their mental well-being and the birth experience they planned for. MaineHealth's latest rationale for closure—patient safety—is at odds with the expectation that patients will now give birth further from home and with providers unfamiliar with their medical history.

I hope these details can help legislators understand how proposed and determined closures affect patients and communities in order to enact more protections for pregnant patients and their communities, and to make sure nonprofit healthcare corporations are fulfilling their community obligations. Thank you for addressing the maternity care crisis in Maine. I believe creative solutions can emerge from dialogue between hospitals and community members, but only if both parties are transparent in their aims. If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Cecilia Ackerman', with a stylized flourish at the end.

Cecilia Ackerman

—
Cecilia Ackerman

(207) 446-2024

cecilia.ackerman@gmail.com

McCarthyReid, Colleen

From: lynne thompson <delightxox@yahoo.com>
Sent: Thursday, August 27, 2026 8:44 AM
To: McCarthyReid, Colleen
Subject: Miles Labor and Delivery

This message originates from outside the Maine Legislature.

Good Morning, I am a Certified Respiratory Therapy Tech of over 54 years and worked at Miles Memorial Hospital as such for the years 1990-2022. We were very involved in difficult births at the facility and kept updated on new equipment and procedures , to include transporting newborns to Maine Med if deemed necessary. We had to help insure that all efforts were utilized in bringing a new life ,lives into this part of Maine. Birth can be a wonderful event if all goes smoothly but there is no guarantee it will and we need qualified people to help in the process especially if accessory equipment is needed. The MD may know what they want but it is the nurses and therapists that operate a lot of the equipment to achieve that result. Weather, traffic and time can all factor into this successful deliveryBabies come when they are ready , not when you plannedit can be just as emergent for the mother's survival as the baby's. Some women will have to drive themselves in the middle of laborlet's not pretend this is a simple matter...and we need to have a moratorium on this and any closing of Delivery units across Maine to be smart and true to our desire to give lifesaving care to our people.

The wonderful passion of our community should be harnessed to fundraise and coordinate solutions to this problem....it isn't a tennis court we are fighting for ...it is LIFE itself!

Please let us work together , respectfully, Lynne Thompson, CRT

PS ...we don't want to overwhelm our emergency rooms with difficult births , either.

McCarthyReid, Colleen

From: Bambi Jones <bambisfarm@gmail.com>
Sent: Thursday, August 27, 2026 8:48 AM
To: McCarthyReid, Colleen; Karen Kleinkopf
Subject: testimony

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Bambi Jones
Whitefield, Maine 04353
August 27, 2026

Senator Bailey, Representative Mathieson and Honorable Members of the Health Coverage, Insurance and Financial Services Committee

Thank you for the opportunity to address the Committee.

My name is Bambi Jones and I live in Whitefield. I am here today to urge you to pause the proposed closure of Labor and Delivery at Lincoln Hospital and to evaluate alternative models and resources that could preserve local maternity care.

I have lived in Whitefield for almost fifty years where I operate an organic vegetable farm. I am childless but have attended several births of friends. Two of those started as home births but had to be moved to Lincoln Hospital because of complications. Who knows how the births would have gone had they been forced to travel another 30 minutes to a more remote facility.

As a farmer I have hosted more than 25 interns who have learned agricultural and basic work skills during a long summer of hard work on the farm. Several of these interns have since settled in the neighborhood and have given birth to their children at Miles (now Lincoln) Hospital.

We all know that attracting young people to Maine, the oldest state in the nation, is a state-wide priority. The lack of a local, easily accessible venue for childbirth and maternal care will significantly diminish the attractiveness to young people looking to settle in and contribute to our community.

Thank you for the opportunity to share my perspective with the Committee. I urge you to pause the closure of the labor and delivery services at Lincoln Hospital. Thank you.

--
Bambi Jones
207-319-4999



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August 27, 2026

HCIFS Committee, Maine Legislature

Senator Bailey, Representative Mathieson, and Honorable members of the Committee on Health Coverage, Insurance, and Financial Services,

My name is Dr. Anne Coates, and I am a pediatric pulmonologist in Portland, and current President of the Maine Chapter of the American Academy of Pediatrics.

Like many other health care professionals and community members, I was distressed to learn about the upcoming closure of the MaineHealth Lincoln Hospital Labor and Delivery and Newborn Services in December 2026. I'm writing to share my perspective on this issue and some potential solutions to prevent future labor & delivery units from closing.

The National AAP has recognized for a long time the unique role that rural physicians and rural hospitals play in the lives of families. Providing care close to home, in the community in which one lives, has always been prioritized by our organization and is one of the tenets of the Pediatric Medical Home.

In Maine, we have a large rural population, and in many regions, services that used to be available are no longer. Since 2015, **twelve** Maine hospitals have or soon will have discontinued their obstetrics and newborn services, and we are very concerned that Lincoln Hospital is the latest casualty in a terrifying trend affecting women and newborn's health. Research indicates increases in infant mortality (1), preterm births, and out of hospital births, (2) in counties where hospital-based obstetric care was discontinued.

The AAP also recognizes that there are unique challenges to providing care in rural environments that include attracting and retaining providers over time, ensuring an adequate workforce to provide necessary care, and ensuring providers and staff are able to obtain and maintain the skills needed to provide excellent care in these communities, even in the face of declining volumes. We believe that innovative solutions to address these challenges exist, including:

1. **Establish pilot programs for "Standby Perinatal Services."** SSB 669, recently passed in California gives some thoughtful ideas to address the problems affecting low volume birth centers. The core idea is to let a low-volume rural hospital get paid for maintaining obstetrical staffing and readiness even between births, rather than being reimbursed only per-delivery - directly targeting the fixed-cost problem that drives many rural labor and delivery unit closures.
2. **Address workforce issues through loan repayment and tax credit programs** targeted at OB-credentialed nurses, OB-GYNs, family medicine physicians who deliver, and CRNAs in rural/HPSA counties. In addition, streamline multistate licensure and reciprocity for obstetrical nurses and physicians to make locum and cross-border coverage more feasible for rural hospitals.
3. **Implement barriers to future closures of currently existing units:**
 - a. Maine just implemented a 120-day notice period for maternity services closures, which is a step in the right direction -



but other states have even **stronger disincentives to closure**. Minnesota passed a 2024 bill moving the requirement from 120 days to 182 days and shortened the state's turnaround to hold a public hearing from 45 to 30 days after notice. Minnesota's law also has a unique twist: before selling a hospital to anyone else, controlling parties must first offer to sell it to the local unit of government where it's located.

b. Mandatory closure impact studies require the hospital or state health department to publish a community-impact and cost analysis before a closure is finalized.

4.) **Improve Medicaid reimbursements** to reflect the actual cost of providing obstetric care. To prevent further labor and delivery unit closures, addressing the issue of low Medicaid reimbursement rates is critical.

The State of Maine will have to work together with healthcare organizations to prevent creative, sustainable solutions that prevent future labor and delivery unit closures. On behalf of the Maine AAP, I ask that the HCIFS Committee continue to evaluate ways to provide a safe birthing experience for all families in Maine.

Sincerely,

Anne Coates, MD FAAP
President, Maine AAP Chapter

(1) <https://pubmed.ncbi.nlm.nih.gov/29986980/>

(2) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5885848/>

Dear Committee Members,

I live in Round Pond, a peninsular town in the midcoast, with a coffee shop, penny candy store, and two lobster shacks (coastal village priorities, right?). My husband and I love the community we live in and look forward to growing our family here. I welcomed my first baby at Lincoln Hospital last October and was fortunate in having a low-risk and typical pregnancy. Despite that fact, I still ended up visiting labor and delivery four separate times before giving birth, and five times in the first two months after delivering my son. That is ten visits to labor and delivery for one typical pregnancy with an unexpectedly difficult delivery.

I want to offer an additional perspective to labor and delivery units; that they serve a greater purpose than just delivering babies. This was my first pregnancy. I wasn't quite sure what was "normal" for my body in pregnancy. Symptoms that would typically be concerning, like shortness of breath, is now part of regular daily life. Symptoms that seem innocuous, like itchy palms, could result in a stillbirth. Over time, I got used to some of the changes during pregnancy. The most familiar being the movements of my baby. After months of wiggles, punches, and rolls, I got a good sense of the activity patterns of my son. I had a few days of minimal movement late in my pregnancy. This no longer felt like my "normal." The labor and delivery unit at Lincoln was able to see me immediately to monitor my baby's vitals to verify all was well. Fortunately it was. A few weeks later, my water broke at home. So back to labor and delivery I went. Turns out, I had a high leak and my water wasn't fully broken, so I was able to return home to see if labor would kick off naturally. When the same thing happened two days later, I returned to labor and delivery. They again were able to confirm my baby's vitals were good and that my water had indeed fully broken this time. Because I lived fifteen minutes from the labor and delivery unit, I was able to return home again for ten hours to comfortably labor there rather than spending the day in the hospital.

Then I had my delivery. It was hard. It resulted in an unexpected c-section and I lost about half of my body's blood. I could write twenty pages about the incredible, competent, and compassionate care I received at Lincoln to save my uterus and life, but I will continue my focus on the importance of local care. After four days in the unit, my son needed additional care one day after being discharged from his birth. He needed to be readmitted to labor and delivery for an additional 30 hours for high bilirubin levels (jaundice). Due to his high bilirubin levels, he was lethargic and not nursing well. This led to him losing weight and experiencing nursing challenges in the first few weeks of his life. After his second discharge from labor and delivery, we needed several follow-up appointments with the lactation consultants in the labor and delivery unit to monitor his weight gain and receive needed support in feeding.

Again, he was able to receive this care because I live fifteen minutes away from a labor and delivery

unit. I would not have been able to receive nursing support if this unit didn't exist. I had just had a c-section and was not able to drive or even ride comfortably in a car for weeks after delivery. If Lincoln Hospital closes their unit, my travel time to labor and delivery will be one hour long at minimum. If that were the case with my first pregnancy, I would have had an additional day in the hospital for my delivery, I would have needed to make the choice to drive at least an hour post-surgery (which is not recommended), and my son and I would not have received follow-up feeding support.

Labor and delivery units offer crucial healthcare to mothers and babies beyond just a single birth. This care is even more significant in rural communities which is the backbone of Maine towns. Please do the right thing by Mainers and pause all labor and delivery unit closures. This will allow for proper time for an independent assessment, data, and solutions to be considered before irreversible damage is done to the future Maine.

Thank you for your time.

Jocelyn Del Muro

Rural women are **64% more likely to die** of pregnancy-related causes than urban women, and 9% more likely to suffer life-threatening complications during pregnancy, birth, or postpartum.

I'm Dr. Judy Stone, an infectious disease physician and medical journalist who has summered in Maine for over 40 years and owns a home in Boothbay Harbor.

MaineHealth is private, but it receives substantial public funding and owes these communities real accountability. It broke that trust once already by closing St. Andrews Hospital and is now closing its urgent care center too. Closing Miles Labor and Delivery is worse still.

My concern led me to write two articles in Forbes on the Miles closure, shared with this committee. I requested an interview with MaineHealth beforehand; they declined, and never answered my follow-up questions. MaineHealth says this closure isn't about money. If that's true, they should have no objection to answering the four simple questions I asked them:

Why the rush — the process ran from June to August 6th — and why not wait until after the November election?

Why weren't the Lincoln County Commissioners consulted?

How will this affect already-stretched EMTs, who'll face longer transports and less availability for other emergencies?

And **where is the economic impact assessment** for Lincoln County?

MaineHealth's estimate of 37 minutes' added travel time is unrealistic, especially for women on the Boothbay or Pemaquid peninsulas. It ignores summer tourist traffic, winter fog and ice, and assumes a car and driver are instantly available. A woman in active labor on the Pemaquid peninsula, in a January whiteout, will not have 37 minutes to spare. How much longer does an ambulance take from the peninsula — and **what other emergencies go unanswered** while it's tied up driving to Brunswick? I strongly believe that **women in labor will die** because of the delay.

Research from the University of Kentucky found that rural counties losing obstetric care saw **business establishments drop 17%**, five points worse than in urban counties. Access to obstetric care is an economic development issue, not just a health one.

The lack of transparency now mirrors the St. Andrews closure. Lincoln County cannot both court retirees and young families while stripping away the maternity care that keeps families here.

I'd ask this committee to **require an independent economic and public-safety review** before any closure proceeds.

Thank you.

Judy Stone, MD

Author, *Resilience: One Family's Story of Hope and Triumph over Evil* and *Conducting Clinical Research*
Infectious Disease physician, Senior Contributor: Forbes Pharma and Health
Drjudystone.com



Testimony in Consideration of Maternal Services in Maine

August 27, 2026 - Delivered by Dr. Julie Pease on behalf of Maine AllCare

Sen. Donna Bailey, Senate Chair, Rep. Kristi Mathieson, House Chair, and Members of the Committee on Health Coverage, Insurance and Financial Services.

My name is Dr. Julie Pease. I live in Topsham, Maine. I am a semi-retired psychiatrist, concerned about closures in essential services throughout the state. I am a long-time board member of Maine AllCare, an organization dedicated to universal health care for all Maine residents. We appreciate the HCIFS Committee's continued work in the area of maternal services, especially in rural Maine.

As today's previous testimony has evidently indicated, providing all levels of maternal or perinatal care in all areas of a rural state is a daunting challenge. This problem is not unique to Maine. Our Canadian neighbors have similar distribution issues of population and healthcare services. They also have similar workforce issues. They have similar decreasing utilization and associated skill retention issues. They have asked the question of "how do we organize" the delivery of maternal services.

But one question all of the Canadian provinces have addressed is the fiscal one. Because of their universal form of payment for healthcare services - and since "everyone knows they will get paid" - then all parties involved can then concentrate on the task of "getting the right patient, to the right place, by the right method, at the right time". And they can focus on delivering necessary services based on patient and community needs rather than line items in budgets.

As you consider this issue, I would ask you to consider how our Provincial Canadian neighbors are addressing this problem. "Reproductive Care Program of Nova Scotia" <https://rcp.nshealth.ca/about>. Visiting this website, you may get some idea of how, with the payment question addressed, the Nova Scotia health system is able to move forward in a patient centric manner. New Brunswick also has been dealing with similar challenges to Maine, related to staffing though not funding. They are directing their resources simultaneously to recruitment and to support for transportation and treatment at other hospitals. Finally, I highly recommend an article on how the British Columbia

Ministry of Health was able to begin to address their rural maternal issue (British Columbia is 5x the population of Maine, but 12x the area, i.e. very rural).
<https://doi.org/10.1186/s12884-023-05898-7>.

With your legislative office, skills and the importance of this committee and this issue, I expect that a call from you to any peer governmental officer or office in any of these provinces would yield valuable information and perspective – not only into the issues raised today, but how their healthcare systems work in their entirety.

Thank you so much for your efforts. If there is any way that Maine AllCare can assist you with your work, please let us know. info@maineallcare.org.

Senator Baily, Representative Mathieson, and Honorable members of the Committee on Health Coverage, Insurance, and Financial Services, my name is Olivia Burke, and I'm writing today to share my perspective on the perinatal care landscape in Maine and recommendations for state intervention.

I trust this Committee understands the maternity care landscape and will instead focus my testimony on the real-life consequences of these closures, my understanding of the root causes, and recommendations based on my work. To level set, 13 of Maine's 28 birthing units have closed since 2014, with 10 closures since 2020. The maternity care crisis in Maine is not slowing down, it is accelerating. These closures have been concentrated almost exclusively in rural communities, where the average one-way drive time to a birthing unit is approximately 45 minutes. For a more in-depth overview, I recommend reviewing this article, which provides essential birth, demographic, and hospital data that sheds light on the maternity care crisis in Maine.

There is no one reason for these L&D unit closures, but there are widely accepted factors that inform these closures, which I have detailed below:

- **Financial Pressures/Operating Costs** – Fully operational L&D units must be open 7 days a week, 24 hours a day, with appropriate staff on-shift or on-call to treat patients. Malpractice insurance requirements for L&D units are complicated, expensive, and often hard to maintain for units with low birth volume. Medicaid (MaineCare) reimbursement rates are often less than the commercial insurance rate, and may be less than the hospital's operating margin, and cover a disproportionate number of rural births.
- **Staffing Shortages** – L&D units require a high level of care, and must have several staff available - including Obstetricians and L&D Nurses, as well as access to other specialty providers, like Pediatricians, Anesthesiologists, Surgeons, etc. Attracting and keeping specialty providers to rural areas is difficult for a multitude of reasons - physical isolation, salary expectations, lack of patient cases to sustain specialized training. Burn out is common for all healthcare workers, but especially for those in rural areas.
- **Declining Birth Rates** – Maine is both the most rural and oldest state in the country. According to the CDC, Maine's fertility rate in 2024 was 46.3 births per 1,000 women; the US average fertility rate in 2024 was 1,626.5 births per 1,000 women. Since 2011, Maine has consistently reported more deaths than births per year.

The State of Maine and statewide partners have been working diligently on addressing the factors listed above, and more, over the last several years. Between the Rural Obstetric and Management Strategies (RMOMS) Grant, the Transforming Maternal Health (TMaH) Grant

and, most recently, the Rural Health Transformation Project (RHTP) funds, millions of dollars have been spent working to improve rural perinatal health outcomes and support rural obstetric care teams. But if the rate of L&D closures is any indication, these initiatives do not seem to be fully addressing the challenges faced by rural obstetrical care teams. Why not?

I've worked on several of the initiatives listed above and know first-hand the good work being done at both a systematic and local level to address perinatal health systems infrastructure. Many of the efforts listed above have been focused on building out the perinatal digital health landscape in Maine, and the programs developed with this funding have undoubtedly improved access to perinatal health services for rural patients. I am a strong advocate for the power of digital health solutions to improve rural health outcomes, reduce barriers in access to care, and improve local provider capacity. But the inconvenient truth is that effective telehealth interventions fail without dedicated local care teams prepared to intervene as needed.

These failures are not theoretical; they are already happening. The OB BP RPM program funded by RMOMS went live at four rural MaineHealth hospitals between January of 2024 and January of 2026 – Waldo, Pen Bay, Lincoln, and Stephens Memorial. Since January 2024, both Waldo and Lincoln have closed their L&D units; when these units close, the OB BP RPM ceases operations at that site. While establishing or expanding access to telehealth services should be an important priority for the state, it is disingenuous and dangerous to rely on telehealth to solve the maternity care crisis Maine faces.

It is my belief – and I say belief as I do not possess the subject matter expertise nor blind confidence to claim this as fact – that the uptick in L&D closures is the result of an essential truth in the United States' political, economic, and social systems - health care is a business. In Maine, it's a major one. The Maine State Economist's Office identified healthcare as one of the highest contributors to GDP growth in Maine, second only to real estate. In 2024, health care spending in Maine accounted for 17.3% of personal expenditures, higher than both the New England and U.S. averages. In 2024, MaineHealth, the largest health system in the state, reported a \$220,823,000 budget surplus, identified as "AMOUNTS EARNED FOR FUTURE INVESTMENTS IN PATIENT CARE AND COMMUNITY HEALTH PROGRAMS" in their annual report. ***How does a non-profit health system end the year with a \$220 million surplus – money they must re-invest back into healthcare services – and allow two of their rural L&D units to shut down?***

When L&D units close, patients in these rural areas do not stop needing obstetrical services. These patients, who are often already well into their pregnancy, are directed to services at the closest birthing hospital to them. When Waldo closed their L&D unit in

2025, all patients were directed to Pen Bay Hospital. With Lincoln's closure slated for December 2026, patients are being directed to MidCoast Hospital, but Pen Bay administrators and providers estimate at least half of Lincoln's patient population will opt to deliver at Pen Bay. In less than two years, the Pen Bay L&D team has absorbed the work of two L&D units **in addition to** their existing patient population, while continuing to navigate the challenges associated with keeping a rural L&D unit operational. To date, there have been no specific budget allowances made to bring on additional care team members to support the influx of patients. Would you do three times as much work for no extra pay? Do you think MaineHealth CEO Andy Mueller, who made a \$2.2 million salary in 2024, up from a measly \$1.2 million in 2021, would take on triple the work for no extra pay?

As pregnant Mainers worry about where to seek obstetrical care, and EMS becomes overburdened with responding to obstetrical emergencies, and L&D nurses at remaining rural birthing hospitals work overtime to ensure patient safety, and the State and public health agencies wrestle with piloting potential solutions, large health systems sit on piles of money tucked away for theoretical "future investments." **This is not just unreasonable; it is an abject policy failure.**

Based on my experience working with rural obstetric care teams, managing perinatal telehealth programming and interventions, and seeing first-hand the consequences of rural L&D unit closures, my recommendations are as follows:

- Establish a state-enforced moratorium on Labor and Delivery unit closures at all Maine hospitals that accept MaineCare and/or state assistance funding as the state works with health system and community organizations to address root causes of unit closures
- Leverage state power to negotiate with Medical Mutual, Maine's largest medical malpractice insurer, to adapt malpractice insurance coverage to meet the realities of rural hospitals, reducing both expense and extensive staffing requirements that complicate care delivery
- Require hospitals with operational L&D units to submit staffing and budget reports to the state, allowing the state to identify where staffing or budget shortfalls exist, and informing state funding allocations appropriately
- Adopt alternative reimbursement models for MaineCare patients that receive pregnancy, birth, and postpartum care services to improve operating margins for smaller rural and/or independent hospitals
- Establish a public health insurance option that allows consumers and/or businesses to opt into state-funded insurance coverage

- Increase state-sponsored incentives – tuition reimbursement, student loan forgiveness and/or payment, professional development opportunities, etc. – for rural obstetric providers
- Require health systems that have closed L&D units in the last five years to allocate funding for additional clinical and operational staff for the OB/GYN clinics and L&D units responsible for absorbing the patient load from closure
 - o Example: Require MaineHealth to fund X additional staff positions at Pen Bay and MidCoast Hospitals to offset increased patient load from Waldo and Lincoln Hospitals
- Establish a state fund that allows rural perinatal patients to apply for funds to subsidize the costs associated with traveling to the nearest birthing unit (transportation, accommodations, etc.)
- Invest state funds in perinatal care training opportunities for EMS, Public Health Nurses, Community Health Workers, and Doulas
- Establish state-wide perinatal telehealth programming that serves patients regardless of health system affiliation, delivery site, or insurance coverage

As you consider the best path forward for state intervention, I urge you to consider that how we treat pregnant and postpartum patients, and their growing families, is a microcosm of life in Maine. I confess I am not a Mainer and have not lived here for all that long, but working on behalf of perinatal care efforts has made this fight a deeply personal one for me. As a young person hoping to build both my professional and personal life in Maine, these closures reflect a larger and more complicated question – what does our state become if you can't give birth here, and you can't go to school here, and you can't find a job here, you can only die here?

Thank you for your time,

Olivia Burke, MPH

If my baby cannot be delivered profitably, with the most benefits and incentives to healthcare providers, corporations, wealthy persons' finances, and people of political ambition, then my baby is not worth investing in.

If the health, well-being, and safe passage of my wife and child to the hospital and through the birthing process is not a worthwhile investment for the State of Maine, of paramount importance, then why invest in the children of Maine at all?

Why bother with child protection, toddler healthcare, K-8 education, and the success and development of our little Mainers into mature, intelligent, balanced adults?

The clear message I am receiving as a young man attempting to start growing my family, is that Maine is not a family-friendly place, nor does it strive to be in the future. Maine is not a place to set down roots, as a once fertile land is now making it more difficult to safely bring a child into this world, and nourish their success, in 2026, in the GREAT country of the United States of America.

As evidenced by my personal experience in the past 4 years, Maine is not a place that is conducive to raising a family. The State's record of protecting and aiding the children under its care is abysmal. Healthcare and access to medical services for young families, as well as all individuals, is shrinking. Access to any public pre-K program, let alone a quality one, is limited at best. Our education record going back 7 years now is shameful, and we should all be disappointed in the lack of action and ideas from legislators. Honestly, I find the asking the public for solutions to be insulting, and a show of every elected officials' lack of preparation and courage on this topic. Our children have had a terrible success rate in the past years and they do not enter the education system ready for success, as only 40% even attend pre-K. The state of education in Maine is only getting worse, the time for an impactful legislative response is long overdue.

The problem is complex, and is a result of our continued trust in corporate entities, and the politicians they corrupt, to have our best interests in mind as citizens. It is also the result of a continued contribution to the State of Maine towards the profits and salaries of MaineHealth, and similar healthcare providing entities across our Country. The only solution I see is trusting in the nurses and good doctors to create private birthing centers (Green Mtn Birthing Center VT) to serve geographically cutoff regions. I would want these centers financially supported with State funds, audited by a 3rd party, and positioned with the mission to serve the region with health services, regardless of profitability.

I say gather a panel of experts, do research on other domestic and international models with successful results on the same problem. Then make a decisions and show me some action within 6 months. Anything else shows the lack of concern you all have for helping families establish themselves, and stay in Maine. Otherwise we will have a State full of retiring, old, sickly people, sitting on assets, and no facilities, and no workers to provide services.

ZACHARY J HANRAHAN 8/27/26

**Testimony of Jay A Naliboff MD FACOG
Re: Maternal Health Services in Maine**

Senator Bailey, Representative Mathieson, Distinguished Members of the Committee on Health Coverage, Insurance and Financial Services:

My name is Dr. Jay Naliboff and I am a retired OB/Gyn and Fellow of the American College of Obstetrics and Gynecology. I currently reside in Chesterville, Maine.

Maternity care in Maine is in crisis. 12 hospitals have closed their birthing units, 9 in the most recent past and one more is pending. Some were too small to safely continue but others, such as St. Mary's, had fully functioning units. Closure of birthing units not only effects pregnant women and their families but also has negative impacts on economic development and the demographic imbalances in Maine. What young family would want to move to a town where they would have to drive an hour or more for OB care? What business would want to relocate to a community where workers would be hard to recruit for that reason? Are OB units being closed for safety reasons or are these decisions based on economics alone? What thoughts are being given to alternatives such as telemedicine, mobile health units, and midwifery care? What support could state government give to keep maternity units open? How will hospitals without obstetrical coverage deal with the inevitable emergency drop-ins?

This is obviously a complex problem with complex solutions tailored to individual community resources and needs. It will require cooperation between health systems, state and local government, providers, and members of the community.

One candidate for Governor has proposed holding a Maternity Summit, bringing the above stakeholders together in one room. I fully support this and hope that whomever becomes Governor will also follow through. I also welcome the announcement by Maine Health of a moratorium on further maternity unit closures and would like to hear the same from the Northern Light system. Such a moratorium will allow some breathing space to find thoughtful solutions to Maine's maternity care crisis.

I thank the Committee for their recognition of the current crisis in maternity care in Maine and stand ready to help find solutions in any way I can.

Respectfully submitted,



Jay A Naliboff MD FACOG

Written Testimony Submitted to the Maine State Legislature

Regarding the Planned Closure of Labor & Delivery Services at Lincoln Hospital, Miles Campus

August 27, 2026

Submitted by: Melissa Keepert, MD

My name is Melissa Keepert, and I am a board-certified pediatrician and the Associate Medical Director of Pediatrics at MaineHealth Lincoln Health in Damariscotta. I have practiced pediatrics in this community for ten years, and I am submitting this testimony regarding the planned closure of the labor and delivery unit at Miles Campus. I am writing in my individual capacity as a community physician and resident, not on behalf of or in my official capacity as an employee of MaineHealth.

I want to start from where I sit clinically. Pediatrics and labor and delivery are not separate services at Lincoln — they are one continuum of care. Every newborn I admit, every early lactation consult, every urgent call about a jaundiced or unstable infant depends on a functioning L&D unit and the nursing and midwifery expertise that comes with it. This is not only a decision about obstetric services. It is a decision about newborn and pediatric care for this community, and I ask the Legislature to weigh it that way.

This closure also fits a pattern I see across rural Maine and rural health systems more broadly, where women's and children's services are often the first to be cut when margins tighten. Each closure can look defensible in isolation, but the cumulative effect is that rural families lose maternity and pediatric care access faster than any other service line, and it rarely comes back once it is gone. Lincoln has an opportunity to be an exception to that pattern rather than another data point in it, and the Legislature has a role in making sure that opportunity is not lost to a process that moves faster than the community can respond to it.

What I am asking of this body is not to overturn a hospital system's operational decision. It is to use the Legislature's oversight role to ask for a pause: for staff and the community to be able to see the data driving this decision, understand what alternatives were considered and why they were set aside, and have a real opportunity to bring forward workforce and partnership models before it is finalized. A community this size, and a hospital this connected to it, should be able to work through a problem like this together rather than have it delivered as a conclusion.

I recognize the financial and staffing pressures behind this decision are real, and I am not asking this Legislature to dismiss them. I am asking that the community and clinical staff be treated as partners rather than an audience before a decision this consequential to newborn and maternal health in this region is finalized.

Thank you for your time and consideration. I am glad to provide any additional information the Committee may find helpful.

Respectfully submitted,

Melissa Keepert, MD

31 Nissen Farm Lane, Damariscotta, ME 04543

Associate Medical Director of Pediatrics, MaineHealth/Lincoln Hospital



August 26, 2026

Senator Bailey, Representative Mathieson, and Honorable Members of the Health Coverage, Insurance and Financial Services Committee,

I write today on behalf of the Maine Women's Lobby. For almost fifty years, the Maine Women's Lobby has worked to build gender justice in Maine through legislative advocacy and systems change.

We are deeply appreciative of the Committee's time and attention to the complex issues surrounding maternal health care access in the state. Expanding and protecting full spectrum reproductive healthcare is a top priority for the Maine Women's Lobby and **we look forward to working collaboratively with the Committee and other stakeholders in the coming session, and beyond, to continue to address the overlapping challenges facing our health care systems.**

The Legislature has addressed issues of maternal health in several critically important ways in recent years, including extending both public and private insurance coverage for the period after birth in 2021, and passing LD 1113, which directed the Permanent Commission on the Status of Racial, Indigenous, and Tribal Populations to create a report on racial disparities in perinatal care¹. Recommendations in that report included expanding access to doula care and establishing MaineCare coverage for doula services is now underway in part through the LD 1523 Resolve in 2025. The legislature also considered the LD 1028 Resolve to study equitable access to birthing facilities, which ultimately did not pass. These initiatives are important building blocks for continued efforts to address the availability of maternal health care services.

Outside the Legislature, other important efforts are taking place. The state's Perinatal Quality Collaborative (PQC4ME) has convened since 2018 to identify and implement evidence-based, equity-focused solutions, including publishing a roadmap for improving the state's system of care². Other reports have considered the issues of access, including the Maine Doula Coalition's Workforce Assessment (2024)³, the Perinatal Health Disparities Needs Assessment (2023)⁴, and the Needs Assessment of the Obstetric Workforce in Maine's Rural Hospitals (2024)⁵, among others. Maine has built on this work over the last two years as part of the ten-year federal grant to implement the Transforming Maternal Health (TMaH) model which has helped facilitate

¹ Permanent Commission on Racial, Indigenous, and Tribal Populations. (2023). LD 1113: Racial Disparities in Prenatal Health Access. Retrieved from <https://legislature.maine.gov/doc/7888>

² Building Maine's System of Perinatal Health: A Roadmap for the Future: <https://pqc4me.org/our-projects/perinatal-systems-of-care-roadmap/>

³ Maine Doula Coalition (2024). Workforce Assessment. Retrieved from https://www.mainedoulacoalition.org/files/ugd/f1ce2f_43e1051193f443e9af6777d7cd742376.pdf

⁴ Maine CDC. (2023). Maine Perinatal Health Disparities Needs Assessment. Retrieved from: <https://www.maine.gov/dhhs/mecdc/sites/maine.gov/dhhs/mecdc/files/maternal/ME%20Perinatal%20Needs%20Assessment%20-%20All%20Components.pdf>

⁵ Roux Institute. (2024). Needs Assessment of the Obstetric Workforce of Maine's Rural Hospitals. Retrieved from:

<https://roux.northeastern.edu/story/needs-assessment-of-the-obstetric-workforce-in-maines-rural-hospitals/>

coordination opportunities for effective regionalization of care, especially in the most rural parts of the state.

This context is shared to reiterate that Maine is not, in August 2026, starting from scratch! These previous (and ongoing) efforts provide an outstanding , expert-informed launch-pad for the work ahead. What remains clear is that the work is very much needed: **Access to consistent, high-quality perinatal care is a key factor in positive perinatal health outcomes. However, as the committee is well aware, Maine is experiencing a perinatal and maternal health care crisis: Since 2015, Maine has seen the closure of 11 obstetrics units, with a 12th just announced earlier this month⁶. Maine's perinatal and maternal health crisis disproportionately affects Black, Indigenous, People of Color (BIPOC)⁷ pregnant Mainers and those living in rural areas⁸.**

We know the Committee will be hearing from many stakeholders offering policy ideas and considerations. Addressing the complex, overlapping challenges facing access to full spectrum reproductive healthcare will not happen overnight, and **will require collaboration and communication from a wide range of stakeholders**. It will also require creativity and willingness to think outside the box. **The Committee and Legislature has a powerful opportunity to help convene and coordinate the many stakeholders, interests and ideas that are necessary to ensure Maine is a safe and supportive place to receive reproductive healthcare, give birth, and raise the health and happy next generation.**

Thank you for your time. **We** look forward to the important work that **lies** ahead!

Sincerely,

Lily Bohen James
Advocacy Director, Maine Women's Lobby

⁶ MaineHealth board votes to close birthing center at Lincoln Hospital in Damariscotta, Portland Press Herald. <https://www.pressherald.com/2026/08/06/mainehhealth-board-votes-to-close-birthing-center-at-lincoln-hospital-in-damariscotta/>

⁷ Permanent Commission on Racial, Indigenous, and Tribal Populations. (2023). LD 1113: Racial Disparities in Prenatal Health Access. Retrieved from <https://legislature.maine.gov/doc/7888>

⁸ Maine CDC. (2023). Maine Perinatal Health Disparities Needs Assessment. Retrieved from: <https://www.maine.gov/dhhs/mecdc/sites/maine.gov.dhhs.mecdc/files/maternal/ME%20Perinatal%20Needs%20Assessment%20-%20All%20Components.pdf>

McCarthyReid, Colleen

From: Julie Brown <julia.margaret.brown@gmail.com>
Sent: Thursday, August 27, 2026 10:01 AM
To: McCarthyReid, Colleen
Subject: Testimony on Rural Maternity Care for the committee on Health Care, Insurance, and Financial Services (HCIFS)

ALERT This email looks suspicious and may have been automatically generated. Be careful as this is likely spam. If you disagree, mark as Safe/Phishing using the Outlook Add-In. Powered by CyberSentriq.

This message originates from outside the Maine Legislature.

To the HCIFS,

I am writing as a patient, mother and community member to urge you to pause the closing of rural maternity units in Maine, and I particularly urge you to do everything in your power to keep Labor & Delivery at Lincoln Hospital's Miles Campus open and to exhaust every reasonable alternative before making an irreversible decision.

I live in Bremen, a very small town east of Damariscotta. I work as a scientist in Lincoln County and manage several employees as part of my research program at an oceanographic lab in Boothbay. Some of my employees have children, others plan to start a family soon. They are stellar workers and excellent community members, I hope that they stay in Lincoln County. Shutting down rural maternity care sends them the wrong message.

Prior to becoming pregnant in 2018, I had been receiving OB/GYN care at Midcoast Hospital. The hour-long drive from my home in Bremen did not seem like a huge hardship because I only visited once a year for my annual appointment. Upon becoming pregnant, I realized that this long trip was going to make the pregnancy and juggling my full time job very challenging. Thankfully, I switched to Miles where I received and still receive the best OB/GYN care I have ever experienced. The care is local and personalized. The team knew me personally through each of my pregnancies.

I gave birth at Miles in 2019 and 2021, and despite both experiences being unpredictable and not-as-planned, I walked away from each feeling strong, proud and respected as a birthing mother, and full of love for the team of nurses, midwives and OB/GYNs that ushered my daughters into the world with me.

These positive feelings surrounding the birth of my daughters are different than those experienced by close friends of mine who have labored at other, larger labor and delivery units in Maine and elsewhere, and I believe it is the unique community, philosophy and history that makes this Labor and Delivery Unit truly special and an important resource for the state of Maine. Miles diverts births from already full labor and delivery units at surrounding hospitals, and gives families an alternative, less hectic, baby friendly option. I worry that the "regionalization" of maternity care will not only make labor and delivery less safe, but also much less personalized and more traumatic for birthing mothers.

My second daughter was born within an hour of half of arriving at Miles. If I had to drive an hour, rather than 12 minutes, to get to the hospital, that second delivery would've turned into an emergency roadside situation.

I understand the challenges in keeping rural units like Miles open are real, but these challenges worth solving as the health, safety and future growth of Maine communities depends on it.

With respect,

Julia Brown, PhD

Bremen, Maine

State of Maine
Joint Standing Committee on Health Coverage, Insurance and Financial Services
Testimony of Megan Stewart on behalf of Maine Primary Care Association
August 27, 2026

Regarding:
The Status of Maternal Health Care in Maine

Senator Bailey, Representative Mathieson and members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, I am Megan Stewart, Director of Government Relations at Maine Primary Care Association (MPCA).

MPCA is a membership organization that represents Maine's Community Health Centers (CHCs), also known as Federally Qualified Health Centers (FQHCs). Maine's CHCs make up the largest independent primary care network in the state, providing high quality and accessible primary and preventive medical, behavioral, and dental health services for over 200,000 people (1 in 6 Mainers) at more than 100 service delivery sites in all 16 Maine counties.

Over the past few decades, we have moved away from the model of allowing primary care physicians that specialize in obstetrics and gynecology to be the primary provider of maternal care. Maternal care is deeply interwoven with primary care because reproductive health concerns are a common entry point for women in primary care.¹ Caring for women means caring for their reproductive health. As Maine's largest primary care provider, our CHCs offer innovative maternal health care in some of Maine's most rural and underserved areas.

For example, Greater Portland Health has created a model to take pressure off hospital providers while providing prenatal, postpartum, and pediatric services. They do this through providing prenatal care for approximately 32 weeks and then transition patients to an obstetrician for the rest of the pregnancy and delivery. The Greater Portland Health team then reconnects with the mother and baby in the hospital and continues their postpartum and wraparound care afterward. We feel strongly that this model could be implemented at CHCs in more rural areas if funding to sustain a maternal health workforce were made available.

Through grant funding, MPCA ran a ten-month maternal health learning collaborative with eight of our member health centers focusing on resource sharing and training around maternal health. We have heard from many of our health centers the need for funding to support workforce development to help increase access to prenatal care, and an interest in hiring more primary care providers with OB/GYN skills. The interest in maternal care is strong at CHCs, but nearly all of our CHCs lack the necessary funding to increase these services.

MPCA feels strongly that there needs to be a unified state approach around maternal health care. There needs to be a requirement that hospitals considering birthing unit closures provide adequate warning to the State and local partners so that there is an opportunity to prevent the closure. There needs to be an ability for a woman to deliver a child at any hospital in Maine regardless of a specified birthing unit. Additionally, mobile maternal health units should also be investigated as a possible solution to safe

¹ Family Physicians Delivering Babies? It's Time to Decide

delivery and care in rural areas. We welcome the opportunity to provide additional ideas and to collaborate with stakeholders and the State to ensure that mothers and their children have access to safe and local maternal health services.

On behalf of Maine's Community Health Centers, thank you for considering our comments. Please do not hesitate to contact me directly at mstewart@megca.org with any follow-up questions.

Megan Stewart, JD
Director of Government Relations
Maine Primary Care Association
mstewart@megca.org

To Whom It May Concern:

My name is Abigail Blake-Sheehy, I am a second-year family medicine resident at Maine Dartmouth Family Medicine here in Augusta. I moved to Maine 6 years ago for medical school and was ecstatic about matching here and continuing my medical training in Augusta. We knew since relocating to Maine in 2020 that we would want to settle down and raise our family here. When we found out we would be staying for residency training, my husband and I were finally able to put down roots. We bought a house, became involved in our community, and my husband has started his own nonprofit focused on helping Mainers with disabilities. Simply put, Maine has become our home.

I chose my residency program in part because of the wonderful training we get in obstetrical care - family medicine is uniquely positioned to take care of parent-child dyads in a way that no other specialty is, and it's a population I am incredibly passionate about working with. To date, I have delivered over 60 babies at Maine General Medical Center, with a goal to deliver at least 100 by the time that I graduate. This is to help me be credentialed to practice obstetrics as a primary care physician when I complete my residency training. I am incredibly worried about the future of obstetrical care in Maine, both from a personal standpoint and from a community standpoint. Family medicine physicians can provide prenatal and obstetrical care in addition to primary care, and in my opinion are an underutilized resource for addressing the maternal health crisis in this state.

At some point systems must shift from caring about the bottom line to caring about our communities. What does it say about us that we are continually putting profit over people? It is impossible for families to feel supported in a place where it is unsafe for patients to seek prenatal care. It is not a surprise to me that we see fewer young people wanting to stay here in Maine if we do not have resources to support growing families. During medical school I completed my rotation in obstetrics and gynecology at Maine Coast Hospital in Ellsworth. At that time, it was not uncommon for patients to travel upwards of two hours to receive care. This disparity in access to care will only worsen as more delivery units close. As a young mother myself, I cannot imagine asking laboring patients to drive multiple hours to the hospital to have a safe delivery. We will inevitably see more adverse outcomes because of L&D closures across the state, including an increase in maternal and neonatal mortality simply because of lack of access to care.

One of my other concerns is that with continued closures of labor and delivery units across the state, job prospects will be impacted. If this is the case, my family and I will be forced to look outside the state for a job that would allow me to keep this part of my practice and continue to practice primary care. We already have a physician shortage in Maine that is projected to increase over time, and the closure of birthing units will turn away even more physicians.

Committee, I urge you to think about your communities as we consider further closures of labor and delivery units. The people of Maine deserve access to safe, quality prenatal and obstetrical care, and family medicine physicians are part of that solution. Thank you.

Abigail Blake-Sheehy, DO, MPH

McCarthyReid, Colleen

From: KATE REYNOLDS <katereynolds@bellsouth.net>
Sent: Thursday, August 27, 2026 1:29 AM
To: McCarthyReid, Colleen
Subject: Hearing on Birthing Center Closure

This message originates from outside the Maine Legislature.

Ms McCarthy Reid,

I am writing to express my profound disappointment with the MaineHealth corporation's decision to close the Lincoln Hospital award winning birthing center. Throughout this process, it felt like there was no genuine good-faith effort to explore any option beyond outright closure. The community's wishes, thoughtful and well researched proposals to preserve services, and creative solutions from residents and providers all seemed to be largely dismissed. The lack of transparency around this decision has eroded trust and left many feeling disregarded.

Thousands of residents, civic groups, medical professionals, elected officials, our governor, and bipartisan candidates for public office voiced clear opposition. Those voices deserved a serious response. Adding to the concern, when MaineHealth announced the closure, it pledged to pause any additional labor and delivery closures at other facilities for two years. Yet Lincoln Hospital was excluded from that commitment. If a pause was warranted elsewhere, why not here? That inconsistency is hard to justify.

As a nonprofit institution, MaineHealth's mission is to serve the community. The Board of Trustees has fallen short of that responsibility. Personally, I don't need maternity care at my age, but I know communities thrive only when young families choose to live, work, and raise children there. Removing essential services for those families threatens our long-term vitality.

I understand that maternity care deserts are a statewide and national challenge, but that reality calls for innovation, not retreat. Our community offered thoughtful recommendations and showed a willingness to collaborate. We could have been a model for creative, community-based solutions. Instead, MaineHealth chose the simplest option, not the wisest one. This decision is short-sighted, seemed pre-determined, and harmful to our region's future. As a nonprofit health system, MaineHealth must be held to the highest standards of accountability and stewardship. The people of Lincoln County, the people of Maine, deserve nothing less.

Sincerely,

Kate Reynolds, Ph.D
76 Upper Round Pond Rd.
Bristol, ME 04539

Good afternoon Chair Bailey, Chair Mathieson, and members of the committee,

My name is Gianna DeJoy. I am a medical anthropologist and public health researcher at the Margaret Chase Smith Policy Center at the University of Maine. Maine's vanishing maternity care – the causes, effects, and how individuals experience these losses – was the subject of my doctoral dissertation research carried out between 2024 and 2026, but I have been focused on rural access to maternity care in Maine since 2014, just a few years after my hometown hospital in Blue Hill ended its labor and delivery program.

Now, so many years and so many closures later, the impacts of these decisions on individuals and communities are much better understood than they were at the time. We know that when a hospital decides that babies can no longer be born there, individuals in surrounding communities typically must travel longer distances to access prenatal care and give birth. This can raise barriers to care beyond the travel time itself; pregnant people without reliable transportation, juggling work and family obligations, facing summer traffic, winter storms, or slippery roads can find it more challenging to coordinate regular prenatal care when that care is far away.

● Obstetric closures also impact communities more broadly. Healthcare workers lose their jobs. Pregnant people feel left in the lurch. They mourn the lost opportunity to receive care close to home from providers who are also community members they know and trust. Parents and providers I spoke with worried about what comes next: Are the pediatricians the next to go? Do closures signal coming school consolidations? Closures also mean pregnant people in a community have fewer choices about the kind of birth they want to have; this can influence where young Maine families want to put down roots. These social impacts can seem abstract, but they have material repercussions. My research has shown that median household income growth stagnates in communities that experience a local obstetric unit closure compared to communities that maintain local obstetric services.

Maine parents who have shared their stories with me want to feel safe, cared for, and respected. They want choices. They want to know their healthcare providers. They want to give birth close enough to home that they can bring in family and support people. They want to see their health systems, municipal and state leadership investing in their families and the future of their communities, instead of giving up and leaving parents and the surviving maternity providers to try to make do in an increasingly untenable maternal healthcare landscape.



Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

TESTIMONY OF THE MAINE HOSPITAL ASSOCIATION

Health Coverage, Insurance & Financial Committee Meeting

August 27, 2026

Senator Bailey, Representative Mathieson and members of the Health Coverage, Insurance and Financial Services Committee, my name is Sally Weiss and I am here on behalf of the Maine Hospital Association to provide comment on issues related to the delivery of maternal health services in the State, including the availability of labor and delivery services in Maine hospitals.

Thank you for the opportunity to share our perspective and provide information about our ongoing work on this important issue. At MHA, I spend a significant portion of my time working to understand the many layers of this challenge and identify solutions—both opportunities to sustain services where feasible and ways to support hospitals and communities where inpatient delivery is no longer viable.

In 2024, MHA convened hospital leaders through the MHA Maternal Health & Access Committee. The committee has developed strategic goals focused on regional partnerships, shared staffing and call coverage, streamlined credentialing, virtual obstetric and neonatal consultation, and rural workforce training. MHA also participates in several Maine stakeholder groups that bring together hospitals, community providers, and state agencies focused on maternal health, perinatal care, access, and outcomes. We also engage in regional and national discussions with other states facing similar service closures due to declining birth volumes, increasing financial pressures, and workforce shortages.

Today, I would like to focus on two areas in which the Legislature can help address the complexities of sustaining rural labor and delivery services in Maine: workforce and payment for obstetric readiness.

Workforce: As we have heard, recruiting a highly specialized workforce to rural Maine has become more difficult as delivery volumes decline, call schedules intensify, and opportunities to maintain competency become less frequent.

Maine can expand training opportunities and loan repayment for family medicine physicians with advanced obstetric training and for Certified Nurse Midwives. These clinicians can strengthen the

rural healthcare workforce beyond labor and delivery by supporting a broad range of services within their communities.¹ That, in turn, can make perinatal care, including labor and delivery, more sustainable.

The March of Dimes' 2026 maternity care access report shows that the number of births attended by midwives increased significantly in New Hampshire and Vermont between 2016 and 2024, while Maine experienced little change.[3] Maine has an opportunity to integrate advanced practice providers more fully into maternity care teams, as other specialties have done, while also investing in obstetric fellowship training for family medicine physicians.

Payment: A hospital must be prepared to care for two patients at any hour, including when an emergency caesarean delivery is needed. Every labor and delivery program requires specialized nursing, a delivery clinician, a caesarean-capable physician, anesthesia, an operating-room team, and newborn support around the clock. MHA's 2024 illustrative model found that a hospital with 100 births per year would face more than \$3 million in minimum annual labor expenses alone, before accounting for equipment and facilities.

Most reimbursement follows a visit or delivery, but not readiness. Cost-based reimbursement for Critical Access Hospitals can recognize allocated labor and delivery costs, but it does not provide a predictable obstetric standby payment.² Federal rules separately recognize qualifying emergency-room on-call costs, and Medicare provides Rural Emergency Hospitals with a monthly payment for maintaining emergency availability.³ Maternal care has no comparable readiness payment yet faces similar operational challenges—be ready to provide care 24/7, 365 days a year regardless of patient demand.

MHA recommends a multi payer rural obstetric readiness/ model, with participation from MaineCare and commercial insurers. Geographically necessary birthing hospitals should receive a prospective monthly or annual capacity payment in addition to reimbursement for the care they deliver. The formula should recognize minimum staffing and call coverage, anesthesia and operating-room capability, newborn stabilization, training, and transfer readiness. It should be transparent, region-specific, and tied to access, quality, and coordination.

However, payment alone will not solve every challenge. Where inpatient delivery cannot continue safely, policy and payment must preserve local prenatal and postpartum care, ultrasound and remote image review, emergency department and EMS readiness, and reliable transport and

¹ For more information on CNM training, please see MHA Report published in November 2025 "Certified Nurse Midwifery Training in Maine: A Feasibility Study." Funded through an RMOMs Grant.

² 42 CFR 413.70 provides cost-based payment for CAH services and expressly addresses certain emergency-room on-call providers; it does not establish a parallel OB standby payment.

³ 42 CFR 419.92 establishes a monthly facility payment for Rural Emergency Hospitals in addition to service-based reimbursement. It is cited as a payment precedent, not as a recommendation that birthing hospitals convert to REHs.

transfer. Time-limited funding through the Rural Health Transformation Program can help build this infrastructure, but it cannot replace sustainable reimbursement.

In closing, not every hospital can safely sustain delivery services indefinitely. But Maine should not allow a geographically necessary rural service to fail simply because we have not invested in the necessary workforce or because we pay for births rather than readiness. We urge the state to protect access and quality together: plan regionally, invest in the workforce, and pay for readiness.

Thank you.

Sally Weiss, M.Sc.

V.P., Workforce Policy & Strategic Initiatives

Maine Hospital Association

Certified Nurse Midwifery Training in Maine: A Feasibility Study

An RMOMS GRANT

Sally Weiss
November, 2025



Maine Hospital Association

PROJECT OVERVIEW

The Maine Hospital Association, through funding from the Rural Maternity & Obstetrics Management Strategies (RMOMS) grant, conducted a feasibility study to evaluate the establishment of a Certified Nurse Midwife (CNM) training program in Maine.

The overarching goals of this study are to assess the demand and feasibility for such training, identify key academic and clinical partners, and explore models that may include either a standalone institutional program or a consortium-based approach. The study also aims to directly address workforce shortages in rural and underserved communities, with a particular focus on enhancing access to maternal healthcare services.

SCOPE OF CNM PRACTICE

Midwifery in Maine is supported by a clear regulatory framework that distinguishes between Certified Nurse Midwives (CNMs) and Certified Professional Midwives (CPMs). CNMs are graduate-level practitioners who have completed programs accredited by the Accreditation Commission for Midwifery Education (ACME) and hold national certification through the American Midwifery Certification Board (AMCB). In Maine, they are licensed as advanced practice registered nurses (APRNs) and practice with full prescriptive authority. CPMs, meanwhile, are licensed under Maine law (Title 32, Chapter 113-B). Their scope of practice includes ordering and interpreting laboratory tests, conducting ultrasounds, administering certain medications (apart from Schedule II-IV controlled substances), and providing maternity, newborn, and reproductive health care.

The scope of midwifery practice in Maine is broad and encompasses the full reproductive health continuum. Midwives provide preconception and family planning services, including counseling, contraceptive care, and health screenings. They manage prenatal care, offering comprehensive monitoring throughout pregnancy, education, and the management of low-risk complications. Midwives also attend births, supporting women through normal labor and delivery across a range of settings that include hospitals, birth centers, and home environments within the bounds of regulation.

Care does not end at birth, as midwives provide extensive postpartum follow-up, including maternal recovery, lactation support, and newborn assessments. For newborns, midwives typically provide well-baby care during the first six to eight weeks of life. CNMs also provide broader women's health and primary care services, extending their role beyond maternity into ongoing gynecological and reproductive health. In fact, the World Health Organization (WHO) contends that midwives could be providing 90% of sexual and reproductive care in the United States but the predominant structure of the healthcare system does not support this care model. [1]

SCOPE OF CNM PRACTICE

The benefits of midwifery care are well established in the research literature and align closely with Maine's maternal health needs. Midwifery-led care is associated with lower intervention rates, including fewer caesarean sections, inductions, epidurals, and assisted vaginal deliveries. Outcomes are consistently positive, with evidence of lower rates of preterm birth and stillbirth, reduced maternal complications, and higher breastfeeding initiation.

The continuity in midwifery models—where women are cared for by the same provider or small team throughout pregnancy, birth, and postpartum—leads to stronger relationships, greater trust, and more positive birth experiences. These models are also cost-effective, reducing reliance on high-cost interventions and shortening hospital stays.

In the context of Maine, midwifery's holistic and relationship-based model is particularly well suited to addressing workforce shortages and the unique challenges of rural healthcare delivery. Maine is fortunate to have a strong CNM workforce and while midwives are known for attending births, 55.1% of Maine CNMs identify reproductive care and 38.5% identify primary care as responsibilities in their full time positions, demonstrating their scope of practice and impact on communities.[2] By expanding access to midwifery services,

Maine has an opportunity to strengthen maternal health outcomes, improve patient satisfaction, and create a more sustainable, community-based model of care.

[1] American College of Nurse-Midwives; ACNM Workforce Study, Executive Summary. 2022
Midwifery Workforce Study - American College of Nurse Midwives.
[2] Ibid.

CONVENING A BROAD STAKEHOLDER GROUP & MEETING SUMMARIES

The MHA convened a group of stakeholders which included, but was not limited to, practicing nurse midwives, nurse midwife faculty, health systems, educational institutions, and state partners, including the Maine Department of Health and Human Services and Department of MaineCare. The first meeting, held on July 30, 2025, established the foundation for discussions around CNM training. Maine is seen as progressive in its approach to midwifery, with nearly one-fifth of births attended by midwives compared to only ten percent nationally. Yet, significant workforce challenges exist.

Participants identified both opportunities and challenges. Fellowship models, such as the one at Mass General Brigham, were highlighted as a possible model to emulate, and potential funding sources were discussed through the Transforming Maternal Health (TMaH) initiative and upcoming rural infrastructure programs. Partnerships with institutions like Frontier Nursing University and Boston College were seen as feasible avenues for accelerating training pathways. However, barriers remain, particularly the limited availability of clinical placements driven in part by the limited capacity of preceptors, organizational resistance in some hospitals, and the absence of patient preference data to guide planning. The meeting concluded with a commitment to explore fellowship feasibility, survey hospitals to assess demand and capacity, expand the stakeholder group, and pursue collaborations with existing programs.

CONVENING A BROAD STAKEHOLDER GROUP & MEETING SUMMARIES

The second meeting, held on September 5, 2025, built on the earlier discussion and incorporated results from a statewide survey of hospitals. The hospital survey found that Maine has forty-four CNMs in practice, with a median of three per hospital. Five hospitals currently train CNM students, while six expressed willingness but noted barriers such as low patient volumes, heavy CNM workloads, and the lack of formal affiliation agreements. Despite these challenges, there was evidence of strong potential for expanding training capacity. Most hospitals reported that their CNMs practice at full scope, although one hospital still requires physician co-signature.

Opportunities identified included regional student rotations, the use of the Building ME Network and Clinician Nexus platform for placement and preceptor support, and the development of fellowship or transition-to-practice programs. Public awareness campaigns and physician champions were also seen as critical for normalizing and advancing CNM integration across Maine. Action steps included drafting affiliation agreements, exploring funding and preceptor support mechanisms, and designing fellowship models tailored to the state's needs.

The third and final meeting for the study was held on October 3, 2025, and delved into some of the earlier identified strategies for expanding CNM training in Maine, including clinical placement pathways, advanced training or fellowship models, and broader policy and cultural changes needed to support midwifery workforce. Participants emphasized the importance of creating consistent clinical placement systems by supporting preceptors through compensation and protected time and leveraging existing statewide infrastructure such as the Clinician Nexus platform and Building ME Network microgrants. A major theme centered on the feasibility of developing formal post-graduate pathways, specifically "transition-to-practice" and fellowship models, to provide structured mentorship and competency-based learning for new CNMs. These models were seen as vital for bridging the gap between education and practice, reducing burnout, and improving retention, particularly in rural settings. Broader conversation also touched on aligning midwifery training with workforce policy initiatives, integrating simulation and community-based models of care, and ensuring equitable access to maternal health services across Maine's regions.

MAINE HOSPITAL SURVEY FINDINGS

The statewide hospital survey was sent to 14 rural and urban birthing hospitals and had 11 responses or a 79% response rate (Appendix A). The responses from the eleven hospitals revealed that nine hospitals employ CNMs while two do not. In total, forty-four CNMs are practicing, with most hospitals employing only a small number, although some larger institutions report as many as ten. Training capacity is mixed: five hospitals already accept CNM students, generally on a small scale, while six others are open to doing so if barriers such as patient volumes, preceptor availability, and policy constraints are addressed. Nearly all respondents indicated a willingness to expand training if the necessary supports are in place.

In terms of practice, seventy-eight percent of hospitals allow CNMs to function at full scope, including prescribing, billing, and recognition as medical staff, while a small minority impose restrictions requiring physician co-signatures. Workforce demand was uneven, with most hospitals not actively recruiting, though at least one site reported an immediate need for three CNMs and another anticipated the need for one to two additional providers. Respondents agreed that rural hospitals represent the greatest growth opportunity for midwifery expansion. The survey participants pointed to several potential strategies to expand midwifery workforce, including the development of a statewide training program with regional rotations, shared precepting models, policy standardization to ensure consistency of practice, and targeted recruitment initiatives aimed at rural communities.

CNM CLINICAL TRAINING REQUIREMENTS & CLINICAL PLACEMENT CONSIDERATIONS

Early discussions with stakeholders, including written communications with Maine-based academic institutions, made it clear that establishing a new Certified Nurse Midwifery (CNM) training program in Maine would be highly challenging and likely not the best use of the state's limited resources. Institutions cited several barriers, such as the significant time and cost required to build the necessary infrastructure, difficulty securing qualified faculty, the lengthy and expensive accreditation process, and the high ongoing operational costs relative to the small pool of prospective students.

Several institutions noted that similar efforts had been explored in the past and were deemed not feasible in the foreseeable future. As a result, conversations quickly shifted toward identifying existing CNM programs outside of Maine, understanding their clinical training requirements, and exploring strategic partnerships that could bring CNM trainees to Maine for clinical education and potential future employment.

Discussions with academic partners highlighted the clinical training requirements necessary for Certified Nurse Midwife (CNM) students, which need to be considered to expand clinical placements in Maine. At Yale University, students must meet the American Midwifery Certification Board (AMCB) requirements to be eligible for the boards. This involves a traditional midwifery integration model that requires students to complete approximately forty clinical hours per week. These hours typically combine inpatient and outpatient midwifery care, though the exact schedule may be adapted to fit the norms of the practice. For example, some students may work two twelve-hour inpatient shifts and two eight-hour outpatient shifts per week, while others may adjust to twenty-four hour call schedules or longer office shifts. Throughout their training, students are evaluated by their preceptors, and a declaration of clinical safety must be signed at the end of each semester to confirm readiness.

CNM CLINICAL TRAINING REQUIREMENTS & CLINICAL PLACEMENT CONSIDERATIONS

Frontier Nursing University offers another pathway that is popular among labor and delivery nurses in Maine, as it allows students to remain in their home environment while completing their education due to it being an online training program with only two in-person training weeks per year. Several Maine practicing CNMs noted that they have taken students from the Frontier University program for clinical rotations demonstrating an established connection between this program and Maine's healthcare organizations. In this program, students are responsible for arranging their own clinical placements (Frontier Nurse Midwifery Program). Georgetown University, which is a new program, also has an online nurse midwifery program that can be completed in as few as 23 months (Georgetown University Nurse Midwifery Online Program). One benefit to an online program is that there may be a way to partner with these programs more directly to support a pathway for Maine applicants into these programs and create satellite locations for hands on training as needed.

Clinical placements in CNM programs are competency-based. Students are required to achieve both skill mastery and a specific number of clinical procedures before graduation. For instance, most programs require students to attend around forty births. These arrangements generally do not create direct costs for hospitals, though loss of productivity and burden on the clinical preceptor must be considered. Many organizations see the benefit of hosting students as a form of extended interview for potential future hires. Although most schools do not pay organizations to take students, exceptions exist. For example, the Massachusetts General Institute of Health Professions provides \$2,000 to individual preceptors for a four-week outpatient placement in its physician assistant program, a practice more common in medical education than in nursing. And, the Yale CNM program provides compensation to preceptors, offering \$1,500 for a full-year placement or \$1,000 for integration-only placements. Preceptors also receive courtesy faculty benefits. Additional resources for Yale's preceptor support and orientation are available online (Yale Nursing Preceptor Resources).

CNM CLINICAL TRAINING REQUIREMENTS & CLINICAL PLACEMENT CONSIDERATIONS

Clinical Placements

The successful expansion of Certified Nurse Midwife (CNM) education in Maine depends on strengthening the clinical training infrastructure that connects learners, educators, and practice sites. Two statewide initiatives, Building ME and Clinician Nexus, provide foundational tools to coordinate placements and expand access to rural training opportunities.

The Building ME Network was created to expand and strengthen rural clinical education opportunities across Maine. Originally funded through the Maine Department of Health and Human Services and federal public health grants, the initiative aims to increase the number and diversity of health profession students training in rural areas. The program awards microgrants of up to \$15,000 to remove barriers that prevent healthcare organizations from hosting learners. Funds can be used flexibly for practical needs such as housing for students, travel reimbursement, educational technology, and small infrastructure improvements to accommodate trainees.

Program administrators noted that, contrary to initial expectations, most requests did not focus on preceptor compensation. Instead, hospitals and clinics prioritized overcoming logistical barriers that made rural placements difficult demonstrating that expanding training capacity requires addressing foundational access issues, such as transportation, lodging, and technology, before preceptorships can thrive.

Building ME provides a strong foundation for increasing CNM placements in rural communities, particularly if future funding can be targeted toward maternal and reproductive health disciplines. Continued investment in this program could help create a more equitable distribution of clinical learning opportunities across the state and serve as a scalable model for other advanced practice disciplines.

CNM CLINICAL TRAINING REQUIREMENTS & CLINICAL PLACEMENT CONSIDERATIONS

The Clinician Nexus platform represents a statewide effort to modernize and centralize the clinical placement process. Adopted by multiple hospital systems and supported by the Maine Hospital Association, the platform enables healthcare organizations and academic institutions to coordinate student placements through a shared online system.

Clinician Nexus includes a “marketplace” feature that allows clinical sites to post available placement opportunities by discipline, schedule, and required competencies. Academic programs can then search and apply for these opportunities on behalf of their students. The system also allows hospitals to track learners, monitor placement capacity, and evaluate long-term recruitment potential by maintaining visibility into where students train and whether they later join the Maine workforce.

Stakeholders highlighted this initiative as particularly relevant for midwifery, given that Maine has no in-state CNM program and relies heavily on partnerships with out-of-state universities. The platform’s statewide reach can bridge that gap, providing a transparent and efficient mechanism to match CNM students with Maine-based preceptors and facilities. Additionally, the ability to gather aggregate data on placements and workforce outcomes can inform policy and planning efforts related to maternal health and rural workforce distribution.

Challenges for CNM Preceptorship and Education

Despite these established initiatives, Maine’s ability to expand CNM training remains constrained by workforce pressures and systemic barriers faced by practicing midwives. Midwifery is unique among advanced practice disciplines in that it lacks a formal academic presence in the state. There are no Maine-based CNM programs and therefore no faculty appointments or funded teaching roles dedicated to midwifery education.

CNM CLINICAL TRAINING REQUIREMENTS & CLINICAL PLACEMENT CONSIDERATIONS

As a result, clinical precepting often relies on voluntary contributions from midwives already managing heavy clinical and on-call workloads. Participants in meetings reported that midwives across Maine face increasing patient volume, staffing shortages, and limited administrative support, all of which contribute to burnout. The additional responsibilities of mentoring and evaluating students without compensation or protected time have become unsustainable for many.

Several midwives in the discussion emphasized that meaningful progress requires recognition of preceptorship as an educational function by providing stipends for teaching time, administrative or clinical release time to accommodate learners and provide effective feedback, professional development opportunities to become better teachers, and ensuring midwives have representation and compensated administrative time in statewide planning and workforce development efforts.

There has been growing discussion about compensation models for CNM preceptors in Maine. Historically, small hourly stipends have been used, such as \$15 per hour for nurse practitioners or physician assistant students. However, many now consider lump-sum payments to be more practical and easier to manage. Suggestions include payments in the range of \$1,000 to \$2,000 for an eight-week placement. Other incentive models could involve non-monetary rewards such as additional vacation days, or institutional-level incentives managed through hospitals rather than individual preceptors. In practice, students are often shared between two midwives or across a group practice, as is the case at Brigham and Women's Hospital and Wentworth Hospital. Overall, while the prevailing model remains unpaid, the discussion reflects increasing awareness of the burden on preceptors and the need to support them in training future midwives.

Without these supports, participants cautioned that even with improved placement infrastructure through initiatives like Building ME Network and Clinician Nexus, the system may continue to rely on overextended clinicians, limiting growth and sustainability.

CNM FELLOWSHIP OR "TRANSITION TO PRACTICE" MODEL

As part of the broader assessment of Certified Nurse Midwife (CNM) training feasibility in Maine, the working group examined structured post-graduate training models that could strengthen workforce readiness, retention, and rural placement. The discussion centered on two complementary models: the Transition-to-Practice (TTP) approach and the Formal Fellowship Model, both designed to bridge the gap between academic education and independent clinical practice.

Newly graduated CNMs often experience significant challenges transitioning into full practice, particularly in rural and resource-limited settings. These challenges include limited mentorship, lack of exposure to rare but critical obstetric emergencies, and variability in onboarding processes across institutions. Without structured support, early-career CNMs may experience professional isolation or leave the state for better-supported positions elsewhere.

Structured post-graduate training programs whether in the form of a transition-to-practice track or a formal fellowship provide a defined framework to support competency development, professional confidence, and workforce sustainability. Such models have demonstrated success in related advanced practice disciplines, such as physician assistant and nurse practitioner programs, and could be adapted to the midwifery context in Maine.

Transition-to-Practice Model

The Transition-to-Practice (TTP) model offers an extended onboarding experience, typically lasting six to twelve months. This model is appropriate for newly hired CNMs who are fully credentialed but require structured mentorship and education to consolidate skills. Typically, in this model, CNMs are hired full time but initially spend only 60-75% of their time in clinical practice ramping over several months to a year. The remaining time is used to gain additional exposure in other clinical settings, for instance rotating through different hospitals or clinics, conduct simulations and participate in didactics and mentorship.

CNM FELLOWSHIP OR "TRANSITION TO PRACTICE" MODEL

This model works due to the structured mentorship the participants receive from experienced CNMs and Obstetricians with immediate feedback on their skill acquisition combined with protected learning time and professional development with the end goal of independent practice. This approach enables new CNMs to practice under guidance while maintaining full employment status and salary. It serves as an effective middle ground for organizations unable to fund a full fellowship but still seeking to ensure quality, safety, and workforce retention.

Fellowship Model

The Fellowship Model represents a more formalized, competency-based post-graduate training structure, typically lasting 12 to 24 months. Fellows are employed as learners within a defined program, often at a reduced salary, and receive comprehensive clinical, didactic, and professional development support.

The fellowship model is defined by a curriculum that outlines core competencies which are met through structured clinical rotations, simulation-based training, and didactic modules covering obstetric emergencies, gynecologic care, pharmacology, and interprofessional collaboration. It includes formal competency assessments aligned with established standards, all supported through faculty oversight provided by a program director, associate director, simulation lead, and program coordinator. Emphasizing interdisciplinary education, the model promotes collaboration across healthcare disciplines to ensure fully integrated maternal and newborn care. Stakeholders noted that it's critical for any advanced practice provider fellowship program to be successful, it must have physician support and ideally a physician champion. Fellows learn within a protected environment where they serve as employed learners with a clearly defined scope of practice and strong support systems, distinct from independent staffing responsibilities.

CNM FELLOWSHIP OR "TRANSITION TO PRACTICE" MODEL

Nationally, similar programs for Advanced Practice Providers have shown high retention rates—up to 75%—and improved confidence and clinical performance. Applying this model to CNM education would create a formal pathway for clinical excellence and workforce stabilization. A resource for future work in this area is the Consortium for Advanced Practice Providers, which has been a national leader in the Nurse Practitioner and Physician Assistant fellowship movement.

Program Design Considerations for Maine

Regardless of whether Maine moves forward with a TTP model or a more formal structure like a Fellowship, stakeholders agreed that a hub-and-spoke structure was the most feasible for Maine's geographic and institutional landscape. Under this proposed design, a centralized hub at a larger birthing facility would provide core didactics, simulation-based education, and statewide coordination as a central entity. In many cases, didactics and simulation-based education could be accomplished inter-professionally combined with physician and nurse training. The regional spokes would allow fellows to rotate among multiple rural sites, gaining experience across a variety of environments and communities. These rural rotations would be critical to ensuring CNMs are well equipped for independent practice in rural settings where there are fewer clinical and material resources. A key piece to the hub and spoke model would be the shared faculty and infrastructure, which increases the sustainability of a program over time. The common curriculum and evaluation tools also maintain standardization regardless of where a fellow is training while at the same time leveraging the expertise of local providers.

CNM FELLOWSHIP OR "TRANSITION TO PRACTICE" MODEL

To ensure viability and success, the proposed program must incorporate several components. First, it should establish clearly defined competency frameworks specifically tailored to midwifery practice, emphasizing both emergency obstetric care and the complex decision-making required in rural clinical environments. These competencies would serve as the foundation for structured learning and consistent assessment across training sites. Second, the program should integrate simulation-based education to prepare fellows for rare but high-stakes clinical situations that may not occur frequently in routine practice. Simulation offers a safe and controlled environment for developing technical proficiency and clinical judgment. Third, the program must include robust evaluation and feedback mechanisms to track fellow progression, identify learning needs, and ensure competency attainment throughout the training period. Finally, successful implementation will depend on well-supported preceptors, as noted above. This includes providing preceptor development opportunities, dedicated administrative time for teaching responsibilities, and appropriate compensation to recognize the critical role these clinicians play in mentoring the next generation of certified nurse midwives.

COST CONSIDERATIONS

The level of investment needed to expand Certified Nurse Midwife (CNM) training in Maine will vary depending on the approach the state chooses. If Maine strengthens partnerships with out-of-state CNM programs and uses existing tools such as Clinician Nexus to coordinate clinical placements, costs will remain relatively modest. In this scenario, the primary expenses involve supporting students during their clinical rotations. These may include housing assistance, preceptor development, and stipends for preceptors who supervise learners. Some programs offer stipends between \$1,000 and \$2,000 per rotation, though this is not consistent across institutions.

A Transition-to-Practice (TTP) model or a formal fellowship requires a more substantial and ongoing investment. In a TTP model, a new CNM typically practices at 0.6 to 0.75 FTE during the first six to twelve months, gradually increasing their clinical workload. During this time, the CNM receives mentorship, structured education, and access to additional clinical settings. Because the organization pays a full-time salary while the new provider works a reduced clinical schedule, revenue generation is temporarily limited. Additional costs include didactic activities, case review sessions, simulation training, and the dedicated time that experienced clinicians spend on oversight, feedback, and evaluation.

A fellowship model represents the most significant investment in infrastructure. Insights from a comparable Critical Care Advanced Practice Provider (APP) Fellowship pro forma provided by Maine Health help illustrate the typical cost structure for advanced practice training. These costs include salary, benefits, faculty and preceptor time, administrative support, simulation and didactic resources, and malpractice coverage. Using that model as a guide, the financial framework for a CNM fellowship can be outlined to help stakeholders understand both the initial investment and the long-term potential benefits, including improved workforce stability, reduced recruitment expenses, and strengthened clinical capacity across the state.

COST CONSIDERATIONS

Fellowship costs fall into two broad categories: direct trainee expenses and the infrastructure required to sustain program operations. Fellows are usually paid a reduced but competitive salary. Drawing from APP fellowship salaries in Maine, a CNM fellow would likely earn between \$65,000 and \$75,000 annually, with benefits adding roughly \$16,000 to \$22,000. Professional liability coverage adds an additional \$700 to \$1,000 each year. Fellows also require structured didactic learning and simulation-based training to build competency in obstetric and gynecologic care. These learning activities are estimated to cost between \$5,000 and \$10,000 per year, with another \$2,000 for conferences and continuing education.

Faculty and preceptor time is often the largest programmatic expense. Comparable fellowship models suggest that 0.25 to 0.40 FTE of combined clinician effort is needed per fellow, at an estimated annual cost of \$30,000 to \$50,000. This includes program leadership, curriculum oversight, individualized learning plans, and precepting across multiple clinical sites. Administrative support adds further cost, typically between \$15,000 and \$25,000 per fellow each year, to manage scheduling, onboarding, affiliation agreements, learner tracking, and accreditation-related functions. Additional operational needs—such as educational technology, learner management systems, evaluation tools, and basic program supplies—are estimated to cost \$3,000 to \$5,000 annually.

Altogether, the expected annual cost of supporting one CNM fellow is estimated between \$130,000 and \$185,000, depending on program design, salary assumptions, cohort size, and institutional efficiencies.

Although fellowships do not function primarily as revenue-generating programs, they do provide meaningful value that offsets some expenses. As fellows progress through their training year, they gradually increase their clinical work, and the latter half of the program often includes measurable billable activity. Based on the APP model, a CNM fellow may generate \$50,000 to \$80,000 in revenue during the fellowship. Beyond this, retention is one of the strongest long-term benefits. APP fellowship programs often retain 70 to 80 percent of graduates, reducing the need for costly recruitment and helping organizations build a more stable workforce. If designed with accreditation in mind, a CNM fellowship may also qualify for partial reimbursement from CMS or other federal programs, which can cover 30 to 60 percent of allowable program costs.

FUNDING AND SUSTAINABILITY

Initial implementation would require combined funding sources, including philanthropic support, state and federal workforce grants, and institutional investment. Long-term sustainability could be achieved through partial federal reimbursement (CMS) for accredited fellowship programs via established cost-reporting mechanisms. Integration with state workforce initiatives, such as the Rural Health Transformation Program, which prioritizes workforce innovation and rural clinician support could provide initial funding to develop and implement infrastructure until federal funding through CMS, which typically taking up to three years, would be available. Lastly, microgrants and foundation funding through Consortium for Healthcare Education and Training (CHET), for example, should be leveraged to support preceptor training, learner housing, and travel between sites.

Estimated costs should include program administration, faculty time, learner stipends, and operational expenses for didactic and simulation components.

Both the Fellowship and Transition-to-Practice models provide critical mechanisms to strengthen the midwifery workforce pipeline in Maine. The TTP approach offers an achievable short-term solution for organizations seeking to improve onboarding and retention, while the fellowship model presents a long-term investment in advanced, structured clinical training.

CONCLUSIONS & RECOMMENDATIONS

The feasibility study to date indicates both a strong interest and several barriers to creating a CNM training pipeline in Maine. While not all hospitals are currently seeking to hire CNMs, upcoming retirements and uneven workforce distribution, especially in rural areas, highlight future demand and the importance of planning for the future. While some infrastructure already exists, with five hospitals actively training CNM students, expansion will require formalized agreements, additional preceptor support, and greater policy alignment. Strategic opportunities include the development of fellowship or TTP programs, regional clinical rotations, and collaborations with out-of-state academic partners. Standardizing CNM scope of practice across institutions and increasing public awareness about the role and value CNMs play in their communities will also be key to strengthening the midwifery workforce.

CONCLUSIONS & RECOMMENDATIONS

Recommended next steps:

1. Align hospital policies across to reflect the full scope of Certified Nurse Midwifery in Maine, ensuring that all CNMs work in their full scope of practice as allowed in Maine.
2. Launch a communications campaign to elevate the visibility of the care CNMs provide to patients and communities, and the attractiveness of CNM careers. What is a Midwife? Midwife Resources.
3. Identify policies and funding sources to support the expansion of CNM training in Maine, including through TMAH and RHTF.
4. Create a clinical training pathway by establishing and strengthening affiliation agreements between clinical sites, such as hospitals and FQHCs, and out of state educational programs, such as Yale, Georgetown, Boston College and Frontier University.
5. Leverage programs such as Building ME Network/Consortium for Healthcare Education and Training (CHET) for the placement of students in clinical sites with the support of Clinician Nexus.
6. Secure funding for preceptors and student supports, which could include preceptor stipends and training, and student housing close to clinical training sites. (Appendix B)
7. Integrate regional simulation training and standardized didactics across Maine. Standardized didactics and simulation are a viable approach for moving work forward and would be needed to launch a fellowship and may also support a transition-to-practice model. A CNM with an education background with or without an academic partner could put together a microgrant proposal and receive some funding to design and create the content for CNM students rotating in rural Maine and/or new graduate onboarding.
8. Create a Maine-based fellowship or TTP model for new graduate CNMs. A fellowship or TTP model would allow new graduates to gain additional clinical experience at a higher volume location and provide mentorship as they transition to independent practice.

APPENDIX A: SURVEY ANALYSIS: CERTIFIED NURSE MIDWIVES (CNMS) IN MAINE HOSPITALS

Survey Participation:

- Total responses: 11 hospitals
- Employing CNMs: 9 hospitals (82%)
- Not employing CNMs: 2 hospitals (18%)

Current CNM Workforce:

Total CNMs reported: 44 (employed + contracted/temporary)

- Median number per hospital: 3
- Highest reported: 10

Most hospitals that use CNMs employ only a handful, but there are a few larger employers with higher counts.

Training of Nurse Midwife Students:

- Currently training students: 5 hospitals

These sites actively take students, sometimes on a small scale (e.g., 4-5 students/year).

- Not training, but could/expressed interest: 6 hospitals

Even among those that answered "No," many provided notes showing capacity or interest but cited barriers such as:

- Limited patient volume to ensure a full range of experiences.
- Competing demands on CNM time (coverage, patient load).
- Lack of formalized arrangements with training programs.
- Administrative or policy hurdles ("not broached before").

Nearly all hospitals are either training or open to training, meaning with support for capacity-building, Maine could significantly expand its CNM training pipeline.

Hiring & Workforce Needs:

Most respondents are not actively hiring CNMs

- 1 site noted possible need for 1-2 CNMs (not actively recruiting)
- 1 site reported need for 3 inpatient midwives

While most feel "fully staffed," there are clear pockets of unmet demand.

****Additional Insights-** Expansion of midwifery services is viewed as valuable but constrained by staffing shortages and training opportunities. Several respondents highlighted the need for more birthing providers statewide. CNMs are generally well integrated with physicians and family practitioners

APPENDIX A: SURVEY ANALYSIS: CERTIFIED NURSE MIDWIVES (CNMS) IN MAINE HOSPITALS

Scope of Practice:

- Strong autonomy: ~78% of hospitals with CNMs report they practice fully independently (prescribe, bill, practice at top of license, considered medical staff).
- Partial autonomy: 1 hospital requires physician co-signature; CNMs are not full medical staff but part of Allied Health.
- No CNMs: 2 hospitals do not employ CNMs, relying instead on family physicians or not offering OB services.

Policy standardization across hospitals could eliminate the small but significant practice restrictions that limit CNM autonomy.

Opportunities for Expansion:

1. Statewide training program: Centralized or regional rotations could address volume concerns. There is strong hidden capacity—over half of the hospitals not training today could do so if barriers were reduced. This suggests an opportunity for statewide coordination.
2. Shared precepting models: Allowing cross-hospital support to ease pressure on small teams.
3. Policy alignment: Standardizing credentialing to maximize full scope practice. Most CNMs in Maine hospitals enjoy full practice authority, aligning with national best practices. A small minority face institutional limitations (co-sign requirements).
4. Targeted recruitment: Rural hospitals (those without CNMs or citing demand) are prime opportunities for workforce growth.

APPENDIX B:

The **Consortium for Healthcare Education** and the Building-ME Network are offering **microgrants** to increase the number of healthcare students being educated and trained in rural Maine communities.

Funding Categories:

Funds can support a variety of needs including healthcare education/training program creation or expansion, equipment, short-term housing, mileage-students or preceptors, preceptor stipends, community engagement efforts to help recruit learners to work in a specific rural community, and/or preceptor education/development.

To apply, please

1. Complete the **Microgrant Application Form**
2. <https://forms.office.com/r/2rrnV0MAWm>
3. Email a simple Excel budget with your organization name in the file name to:
4. Meredith Bullard, Program Manager, meredith.bullard@mainehealth.org

The Microgrant Application Form will request the following information:

- Organization Name, address, contact name and email
- Requested funding amount
- Brief summary of your request, including problem to be addressed, planned use of funds, and expected outcomes/impact
- Healthcare Learner discipline(s) who will benefit
- Funding categories (see list above)
- Date budget was submitted via email

Applications will be reviewed on a rolling basis while funds remain available. First review will occur after 11/1. We look forward to your application and to supporting the growth of clinical healthcare education and training opportunities across rural Maine.

Rural Perinatal Care in Maine

Access at a Tipping Point

Maine's maternity care system is undergoing structural change, not a temporary fluctuation. Hospitals are working to preserve safe, local care while confronting low birth volumes, workforce shortages and payment models that do not cover the cost of 24/7 readiness.

12,140	9	52%	45 MIN
Maine births in 2025 with residency in 5's births occurring in a rural hospital	inpatient obstetric services closed, 2021-2025 (2 in 2025)	of hospitals in rural Maine communities no longer have maternity units	average one-way drive for prenatal care and delivery in rural Maine

Why rural maternity services are difficult to sustain

An inpatient obstetric service cannot scale its core cost to the number of births. It must be ready for two patients - mother and baby - at any hour, including an emergency cesarean delivery.

- 24/7 readiness has high fixed costs.** A rural program needs a delivery clinician, cesarean-capable physician, anesthesia, operating-room staff, newborn support and L&D nursing on hand or immediately available. MHA's 2024 illustrative model estimated more than \$3 million in annual labor costs for a roughly 100-birth program, before equipment and facilities.
- Low volume compounds every pressure.** Several remaining rural units have fewer than 200 births annually. Lower volume can make it harder to recruit, maintain competencies, distribute call and meet malpractice requirements - even though standby obligations remain.
- The workforce is thin and highly specialized.** Rural hospitals compete for OB/GYNs, family physicians with obstetric training, midwives, nurses, anesthesia professionals, pediatric/newborn clinicians, surgical staff and sonographers. Lower birth volume makes specialized recruitment more difficult, as small teams face intense call schedules, few backups, and difficulty maintaining competency and skills.
- Payment is tied mainly to encounters and deliveries, not readiness.** Hospitals are paid using a fee-for-service payment model with pre-established reimbursement rates well below the cost of maintaining readiness and delivering care.
- Patients are often more clinically complex.** Chronic disease, behavioral health and substance use conditions increase the need for coordinated specialty support in settings with fewer deliveries.

What communities experience when services close

- 1. Longer travel and delayed access.** A 45-minute average one-way drive means 90-minute round trips for routine visits – and greater risk when labor or complications are urgent. In Maine’s northern region, in addition to its eastern region, the average drive time increases to around 150–180 minutes to reach a birthing facility or obstetric care.
- 2. Fragmented care and new pressure on emergency services.** EDs, EMTs and hospitals without obstetric teams still must respond to pregnant patients and newborn emergencies.
- 3. Community-wide consequences.** Loss of maternity care affects where families live, employers’ ability to recruit and the long-term vitality of rural communities.

[illegible]

A Practical Policy Path for Maine

Preserve access. Modernize care. Plan regionally.

Not every hospital can safely sustain inpatient deliveries indefinitely. Maine's goal should be to prevent avoidable closures, stabilize remaining services and ensure coordinated prenatal, emergency, delivery and postpartum care in every region.

What legislators can do

1. **Pay for readiness, not only volume.** Direct MaineCare and commercial insurers to develop rural obstetric capacity payments - such as monthly standby payments, rural add-on payments and routine cost-based rate review - alongside payment for each delivery.
2. **Build regional systems of care.** Support hub-and-spoke agreements, shared staffing and call coverage, streamlined credentialing, common transfer protocols and 24/7 virtual OB and neonatal consultation.
3. **Invest in people and competence.** Support rural training tracks and rotations, family medicine-obstetrics fellowships, midwifery and nursing pathways, loan repayment, shared staffing pools, simulation, higher-volume immersion experiences and malpractice solutions aligned with regional practice.
4. **Preserve safe access after a closure.** Fund local prenatal and postpartum clinics, OB ultrasound and remote image review; maintain ED and EMS obstetric and neonatal preparedness; improve transport and transfer capacity; and support remote monitoring and telehealth.

MHA is focused on connected solutions:

MHA is convening hospitals and partners to advance:

- **Flexible workforce and regional sharing.** Cross-setting models for OB/GYN, FM-OB, midwifery, nursing, anesthesia, pediatric and support services.
- **Telehealth and virtual support.** Virtual OB consultation, remote triage, tele-NICU, remote prenatal care and monitoring.
- **Nursing capacity and emergency readiness.** L&D nurse pools, skills maintenance, simulation and preparation for EDs and non-birthing hospitals.
- **Specialty imaging access.** Rural OB sonographer training, targeted imaging hubs and remote image review.
- **Data and outcomes.** Identifying patient travel and access gaps; monitoring outcomes to guide investment.
- **Coordinated planning.** State, regional and hospital strategies that balance access, quality and long-term sustainability.

POLICY PRINCIPLE II Protect access and quality together. Birth volume matters, but no single threshold can determine whether a service is safe, sustainable or geographically necessary. Maine needs transparent, region-specific planning and support for both birthing and non-birthing hospitals.

SHARED GOAL: SUSTAINABLE, ACCESSIBLE, HIGH QUALITY MATERNAL AND NEONATAL CARE FOR EVERY MAINE COMMUNITY

POLICY PRINCIPLES AND MHA GOALS were synthesized from MHA's (2023), MHA's Current State of Maine's Rural Birthing Hospitals (2024), and MHA's Supporting Rural OB in Maine: Coordinated Solutions Stronger Together (2024).



Maine Hospital Association

Current State of Maine's Rural Birthing Hospitals

June 2024

Situation & Background:

Across the United States, the number of hospitals providing obstetric services in rural areas has declined since 2014. Over half of rural counties did not have a hospital that provided these services, as of 2018. In Maine, seven hospitals have closed their maternity services since 2015, with many of those closures in the past few years. In 2023, Maine had 11,617 births with rural births accounting for 20% of all births, reflecting the value these services bring to rural communities.¹

Many factors are driving these closures, often converging, and pushing a hospital to close services after years of working to sustain services. The most significant factor affecting rural birthing hospitals is the declining population, making it more difficult to recruit and retain workforce, maintain competence of healthcare providers, and obtain malpractice coverage for those providers caring for birthing women.

For example, in Piscataquis County, where Northern Light Mayo operates, the 18- to 35-year-old population is set to decline by 22% by 2035 and had only 112 births last year across the entire county. Greenville, one of the larger communities, had only six babies born in 2023.

Maine's Rural Hospitals' Births 2023:

HOSPITAL	NUMBER OF BIRTHS 2023
NLH Inland Hospital (Waterville)	2700
Franklin Memorial Hospital (Farmington)	2440
Pen Bay Medical Center (Rockport)	2334
Stephen's Memorial Hospital (Norway)	2225
Cary Medical Center (Caribou)	2224
NLH AR Gould Hospital (Presque Isle)	1175
NLH Maine Coast Hospital (Ellsworth)	1171

¹ Vital Statistics for Births, Provisional Data for 2023 April 2024, Vital Statistics Rapid Release (cdc.gov)

Down East Community Hospital (Machias)	141
NLH Mayo Hospital (Dover-Foxcroft)	112
Redington Fairview General Hospital (Skowhegan)	112
Lincoln Health Hospital (Damariscotta)	101
Waldo County General Hospital (Belfast)	98
Houlton Regional Hospital (Houlton)	88
Mount Desert Island Hospital (Bar Harbor)	67
TOTAL RURAL BIRTHS	2,258

Required Workforce to Maintain Obstetric Services:

Rural birthing hospitals that have maintained maternity care services must provide 24-hour coverage 365 days a year, regardless of the number of births. Many life-threatening complications around the time of childbirth occur infrequently, so maintaining staff competence and confidence in dealing with them requires special planning, especially in facilities with a low annual number of births, such as those in rural settings. To avoid ‘too much too soon, too little too late’ (2) in the provision of care, a high level of team capacity is needed, with competencies to identify and manage complications while having confidence to avoid unnecessary medical interventions of uncomplicated labor, delivery and newborn care.² Many Maine rural hospitals noted that this balance has become more difficult as more often the pregnant women they serve have multiple co-morbidities—including, but not limited to, obesity, chronic disease, and substance use disorder—making the provision of care more challenging due to the increased risks to mother and baby combined with fewer deliveries and the resulting clinical experience of providers. Lastly, team members must be competent in providing care that includes support to families to manage both positive and negative outcomes surrounding pregnancy and post-partum.

² Stones W, Nair A. Metrics for maternity unit staffing in low resource settings: Scoping review and proposed core indicator. *Front Glob Women's Health*. 2023 Mar 15;4:1028273. doi: 10.3389/fgwh.2023.1028273. PMID: 37009093; PMCID: PMC10050730.

For a rural hospital to maintain obstetric services for approximately one hundred births per year, the following outlines the minimum workforce required and the respective cost:

Labor	FTE Needed	Average Salary in Maine	Total Cost
Obstetric Physician	22	\$350,000.00	\$7,700,000.00
Anesthesiologist	115	\$46,720.00	\$5,320,080.00
OB Nurse	88	\$80,176.00	\$6,411,408.00
OB Nurse Manager	11	\$83,200.00	\$83,200.00
Midwife/FMw/OB	11	\$130,000.00	\$1,300,000.00
Respiratory Therapist	05	\$70,000.00	\$350,000.00
Pediatrics	05	\$250,000.00	\$1,250,000.00
TOTAL			\$2,234,688.00

Additional Labor Costs

Malpractice	3.2%	\$1,350,080.00	\$ 43,202.56
Fringe Benefits	25%	\$2,234,688.00	\$ 558,672.00
FICA	7.65%	\$2,234,688.00	\$ 170,953.63

TOTAL LABOR COST \$ 3,007,516.19

These labor costs do not include other costs associated with maintaining equipment and facilities to provide obstetric services. For additional context, one Maine rural birthing hospital reported that program costs for one hundred deliveries each year incurs a million-dollar operating loss. Also, it is important to note that while only two obstetricians and eight nurses are needed, it is impossible to function with so few staff due to vacations, unplanned absences, on-call demands, and other realities of hospital operations. Thus, this represents the minimum staff required to offer birthing services.

The low volume of births due to a declining population, along with the inability to maintain competence, is a major impediment to hiring specialists who can provide the critical services required, such as delivering babies, providing anesthesia, and if needed, doing surgery. At the time of this report, Northern Light Health shared that they have twelve full time Ob-Gyn provider openings, many of which are for their rural hospital settings. Simply put, a fully trained and licensed Ob-Gyn will not choose to practice in a community where they can expect to deliver only one baby per week.

While volume is a major barrier, it is difficult for hospitals in rural areas to recruit and retain maternal health providers for many reasons—these include:

1. Low volume of births and concern regarding inability to maintain competency and fully leverage medical training and education.
2. Fewer family physicians trained in obstetric care, which were, historically, widely used in rural communities to provide prenatal, delivery and post-partum care.
3. Scheduling challenges and heavy call burden due to fewer providers covering services 365 days a year.
4. Lack of collegial mentorship, especially among newly trained physicians.
5. Need to float to other medical floors or cover other services. This is especially true for obstetric nurses who may be required to cover other floors when volume is low.
6. Declining populations and lack of younger families in rural areas, making it more difficult for younger healthcare workers and their families to connect with the community.
7. Lack of diversity in rural communities makes it difficult to attract healthcare workers from various backgrounds, cultures, and ethnicities.

Additional Difficulties for Rural Birthing Hospitals:

In addition to decreased obstetric volume and difficulty with recruitment, lower birth rates create several operational challenges to rural hospitals. One challenge is securing malpractice coverage for providers that deliver babies. One Maine hospital shared that they have continued to struggle with ensuring that each provider gets the required number of deliveries each year to maintain malpractice coverage. Specifically, if a rural hospital needs at least three obstetricians with some additional coverage from Family Medicine physicians or midwives on staff to provide around the clock obstetric services and the malpractice insurance carrier requires that each provider, at a minimum, have at least 20 deliveries within a two-year period to be eligible for coverage it becomes more difficult to ensure that all providers can meet the minimum requirements to secure coverage. This is especially true in a hospital that has seen a decline in the number of births and had fewer than one hundred births in a one-year period.

A larger operational factor impacting rural birthing hospitals is reimbursement rates for providing maternal healthcare, especially for Medicaid beneficiaries. In 2022, 37% of all Maine births were covered by Medicaid.³ However, the percentage of births in Maine's rural hospitals covered by Medicaid was 46% in the same year.⁴ Maine's Medicaid program, or MaineCare, has not increased reimbursement to Maine hospitals for a bundled prenatal,

³ KFF: <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22maine%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%7D%22Location%22.%22sort%22:%7D%22asc%22%7D>

⁴ BIRTHS: Kids Count Data: <https://datacenter.aecf.org/data/tables/11668-births-and-mainecare-status?loc=21&loc=5#ranking/5/any/true/1095/any/22946>

delivery and postpartum care for 14 years, and it's been at least 20 years since Maine hospitals have seen a significant and meaningful rate increase. The last rate adjustment for obstetric services was in 2011 and the rate adjustment was based on payments made by the Medicaid program from the prior year and not the actual cost of care.

Maine, like many other states, pays for maternity care in Medicaid using a bundled payment for professional services provided during the perinatal period, including prenatal care, labor and delivery, and postpartum care. Currently, for Critical Access Hospitals (CAH), the average MaineCare bundled payment per delivery is \$13,438. For Rural Non-Critical Access Hospitals (Non-CAH), the total bundled payment is between \$4,448 and \$5,952 depending on a vaginal versus cesarean delivery. Keeping in mind the cost of providing maternity care services, regardless of the number of deliveries, both CAH and non-CAHs struggle to cover the costs with the current reimbursement. For instance, one hundred births at a CAH would equate to approximately \$1,343,800 in total reimbursement, while one hundred births at a non-CAH would equate to approximately \$595,200 and \$444,800 in reimbursement. It is important to note that commercial insurance reimbursement rates do not fill the gap between the cost of providing services and total MaineCare reimbursement.

While the MaineCare program is slated to adjust their reimbursement rates this summer to better reflect the full cost of care, it has yet to be seen how much of the cost will be covered and what the adjustments will look like in the future. Furthermore, MaineCare has proposed to significantly reduce MaineCare rates for off campus practices established or acquired in or after 2015 by adopting a "site neutral" reimbursement policy. This policy would most notably impact rural obstetric, pediatric, and family medicine care, as it would be virtually impossible for hospitals to consider expanding new off campus services (satellite practices) due to the financial sustainability of these practices and could force difficult decisions for off-campus practices already under financial strain. This policy is likely to disproportionately impact rural communities and their access to care.

Next Steps:

- **Increasing Medicaid reimbursement** would help to keep obstetric services open, as Medicaid covers a higher proportion of births in rural areas than urban areas.
- **De-bundling prenatal care payments** would allow for mothers to get their prenatal care close to home, including laboratory and ultrasound visits. Current reimbursement for obstetric services, which includes prenatal, delivery, and immediate postpartum care, are paid by insurers to hospitals in a bundled payment, which hinders a hospital's ability to provide a portion of the care. One rural birthing hospital noted that since their closure they have seen an increase in women presenting in their Emergency Department with little to no prenatal care. If women were able to access care closer to home and hospitals were reimbursed for

this provision of care, then overall health outcomes may be improved, and risks decreased. If de-bundling is not possible and the global fee goes to the birthing hospital, then offering an “add on payment for satellite care” may be another option. This could entail creating a new payment allowable to rural hospitals for providing all prenatal care and coordinating delivery at another hospital.

- **Increasing remote consultations**, such as through videoconferencing or phone calls, between clinicians could help ensure that rural patients who live longer distances from higher levels of obstetric care have access to such care through their own clinicians in their communities. Align reimbursement for such services.
- **Establishing regional partnerships**—such as a hub-and-spoke model where a larger hospital (hub) partners with smaller rural hospitals (spokes) for care coordination and to provide training and other resources—could help ensure rural patients receive risk-appropriate care in their communities. For example, a specialist from the hub hospital could help manage a rural patient's high-risk condition as needed and support the rural clinician for planning delivery at the local hospital. Community hospitals can retain diagnostics, laboratory, and connection to community for postpartum and postnatal care, while the hub partner at the larger hospital can provide services associated with the delivery of the baby. This model of care may not work for all moms and babies, as obstetric needs are unpredictable and depending on the distance between the two hospitals, travel may not be feasible. This would also require a de-bundling of payment, as noted above.
- **Supporting the recruitment and training of obstetric providers and clinicians**, which could include targeted loan repayment programs for those practicing maternal and child health, tuition remission programs for midwifery and nursing, and sponsorship programs to send family medicine physicians to complete a one-year OB Fellowship in exchange for an equal amount of service commitment. These strategies could help reduce the physician shortage in our rural birthing communities.

Regardless of additional funding or flexibilities rural birthing hospitals gain, it is important to note that a hospital may still need to close birthing facilities and services due to declining population and access to workforce. Hospitals at most risk are those that have fewer than one hundred deliveries a year with continued downward trends. Efforts to support these hospitals and communities should include creating plans for when services are not safe to provide any longer.

Karen Kleinkopf
Damariscotta ME
August 27, 2026

Dear Senator Bailey, Representative Malthusson, and Honorable Members of the Advisory Council on Affordable Health Care,

Thank you for the opportunity to address your Committee. My name is Karen Kleinkopf and I am a resident of Damariscotta. I am here on behalf of all women and children in Lincoln County.

I am asking you to pause the proposed closure through a legislative moratorium for MaineHealth Lincoln Hospital Labor and Delivery while the committee and relevant state agencies fully review the consequences of the proposed closure.

I can speak from personal experiences. I am the mother of three daughters who were all delivered at Miles in 1999, 2000 and 2003. My family experienced firsthand the quality and compassion of their professional staff. I do not want to imagine this community without Labor and Delivery at Lincoln Hospital Miles Campus. I live 9 minutes from the hospital, and for my first birth, it took 30 minutes to get there. Each time I had a contraction, I thought I would go through the windshield. Can you imagine sitting in Wiscasset traffic in the summer or winter weather and trying to get to Midcoast Hospital?

The first two deliveries were uncomplicated water births, but our youngest daughter needed an emergency C-section. Her umbilical cord was wrapped around her body 3 times and her neck twice. If not for the emergency C-section, she might not be here today. Everyone on staff that was needed, was woken up, OBGYN Doctor, my Midwife, nurses, phlebotomist, ultrasound technologist. The room was full of professionals from 12:30 am until our daughter was born at 3:52 am. She is healthy, but the outcome could have been very different if we needed to travel to Brunswick. At Miles, my family and I received excellent care from an outstanding staff. I very much want that to remain an option for other families in Lincoln County.

MaineHealth claims in a full page advertisement, "Trusted Care Close to Home, At MaineHealth, trusted care means providing our local communities with the highest quality health care and outcomes among the nation's best." Please hold them accountable for the safety and care of women and children.

Please keep our Labor and Delivery open. I urge you to do the right thing. We want this to be a thriving region for generations to come, and that will only be possible if people can safely be born here in Lincoln County.

Thank you for the opportunity to share my perspective with the Committee. I urge you to place a moratorium. Thank you!

Sincerely,
Karen Kleinkopf, MEd
Damariscotta
mefarms@gmail.com
(207) 356-9006

Deb Eisenberg Letter:

To the Maine Legislature

My name is Deb EISENBERG and I'm a board certified OB/GYN that has worked at Lincoln health since 2017. When I started, I joined another physician, and for three years we covered all of the physician call with two midwives doing first midwifery call. However, during Covid, the other physician unexpectedly left, and we have struggled since that time. I'm not going to go back through issues, though I would be happy to share my take on what occurred during those years. However, I did leave in 2025 with the initial plans of retiring and just doing some per diem for Miles. However, I instead took a position with a company, OBHG or OB hospitalist group, working in Randolph, Vermont. OBHG is a unique locums company which initially started by supplying laborists to medical facilities. With time they saw a new need specific to maternal health access. They were finding rural and smaller facilities were facing challenges which were often leading to cuts in maternal services or the closing of departments. This prompted them to explore and then develop a separate division called maternal health access service. This program is a customized flexible approach to support these institutions to allow continuation of services and to help grow women's health access.

Randolph, Vermont or Gifford Hospital, is also a critical access hospital as is Lincoln. They are busier in that they do more than 200 deliveries a year. They also utilize a blended midwifery physician program with midwives taking first call and MD's as back up. They also were in a stable position with two full-time physicians but after they retired, I believe they encounter the same issues. I know that they ultimately approached OBHG and their MHAS program. What OBHG brought to them was guaranteed coverage, stability and continuity. One of the first doctors that rotated there liked it and ultimately took a full-time position with the hospital. OBHG/MHAS then guaranteed 20+ days a month coverage for a second physician. OBHG recruits physicians specifically to the program. The physician agrees to going to the same place with a set number of days per month. There were three of us, one doing 10 days, and the other two 5 days each.

Every institution develops its own unique contract which fits their specific needs. I can't claim if anything's changed or not since I left 1 year ago, but to the best of my knowledge it is still a stable situation. I'm presenting this because this would be another option that Lincoln health could approach to bring stability to the program that was not considered previously.

* There are alternatives. They have not been explored. There are local physicians that are willing to help. Ironically the physicians that have been here the longest were never asked to sit on any committees or asked for suggestions. We have suggestions if any wants to ask for our experiences.

It will be a tragedy to allow Miles L&D to close their doors. It will be a loss to the community as a whole but an irreplaceable loss to Women's Healthcare and maternal health.

Deb C Eisenberg MD FACOG

Maternal Health Access Solutions

POWERED BY Ob Hospitalist Group

A women's health solution built just for your hospital



As a healthcare leader, you're committed to meeting the needs of the women in your community. But what happens when staffing shortages, physician burnout, or resource limitations threaten your hospital's ability to provide essential OB/GYN services? Many hospitals—especially rural facilities or hospitals in smaller neighborhoods or communities—face these challenges and may even be forced to consider cuts to crucial services. Maternal Health Access Solutions (MHAS), powered by Ob Hospitalist Group, is designed to bridge these gaps, offering flexible, tailored care solutions that help you keep women's health services local.

We partner with hospitals like yours to provide continuous, high-quality care, ensuring that every woman in your community has access to maternal services—right where they live.



Core Benefits:

Tailored OB/GYN solutions for small hospitals: We work closely with your leadership team to create a plan that fits your hospital's unique needs. From expanding clinic hours to providing emergency OB care, we ensure you can meet the needs of your patients without having to send them to distant facilities.

Stabilizing care options: MHAS provides a dedicated team of clinicians that will integrate into your community long term, reducing your reliance on locum to provide continuity of care and peace of mind. Our national standards of care elevate the quality of OB/GYN services in your community.

Keeping services local: By offering expanded GYN surgery, prenatal, and well-woman care, MHAS helps you retain patients in your area, improve outcomes and patient satisfaction, build community trust, and increase hospital revenue. We have even helped hospitals reopen closed units to restore critical services closer to home.

“We customize each MHAS program based on the hospital's needs, bylaws, and clinic goals. The program can be all-inclusive, totally supplemental, or somewhere in-between, but the ultimate goal is to improve access to care for women at every stage of their life, whatever that needs to look like.”

—Jami Walker, Vice President of Maternal Health Access at OHG

Flexible Solutions

While OBHG's traditional full-time and part-time OB hospitalist models suit many hospitals, some require a broader approach. OBHG's Maternal Health Access Solutions offer customizable solutions designed to address the unique needs of your hospital. Using one or more of the solutions below, we will work with you to build a program designed to best serve your community.



Emergency & 24/7
Clinician Availability
for Labor & Delivery



Expanded Clinic
Access



GYN Surgery



Prenatal Services



Well-Woman
Care

Coverage Examples:

Through our Maternal Health Access Solutions program, we've worked with dozens of hospitals across the country to improve access to women's healthcare in their communities.

- **On-site coverage** - One rural hospital struggled to find providers. OBHG partnered with them to provide 24/7 onsite support from a physician and certified nurse midwife, plus five days of outpatient clinic coverage each week.
- **Part-time coverage** - At another hospital, OBHG clinicians provide supplemental coverage for the clinic and handle unassigned patients, OB and GYN emergencies, deliveries, C-sections, and consults.
- **Certified nurse midwife care** - To support one hospital's aging physicians, ease call burden, and elevate the quality of care, OBHG is providing certified nurse midwife coverage for the clinic and OB calls.
- **CNM and birthing center support** - With a recent decline in OBs in the market, OBHG is supporting community CNMs and increasing coordination with one hospital's birthing centers, including clinic and labor & delivery unit coverage on a supplementary basis.
- **Local clinic support** - OBHG is supporting one community's existing Family Practice OB in clinic, handling deliveries and enabling the hospital to continue providing GYN surgeries.
- **OBED implementation** - OBHG helped a rural hospital enhance the quality and consistency of emergent care by implementing an OBED and providing a full-time physician to support their women's health services, building on an existing partnership with a larger hospital in their system.

Benefits

- Keeps essential services within the community.
- Ensures higher-risk patients receive care within the local market.
- Enhances maternal and birth outcomes through dedicated, expert care.
- Provides safer coverage solutions that align with your financial constraints.
- Reduces malpractice exposure for your hospital and providers.
- Alleviates staffing challenges and reduces dependence on locums.
- Aligns with your labor and delivery growth strategies for future success.
- Decreases payer costs associated with high-risk pregnancies and emergency transfers.
- Mitigates physician burnout by offering a sustainable and balanced work environment.

“Through our MHAS program, we help hospitals provide essential healthcare with customized solutions that meet the unique needs of their communities. Our goal is to ensure women receive high-quality care close to home, where it matters most.”

– Dr. Mark Simon,
Chief Medical Officer at OBHG



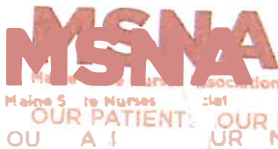
Is your hospital ready to improve healthcare
access for women in your community?
Let's get in touch!

obhg.com/maternalhealthaccesssolutions

Maternal Health
Access Solutions

POWERED BY Ob Hospitalist Group™

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Comments from Portia Judson, RN
Health Care, Insurance, and Financial Services Committee Interim meeting
August 22, 2006

My name is Portia Judson and I have been a registered nurse for 11 years. I work in the ER at Mount Desert Island Hospital and I'm a member of the Maine State Nurses Association.

Mount Desert Island Hospital closed its obstetrics department last year. Our hospital cannot serve the needs of our patients without an OB. Earlier this year, I told you about a patient I saw soon after the closure. She came into the hospital at 23 weeks pregnant, with horrible abdominal pain. She was terrified when she found out we did not have an OB department. We are on an island. I can't promise patients that transport to another hospital will be available in time to save them if they need it.

The hospitals tell us that closures are necessary because OB staff can't keep their skills current with low birth rates. But I know that the experienced OB nurses who worked in the MDI unit before the closure were better equipped to care for laboring mothers than those of us in the ER and the emergency services personnel in ambulances on long trips to other hospitals.

A year later, more of our community members know they can't count on us for OB care. They travel hours for the care they need—or they move away. It is hard to keep healthy rural communities like mine on Mount Desert Island if people can't have babies near their homes.

I am worried that all the closing labor and delivery units are a harbinger of what is to come. More and more hospitals seem to be dropping essential services due to their lack of profitability. Are hospitals going to end up serving ever fewer community members? Where does that leave rural healthcare? And without healthcare, where does that leave our community? Being able to count on safe hospital care is a core part of what rural communities like mine need to thrive.

Testimony of Constance Adler, MD, FAAFP
Re: Maternal Health Services in Maine

Senator Bailey, Representative Mathieson, Distinguished Members of the Committee on Health Coverage, Insurance and Financial Services:

My name is Constance Adler and I am a retired Family Physician who provided Women's Health care in Farmington for almost 30 years.

I want to thank you for your serious attention to the maternal health services crisis in our state.

You will hear about many issues today, but I want to emphasize just two important aspects for your consideration.

- 1. There are models of care different from the usual hiring 4 obstetricians - models that can work better in rural communities. I know because I was a part of a very successful practice that did just that. In Farmington in 1992 there were 3 obstetricians and one was planning on leaving. I joined the other two. I am a Family Physician who had been trained to perform Caesarean sections, and together we rotated call and assisted at more than 350 deliveries/year. For years. This benefited our community enormously, not only because we had a stable Labor and Delivery unit, but because as a primary care physician I had skills/knowledge the OBs did not - treatment of depression, pneumonia, chronic disease, etc. as well as advanced skills in resuscitation of babies.**

A diversified maternal care team that includes a variety of providers - obstetricians, Family Medicine docs, and Nurse-Midwives - is a stronger alternative and better meets the needs of patients and actually enhances the quality of care. It was supportive and good for us, extremely helpful to the community and responsive to the needs of the women of western Maine.

- 2. Two-thirds of our maternal mortality is postpartum, not during delivery. Postpartum care is not getting the attention it requires in these discussions of hospital closings. Women die of hypertensive disease, suicide, depression, psychosis, drug use. And many more suffer. I have had patients come to the office frankly hallucinating postpartum or immobilized by sadness. If their obstetrical provider is an hour away, these women are much less likely to be able to take the time to see them or to get help. As you look at maternity care in the state, please do not forget that the delivery is one event, albeit an important one. But the next year of life for both mother and baby requires active involvement of healthcare personnel and it needs to be available. In a Maine winter, an obstetrician an hour away might as well be on the moon. It is critical to plan on local care, public health nursing, and systemic outreach to save the lives of these women and children.**

I would be happy to answer any questions about prenatal obstetrical care and to help in any way. Thank you.

Respectfully submitted,

C. Adler, MD

Constance Adler, MD, FAAFP
Chesterville, ME

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TESTIMONY OF STEPHANIE MCCULLOUGH, MD
REGARDING THE CLOSURE OF LABOR & DELIVERY SERVICES AT
LINCOLN HEALTH MILES MEMORIAL HOSPITAL, DAMARISCOTTA, MAINE

Joint Standing Committee on Health Coverage, Insurance, & Financial Services
Room 209, Cross State Office Building
Thursday, August 27, 2026

Senator Bailey, Representative Mathieson, and distinguished committee members,

My name is Dr. Stephanie McCullough, and I am a family physician with additional fellowship training in surgical and high-risk obstetrics. I have been practicing in Damariscotta for 2 years, and am speaking solely as an individual physician from the affected community because I want you to hear my personal experience of advocating for the preservation of maternity care services.

My expertise is rural healthcare. I have worked across the country and throughout Maine. As of now, I am the only surgical family medicine-OB doctor across the entire system. Since my arrival here in 2018, healthcare leaders in Maine have tried to reassure me that I need to be patient for family medicine-OB to be accepted. And in the microcosm of exceptional, patient-centered, holistic maternity care provided in Damariscotta, I felt I could be.

But in January, I was asked to join in the discussions about closure of the Miles L&D unit. When leadership cited OBGYN recruitment as a barrier to maintaining the service, I introduced reports from the Commonwealth Fund¹ about how to successfully staff and maintain rural L&D units. I recommended utilization of Stroudwater Associates, a consulting firm in Portland that assists rural hospitals across the nation in the maintenance of services. I proposed an on-the-job training model for non-surgical family physicians to train to do Cesarean deliveries. I submitted high-quality literature² demonstrating that surgical family medicine-OBs provide care that AT LEAST matches the quality provided by OBGYNs. Unfortunately, my suggestions were dismissed and communications to the community grossly misrepresented the Family Medicine specialty and skillset, casting doubt about the excellent quality of care that I, and my colleagues, provide. Indeed, recruitment of OBGYNs is challenging nationwide, but OBGYNs did show interest in our practice during the time when a job was posted, prior to October 2025.

¹ Klein, S and Castle Work, M. (2025 Oct 24). Positive Outliers: How Some Rural Communities Maintain Access to Labor and Delivery Services. Feature article, Commonwealth Fund, Oct. 24, 2025. <https://doi.org/10.26099/mrm2-6e21>.

² VanGompel EW, Singh L, Carlock F, Rittenhouse C, Ryckman KK, Radke S. Family Medicine Presence on Labor and Delivery: Effect on Safety Culture and Cesarean Delivery. *Ann Fam Med*. 2024 Sep-Oct;22(5):375-382.

Partin M, Sanchez A, Poulson J, Berg A, Parascando J, Ramirez SI. Social Inequities Between Prenatal Patients in Family Medicine and Obstetrics and Gynecology with Similar Outcomes. *J Am Board Fam Med*. 2021 Jan-Feb;34(1):181-188.

Aubrey-Bassler K, Cullen RM, Simms A, Asghari S, Crane J, Wang PP, Godwin M. Outcomes of deliveries by family physicians or obstetricians: a population-based cohort study using an instrumental variable. *CMAJ*. 2015 Oct 20;187(15):1125-1132.

Homan FF, Olson AL, Johnson DJ. A comparison of cesarean delivery outcomes for rural family physicians and obstetricians. *J Am Board Fam Med*. 2013 Jul-Aug;26(4):366-72.

We often hear 200 deliveries/year cited as a threshold for safety and financial viability of a Labor and Delivery, but I want the Committee to know that that number is NOT rooted in high-quality studies³. In your decision-making about the future of obstetrics in this state, I implore you to disregard the 200-delivery annual threshold as an appropriate standard.

When a large health system owns multiple hospitals in a region, it is uniquely positioned to develop a triaged system of care, where low-risk patients stay in their communities to birth, slightly higher-risk patients deliver in regional centers, and the highest-risk patients deliver at the tertiary/academic center. But this takes innovation and planning! It is a faster and simpler, but short-sighted task to close small units, while expecting patients to commute the difference.

It has been my experience that there is a dearth of healthcare leaders in Maine with any substantive experience in the practice, preservation, or innovation of rural healthcare services. This is where I hope our legislative leaders can make a difference - by facilitating the recruitment of such an innovator who is able to navigate rigid corporate strategic plans with alternative models for care delivery. This innovator must be independent of any one health system.

Lastly, it has been reported that monies saved with the closure of the unit in Damariscotta will be used to prioritize maternal mental health, address intimate partner violence, and bolster substance use services. I also urge the legislature to ensure those commitments are kept.

Thank you for considering my perspective.

³ Kozhimannil KB, Interrante JD, Admon LK, Basile Ibrahim BL. Rural Hospital Administrators' Beliefs About Safety, Financial Viability, and Community Need for Offering Obstetric Care. JAMA Health Forum. 2022 Mar 25;3(3):e220204. doi: 10.1001/jamahealthforum.2022.0204. PMID: 35977287; PMCID: PMC8956977.

August 27, 2026

Good afternoon members of the joint Committee of Health Coverage, Insurance and Financial Services.

I am Dr. Rose Fuchs, a Family Physician from rural Aroostook County in independent private solo practice in the middle of a maternity care desert in Patten. I practice full spectrum family medicine caring for people from cradle to grave. I closed my clinic today to come and represent the front lines of rural health care and my patients in particular.

I have been a physician for 26 years. I was a midwife before I was a doctor, so I have delivered babies for 38 years. I have done hospital births and home births. For the first 13 years as a doctor, I worked in Georgia. In Atlanta, Georgia, family physicians, even ones like me who do not do C sections, worked seamlessly alongside obstetricians covering the hospital births. At times, I delivered over 100 babies a month at the hospital.

Hospital Privileging Barriers

For the last 13 years as a doctor after moving to Maine, I have only done home births. This change occurred because of barriers peculiar to Maine, in hospital privileging for family physicians. When I inquired about doing hospital deliveries here, I was told that hospital policies in Maine didn't favor family physicians on the maternity unit, and so "not to bother." I was told my home was located "too far" from the hospital to get maternity privileges, according to their policy. Ironically, I travel further than that to do home births in Maine. I chose not to waste my money applying for hospital maternity privileges that would be a fight and likely be denied anyway.

Hospital Maternity Unit Closure Consequences

There are many issues facing physicians in our currently collapsing health care system. The maternity care issue is one of the more pressing ones. The closure of hospital maternity units directly impacts my patients, particularly the sudden closure of Houlton Regional Hospital in May 2025. The nearest maternity hospital is now 1 ½ hours from my practice *if* there is good weather and little traffic. Permit me to share my real-life experiences from the front lines.

Prior to the closure of Houlton Regional Hospital's maternity unit, I was involved prenatally in a case where the Amish midwife's patient ended up experiencing a uterine rupture in early labor. The infant died, and the mother barely survived by having emergency surgery and transfusions at Houlton. Had the hospital been any further away, the mother, who had several other children already, would surely have died as well.

After the closure of Houlton Regional Hospital, one of my primary care patients who had planned to deliver at Houlton hospital, was required to then go to Presque Isle. This ended up

involving an induction of labor and a longer hospitalization because of fear that the distance would be too great to Presque Isle if natural labor was allowed to ensue for her. Healthcare costs *will* increase for these labor inductions which often create prolonged hospitalizations, and are occurring now due to time and distance concerns.

After the closure of Houlton Regional Hospital maternity unit, in the very last day of the 30-day window of required emergency coverage they provided, my patient Katie, experienced an obstetric emergency of a prolapsed umbilical cord in labor. This emergency requires an immediate C section, usually within 30 minutes. Even with Houlton Regional accepting our ambulance transport, it took 90 minutes until completion of the C section. Mother and baby did survive and are doing well. Had we been required to get to Bangor or Presque Isle, even by life flight, the baby would surely have died.

Just last week, I delivered a slightly premature baby at the mother's home. This woman would have had no choice about going to a hospital. Premature labor can progress too rapidly to travel that far. We decided it was safer to deliver at home with my experience and equipment, than to risk traveling and delivery en route. Mother and baby are thankfully doing fine, but there aren't many doctors, or maybe even any doctors, willing to accept the risks that I am now forced to face.

This is really NOT a question of "IF" a death (whether mother or baby) will occur, but rather a question of "WHEN" a death will occur. And whose family member will it be? How much is a life worth? Quite a lot, to me, and I hope to this committee.

*Let's **Decide** to Fix It*

I still believe in this country, in this state. Surely the country that could win WWII, build the Panama Canal, and build the interstate freeway system, can find a way to bring adequate critical access maternity care to rural areas.

What I believe is most needed is the **WILL**, and the **PASSION** to find a solution. If there is a WILL to solve this problem, there will be a way to fix this. I have the will and the passion, which is why I take risks to care for patients in need, and why I traveled over 6 hours round trip today to testify. I hope you each have this same will and passion too.

Thank you.

Rose M. Fuchs, M.D.

Cornerstone Family Practice

17 Founders Street

Patten, ME 04765

Public Comment on the Status of Labor and Delivery Units in Maine**James Myall, Senior Economic Policy Analyst****August 27, 2027**

Good afternoon Senator Bailey, Representative Mathieson, and members of the Joint Standing Committee on Health Care, Insurance, and Financial Services. My name is James Myall and I am a Senior Economic Policy Analyst at the Maine Center for Economic Policy. Thank you for the opportunity to offer comments on the issue of labor and delivery services in Maine.

In the past decade, 12 labor and delivery centers across the state have closed. As others have shown in their testimonies, these closures mean that families in rural areas increasingly struggle to access vital healthcare services, which can have serious and life-threatening implications for birthing parents and children. Their impact goes far beyond health and wellbeing, however.

In many rural areas, the hospital is one of the largest employers. The loss of infrastructure can also have implications for the viability of the community for residents of all ages, whether they are just starting their family, navigating health challenges, or seeking preventative care as they age.

It's increasingly clear that the health care status quo is unsustainable. The closure of 12 birthing centers over the past decade is just one symptom of the dysfunction in our health care system. We're also seeing double-digit increases to health insurance premiums every year,¹ tens of thousands of Mainers are on the verge of losing their health care coverage next year,² and medical debt is so pervasive that one in three Maine families struggles to afford other necessities because of it. Two thirds of Mainers describe our health care system as "unaffordable" and "profit-centered."³

The only way countries around the world have succeeded in constraining health care costs and improving access for patients is through government intervention of one kind or another, and I think that's what you will have heard here today. If it is not financially feasible for nonprofit hospitals to offer labor and delivery services in rural Maine, the only way to continue that service will be more taxpayer funding. While there are a number of ways the state could help support labor and delivery services financially, I would invite you to consider publicly-operated health care centers as part of the solution.

Although we mainly rely on private nonprofit hospitals to deliver health care in Maine, there are more than 900 state and locally-run hospitals in the United States⁴ that help meet gaps in the care system that wouldn't otherwise be met. Cary Medical Center in Caribou has been operating as a public hospital for over a century.

The major benefit of providing rural labor and delivery services through public health care centers would be accountability. Members of the public would have much more input on decisions around which services are offered – and where – than they currently do. Additionally, if state or local taxpayers need to subsidize services, public ownership allows taxpayers more say on how that money will be spent. Providing Labor and Delivery services through a public ownership model would be particularly appropriate because having care available locally is a community priority that enjoys support beyond just those residents who are current or future patients.

The details of standing up and running public labor and delivery centers in Maine will require more conversations and study, but I would urge you to consider the idea in your deliberations.

Thank you for your time. I'll be happy to take any questions.

Notes

¹ "Maine Bureau of Insurance Releases 2027 Health Insurance Premiums for Individual and Small Group Market." *Maine Bureau of Insurance*. August 14, 2026. <https://www.maine.gov/pfr/insurance/press/maine-bureau-of-insurance-releases-2027-health-insurance-premiums-for-individual-and-small-group>

² "Federal Budget Reconciliation Law Now in Effect: Impacts on MaineCare, SNAP & CoverME.gov." *Maine Department of Health and Human Services*. July 11, 2025. <https://www.maine.gov/dhhs/blog/federal-budget-reconciliation-law-now-effect-impacts-mainecare-snap-covermegov-2025-07-11>

³ "Examining Maine Voters' Views on Health Care Affordability And Medical Debt in Maine", Consumers for Affordable Health Care/Digital Research Inc poll of 514 registered Maine voters, February 2026. Available at <https://mainecahc.org/advocacy/expanding-access-affordability.html>

⁴ "Fast Facts on US Hospitals 2026." *American Hospital Association*. <https://www.aha.org/statistics/fast-facts-us-hospitals>

Testimony

Regarding the Closure of Labor and Delivery at Lincoln Hospital

Senator Bailey, Representative Mathieson, and members of the Committee:

My name is Moira Rose Richards, and I am here on behalf of the Miles Delivers Action Coalition, a group of patients, providers, families, and community members working to preserve hospital-based maternity care in Lincoln County.

I want to focus today on one question: **What problem is MaineHealth actually trying to solve by closing Labor and Delivery at Lincoln Hospital?**

That question should be easy to answer. It is not.

Over the last several months, MaineHealth's explanation for this decision has repeatedly changed.

First, it was financial.

Early in this process, patients were told verbally that finances were a factor. So our Coalition examined Lincoln Hospital's publicly available financial data.

Lincoln Hospital had been operating in the black for years. In FY2024 alone, it reported a 5.56% operating margin, \$8.73 million in operating income, and nearly \$10 million in total surplus.

Then MaineHealth told the public this was not a financial decision.

Then, it was birth volume.

At two listening sessions in June, MaineHealth leadership emphasized Lincoln's roughly 130 annual deliveries, arguing that the volume made recruiting OB/GYNs difficult.

So we looked for solutions to that problem.

We identified physicians who were specifically interested in practicing in a lower-volume setting like Lincoln. MaineHealth's own physicians helped develop alternative coverage schedules. We brought those options forward.

The decision did not change.

Then, it was staffing, recruitment, and retention.

Again, our Coalition went to work.

We developed recruitment strategies specific to our community. We identified MaineHealth physicians interested in transferring to Lincoln. We brought forward CVs and alternative staffing and coverage models, including models developed with MaineHealth's own clinicians.

We even offered to pay for an independent assessment of whether Labor and Delivery could safely and sustainably remain open.

Before the vote, we told every MaineHealth Trustee that we understood the existing staffing model might need to change. What we challenged was the assumption that permanent closure was the only alternative.

Governor Janet Mills called on MaineHealth to pause, in part so unanswered questions could be examined and alternatives considered. Clinicians, elected officials, EMS providers, patients, and community members asked for the same.

MaineHealth did not pause.

Then, it was a financial trade-off.

The day before the MaineHealth Board of Trustees voted, our Coalition met with MaineHealth leadership and two Trustees.

We were told that maintaining Labor and Delivery "comes with a high price tag" and that MaineHealth intended to stop delivering babies at Lincoln and reinvest those resources into other women's health services.

One MaineHealth leader described the trade-off this way: "The price tag is not delivering a baby in that space to reinvest in the way that we think about this model."

That conversation included Trustee Marie McCarthy.

That matters because of what came next.

Now, MaineHealth says this is about patient safety.

After the Board voted to close Labor and Delivery, MaineHealth Board Chair Marie McCarthy and Lincoln Hospital Board Chair Bruce Garren argued publicly that safety concerns made further delay irresponsible. They pointed specifically to four diversions during a six-month period.

But MaineHealth's own July 23 white paper stated that Lincoln's Family Birthing Center had "no clear or persistent quality or safety concerns" and performed well on publicly reported quality measures.

That leaves a question this Committee should ask MaineHealth directly:

How did Lincoln go from having "no clear or persistent quality or safety concerns" before the vote to patient safety being a reason further delay was supposedly impossible after the vote?

Our Coalition raised this exact issue with the Board before it voted.

We asked Trustees not to accept staffing instability alone as justification for permanent closure. We specifically asked them to require MaineHealth to demonstrate that eliminating Lincoln County's only hospital-based maternity service was **"the safest and most responsible available option, rather than simply concluding that the current staffing model is difficult to sustain."**

That distinction matters.

There is a fundamental difference between demonstrating that staffing instability creates safety risks and demonstrating that eliminating the birthing center is safer for patients.

MaineHealth has demonstrated the former.

It has not demonstrated the latter.

In fact, MaineHealth's own safety argument illustrates exactly why this matters.

A pregnant patient can hemorrhage. A baby's heart rate can suddenly drop. A placental abruption can occur. An emergency C-section can become necessary within minutes.

Those emergencies do not disappear when Labor and Delivery closes.

What disappears is Lincoln County's ability to respond to many of them locally.

Before the vote, we asked MaineHealth to evaluate what closure would mean for patients, EMS, receiving hospitals, travel times, and maternal and infant outcomes.

We asked them to meaningfully account for the realities of rural Maine: winter weather, summer traffic, island communities, ambulance availability, transportation barriers, receiving-hospital capacity, and the consequences of delayed care.

We have not seen an analysis that adequately answers those questions.

Meanwhile, published research has documented serious consequences when rural communities lose maternity services, including worse maternal and infant outcomes and increases in out-of-hospital and preterm births.

So our request today is simple.

Ask MaineHealth to show its work.

If this is a financial problem, put the financial analysis on the table.

If this is a staffing problem, show why the staffing alternatives presented were inadequate.

If this is a patient-safety decision, demonstrate that patients will actually be safer after Lincoln County loses its only hospital-based maternity service.

And if MaineHealth cannot do that, then this closure should be paused.

A Board vote is not irreversible. Labor and Delivery is not scheduled to close until December 18. There is still time for MaineHealth to submit this decision to a truly independent review, including one our community has offered to help fund.

This matters beyond Lincoln County.

If Maine's largest health system can eliminate an essential rural service first and provide changing explanations afterward, then every rural community in Maine should be concerned about what happens when its hospital is next.

We are asking this Legislature to demand something remarkably basic from an organization entrusted with the health of our communities:

Identify the problem. Put the evidence on the table. Evaluate the alternatives. And prove that taking away care is safer than preserving it.

Until that happens, pause this closure.

Our lives are worth getting this right.

Community Response to MaineHealth's Statements about the Miles Labor and Delivery Unit

A review of the evidence, research literature, and publicly available data.

This response was prepared by a coalition of patients, caregivers, community advocates, and professionals with combined experience in public administration, healthcare policy, disability advocacy, and patient engagement. Our comments are based on a review of the hospital's published materials, relevant regulations and best practices, and the lived experiences of community members.

This is a living document that will continue to evolve. If any statement is factually incorrect or lacks important context, please let us know. We will issue corrections promptly. We believe the community deserves information that is accurate, balanced, and supported by evidence, and we have no interest in advancing our position through misleading or incomplete claims.

Photo: Damaris Scotta Listening Session on 6/2/26
July 28, 2026, Version 3 | milesdelivers.org

June 30, 2026: LCTV Interview

MaineHealth statement on LCTV:

Marva Nesbit, MaineHealth Board Member: **"Besides the two community forums that were hosted [in early June], what other discussions have you held with other groups here in the community as this has taken shape?"**

Cindy Wade, MaineHealth Lincoln Hospital: **"Those are our biggest outreaches for the community."** [18:05-18:35]

Community Response: For generations, Lincoln Hospital and the people of the Damariscotta region have supported one another. The community has provided patients, employees, volunteers, philanthropy, civic leadership, and public trust. In return, Lincoln Hospital has provided essential healthcare, good jobs, and economic investment. The relationship has always been reciprocal.

That is why major changes to essential community services should be developed in partnership with the people who built and sustain the hospital - not simply announced after internal decisions have already been made.

For decades, the Miles Campus has served as an anchor institution: a place-based organization whose success is inseparable from the well-being of its community. Anchor institutions do more than provide services. They invest locally, strengthen the workforce, attract philanthropy, foster civic engagement, and build long-term trust.

That partnership continues to benefit MaineHealth today. The community provides:

- Tax-exempt status through nonprofit support
- Philanthropic contributions
- Volunteers
- A dedicated workforce
- Public trust and goodwill
- Political and community support

Trust is the foundation of an anchor institution. It is earned over decades and can be diminished quickly when consequential decisions are made without meaningful

collaboration. A hospital may continue to operate in a community, but without the community's trust, it ceases to function as a true community institution.

When generations of residents have invested their financial, social, and civic capital into a nonprofit hospital, decisions that reshape essential healthcare services should reflect that shared investment through transparent engagement, genuine partnership, and co-design with the community they serve.

Sources:

- <https://vimeo.com/1202218165/aae25fbbdf9?fl=pl&fe=cm>
- <https://map.nationalacademies.org/resource/24624/anchor-institutions/>
- <https://pmc.ncbi.nlm.nih.gov/articles/PMC7002960/#abstract1>
- <https://icic.org/blog/role-anchor-institutions-supporting-local-communities/>

MaineHealth statement on LCTV:

Marva Nesbit, MaineHealth Board Member: **"I think immediately of our ambulance service.** I remember chatting at one of our community forums with someone from the ambulance service and saying, **'So are you ready to have babies in ambulances?'"**
[13:40-13:56]

Community Response: For many families, the prospect of giving birth in an ambulance is not hypothetical: it is one of their greatest fears.

This comment captures our central concern: the conversation has centered on providers, administrators, and system operations, while the person that should stay central, the patient, has receded.

What does this change mean for a mother in labor? For a newborn needing immediate care? For a family navigating an emergency miles from a maternity unit?

The community has been asking to be part of this conversation. We have shown up, shared our experiences, raised concerns, and offered solutions. We are not asking to be informed after decisions have already been shaped through multiple rounds of private and confidential board discussions; we are asking for a seat at the table while there is still an opportunity for meaningful collaboration. We would gladly walk alongside MaineHealth leaders- not against them- because the goal is the same: safe, sustainable care for mothers

and babies in our community. True partnership requires meeting people where they are, hearing their stories directly, and engaging in a conversation that goes both ways.

A mother's labor, a baby's first moments, and a family's birth experience should not depend on whether an ambulance can arrive in time, whether roads are clear, or whether emergency responders can safely manage a complex obstetric situation outside a hospital setting. What may sound like a hypothetical scenario to decision-makers can feel like a very real possibility to the families who must plan around it.

The voices of the families who will live with the consequences must be part of the decision, not an afterthought.

Sources:

- <https://apnews.com/article/1193f1a13210502c85431509cc4dc711>
- <https://psnet.ahrq.gov/issue/patient-and-public-involvement-healthcare-systematic-mapping-review-systematic-reviews>
- <https://digitalcommons.hollins.edu/cgi/viewcontent.cgi?article=1085&context=ughonors>

MaineHealth statement on LCTV:

Dr. Timothy Fox, MD Chief Medical Officer, Miles Hospital: "Our emergency department is staffed and always has been staffed with highly trained emergency physicians who do emergency medicine residencies. They're board certified. Part of their training is Obstetrics. I'm not saying that we replace OBGYNs, but **we're there to handle emergencies**, and that's what we're trained to do. **That said, in a community setting, you don't do it too often, especially at a community setting when you have OB on site. Yes. So you tend to not do them over the course of a 10-year or 20-year career.**

So we do need to make sure our staff is trained up and refreshed on everything OB."

[14:17-14:41]

Community Response: Lincoln County deserves more than an emergency backup plan for maternity care.

MaineHealth's emergency physicians are highly trained and essential to our community. They provide lifesaving care when emergencies happen. But emergency medicine is not a substitute for a dedicated Labor & Delivery program with continuous obstetric expertise, trained maternity nurses, and a team prepared for the full range of pregnancy and birth needs.

MaineHealth acknowledges that emergency physicians rarely perform deliveries because Labor & Delivery services are typically available. Removing Miles Labor & Delivery changes that safety equation by shifting more responsibility onto emergency departments, EMS crews, and families.

Lincoln County families deserve a maternity system that keeps appropriate care close to home while using regional partnerships for higher-risk needs.

Emergency departments and EMS should remain what they are designed to be: a safety net for unexpected emergencies, not the foundation of a rural maternity care system.

Sources:

- <https://www.maine.gov/ems/node/1963>
- <https://www.gao.gov/products/gao-11-414r>
- <https://www.aafp.org/afp/2022/1000/graham-center-obstetric-care>
- <https://pmc.ncbi.nlm.nih.gov/articles/PMC11622357/>

MaineHealth statement on LCTV:

Dr. Timothy Fox, MD Chief Medical Officer, Miles Hospital: "The ED, OB, EMS workgroup, where we are trying to get everybody in one room or on one screen together, including the ER physicians, the people who manage our ER nurses our EMS crews, EMS chiefs, the EMS liaison at MaineHealth and all of our four services in our catchment area, we're all represented on screen, as well as pediatrics and OB.

We had our first meeting last week to discuss things like what are the gaps or what do we need to learn, what do we need to train up on and what certifications do we need to get in order to feel most comfortable with these emergencies." [15:02-15:47]

Community Response: MaineHealth says no final decision has been made about Labor & Delivery services, yet it is already forming an ED/OB/EMS workgroup focused on preparing for out-of-hospital birthing emergencies. That raises a critical question: where is the equal effort to preserve and strengthen local maternity care?

Emergency physicians, EMS teams, pediatric providers, and obstetric clinicians are essential to protecting families during emergencies. But preparing for emergencies after care is lost is not the same as preventing them.

Rural communities need more than faster transfers and response plans—they need investment that keeps mothers and babies safe before a crisis begins. Investing in emergency transport solutions, including helicopter access, does not replace the need for timely local maternity care. Transport is a response after risk has already developed—it does not prevent the emergency from occurring.

If all options remain on the table, MaineHealth should explore every path to sustain local maternity care, including Family Medicine Obstetrics, midwifery, tele-obstetrics, innovative staffing models, recruitment strategies, and community partnerships.

The answer is not just an ambulance response or a helipad; it is a rural maternity model that supports families before a crisis, not only after one begins.

Sources:

- <https://nap.nationalacademies.org/catalog/10027/crossing-the-quality-chasm-a-new-health-system-for-the-21st-century>
- <https://www.aha.org/center/leadership-development>
- <https://psnet.ahrq.gov/primer/high-reliability>
- <https://vimeo.com/1197703982/cd16ee91e7?share=copy&f=sv&fe=ci> [10:00]

MaineHealth statement on LCTV:

Cindy Wade, RN, BSN, MHA, President, Miles Hospital: "Getting that discussion in the community is **having people aware that not always can we provide the care as close to home** as possible if we don't have providers.

So for instance, urology. All four hospitals in the region can't have enough urologists to provide care only on their campus, so **we share urologists up and down the coastal region**, and we try to provide that care as close to home as possible by providing it in the region. There **aren't enough urologists in the nation for all of us to have enough urologists at each site** to provide that care. So that **working together is super important.**" [18:35]

Community Response: MaineHealth's comparison between urology and obstetrics does not hold and understates the unique access needs of maternity care.

Urology is a highly specialized field with approximately 15,000 practicing physicians nationwide. Most care is scheduled or outpatient, allowing health systems to maintain access through regional specialists and shared coverage.

Maternity care is different. Labor is unpredictable, and emergencies can develop within minutes. Safe obstetric care depends on timely local access, making labor and delivery fundamentally different from services that can be scheduled or delayed.

If MaineHealth believes regional collaboration is the solution for workforce shortages, that same approach should be used to strengthen, not replace, labor and delivery at Miles. By combining local labor and delivery with regional physician partnerships, multidisciplinary teams, and innovative staffing, MaineHealth could preserve access while building a more sustainable model for rural communities. Applying a urology-style regionalization model to obstetrics is a poor fit and could lead to an unnecessary closure.

Sources:

- <https://pubmed.ncbi.nlm.nih.gov/33200829/>
- <https://pmc.ncbi.nlm.nih.gov/articles/PMC12906581/>
- <https://www.auanet.org/research-and-data/aua-census/census-results>

MaineHealth statement on LCTV:

Dr. Timothy Fox, MD Chief Medical Officer, Miles Hospital: "Yeah there's **no plans right now to close anything down or remove anything else. In fact, we're going to be adding services...** The ability to bring other doctors here to provide more outpatient care and more surgical care that is not available currently, like ENT and certain GYN surgeries. These are important adds for the community.

"To be able to continue pre- and postnatal care is still a big bonus, or a big plus, for the community. But at the moment, although we do look at every service, there's no plans to close anything down. [32:41-33:20]

Community Response:

Describing prenatal and postpartum care as a "bonus" reflects a disconnect from the realities facing families in Lincoln County. Pregnancy care is not a collection of separate services - it is a connected journey from early prenatal visits, through labor and delivery, to postpartum recovery. Each stage is essential to identifying risks, addressing complications,

and protecting the health of mothers and babies. This continuity matters because maternal health risks do not end at delivery; a significant share of pregnancy-related deaths occur after birth.

Elective surgical services can provide valuable care, but they are not interchangeable with essential, time-sensitive services like labor and delivery. The ability to give birth close to home, with trusted providers throughout pregnancy and recovery, is not a bonus—it is the foundation of the maternity program this community has spent generations building.

Expanding elective surgery services may benefit some of the community, but it also raises an important question: are healthcare decisions being guided primarily by what is most essential for families and community health, or by which services are easier to sustain financially?

Sources:

- <https://pubmed.ncbi.nlm.nih.gov/38982401/>
- <https://journals.ku.edu/kjm/article/view/18523>
- <https://pubmed.ncbi.nlm.nih.gov/38720255/>
- <https://pmc.ncbi.nlm.nih.gov/articles/PMC12837410/#Abs1>

MaineHealth statement on LCTV:

Dr. Timothy Fox, MD Chief Medical Officer, Miles Hospital: "I'm one of the ER doctors—I **don't plan on retiring, at least in the next couple of years, so hopefully we're not looking at closing the ER, right?** And same goes for the OR's. We're not looking at closing down our ORs or shutting down the hospital." [33:24-33:38]

Community Response: While MaineHealth has claimed no plans to end other services at the Miles campus of Lincoln Hospital, the community's concerns are grounded in recent experience. The closure of emergency and inpatient services at Boothbay's St. Andrews followed a similar pattern: a summertime announcement, a compressed timeline, and no recourse on the grounds that it was a "clinical decision."

Deeply integrated community services like Miles Labor & Delivery unit require meaningful and transparent engagement with the people who rely on them. Rural hospitals are more than healthcare facilities - they are anchor institutions built through generations of community trust, workforce relationships, philanthropy, and local partnerships. Healthcare leaders must consider more than the bottom line and reducible costs when making

decisions on critical services; they must also consider the patients, families, and providers who depend on those services.

Financial sustainability matters, but it cannot be the only measure of success. Too often the question is limited to: "How do we keep this facility sustainable?" The better question is, "Can a facility remain sustainable if it loses the trust, workforce, patients, volunteers, donors, and partnerships that support it?"

Sources:

- <https://www.boothbayregister.com/print-boothbay-register/article/how-did-we-get-here/2087>
- <https://journalofethics.ama-assn.org/article/what-should-be-scope-health-networks-obligation-respond-after-hospital-closure/2019-03>
- <https://icic.org/blog/role-anchor-institutions-supporting-local-communities/>

MaineHealth statement on LCTV:

Marva Nesbit, MaineHealth Board Member: "The hardest part for me when I've been questioned is... **One very emotional young woman who stopped in at the [Miles Auxiliary] Thrift Shop recently, after hearing the facts said 'But where's your compassion? Where's your compassion in keeping this unit open?' And I said, 'Compassion doesn't pay the bills. We care a lot. We don't want to be doing this.' But the facts have to speak for the decision making process. But anyways perhaps that sounded cold, but that was my response.**"

[38:10-38:33]

Community Response: The facts that Ms. Nesbit is referring to - the facts that would demonstrate that the closure of Miles L&D is necessary - have yet to be provided to the community. Throughout this document, the same questions have been raised using the same information available to MaineHealth, and the community's response has been clear: no facts have been presented that support the need to close Miles L&D.

Further, MaineHealth has stated that this is not a financial decision. If financial considerations are part of this assessment, then MaineHealth must be transparent and acknowledge that. We understand that financial factors are an important part of healthcare

decision-making; however, the community deserves honesty about what is driving this process.

It is also important to recognize that obstetric billing is changing in 2027. Any financial assessment of Miles L&D must account for these upcoming changes and how they may impact reimbursement, revenue, and the long-term sustainability of obstetric care. Without considering these changes, the financial picture presented to the community is incomplete.

If the concern is staffing, the community has not simply identified the problem—we have brought forward solutions, which deserve meaningful consideration before a decision is made to eliminate local labor and delivery care.

Regardless, Ms. Nesbit's comments appear to come from the perspective of a board member seeking justification for a decision rather than a community member seeking solutions. In response to her comments, we would like to share the words of one community member, which reflect the feelings of many of us:

"Compassion doesn't pay the bills. Perhaps. But neither does grief. Neither does an empty nursery, a folded baby blanket, a car seat carried back inside still waiting for the child who never rode in it. Neither does a town that knows exactly where its mothers died." *From "Forty More Miles," Ellie Cadsby, born at Miles*

Sources:

- <https://www.ama-assn.org/practice-management/cpt/cpt-2027-maternity-care-services-code-changes>

June 30, 2026: Community Questions

Question published by MaineHealth:

Why can't Lincoln Hospital use family medicine physicians with obstetrics and surgical training instead of closing labor and delivery services?

Community Response:

Family Medicine Obstetrics (FMOB) builds on the broad-scope rural family medicine model by providing physicians with advanced obstetric and surgical training. FMOB does not

replace OB-GYN care; it expands local maternity care capacity by allowing trained family physicians to provide deliveries, cesarean sections, and emergency obstetric management while working within referral networks for higher-risk cases.

A one-year FMOB fellowship prepares physicians to perform obstetric surgery such as:

- Planned and emergency cesarean delivery
- Operative vaginal delivery and VBAC
- Complex laceration repair
- Management of postpartum hemorrhage

FMOB physicians care for low- to moderate-risk pregnancies, identify complications early, stabilize emergencies, and coordinate transfer when specialty care is required. Maintaining local delivery capability provides a safety layer in rural communities where transfer times can delay critical treatment.

Nearly 50 FMOB fellowships across 30 states train physicians to perform cesarean deliveries independently, and many graduates continue practicing in rural areas. These programs help communities maintain maternity services while supporting collaboration with OB-GYN and maternal-fetal medicine specialists.

For MaineHealth, developing an FMOB pathway would require investment in training, clinical support, and structured mentorship, but it is a focused approach compared with creating an entirely new residency program. Lincoln Hospital already has a family physician supporting the Miles Maternity Unit, providing a foundation for developing an FMOB training pathway.

FMOB offers a practical strategy to strengthen rural maternity care by expanding local expertise, improving emergency readiness, and creating a sustainable workforce for the future.

Sources:

- <https://pmc.ncbi.nlm.nih.gov/articles/PMC112969530/>
- <https://www.obssus.org/family-medicine-obstetrics-fellowship-programs/>
- <https://www.obssus.org/obstetrics-rural-medicine/>
- <https://www.thedbfm.org/research/research-library/rural-family-physicians-have-a-broad-de-scope-of-practice-than-urban-family-physicians/>

- <https://www.mainehealth.org/news/2025/01/mainehealth-receives-hrsa-grant-enhance-rural-obstetric-training>
- <https://rhrc.umn.edu/publication/state-variations-in-the-rural-obstetric-workforce/>

Question published by MaineHealth:

You state the birth volume at Lincoln Hospital is very low. What is considered acceptable? And can you share the actual number of deliveries?

Community Response: Birth volume should not be the sole measure of the value or safety of a rural maternity program. No professional organization establishes a minimum number of annual births below which a labor and delivery unit is considered unsafe. MaineHealth has referenced approximately 200 births as an operational benchmark, but this figure reflects institutional norms rather than an evidence-based safety threshold, and treating it as one shifts attention away from the access risks created when care moves farther from home.

Higher-volume hospitals may achieve greater operational efficiency, but rural maternity units serve a critical access function that delivery volume alone cannot measure. A 24/7 labor and delivery service provides immediate assessment, stabilization, emergency intervention, and obstetric expertise when complications arise. Those benefits extend beyond the number of deliveries performed.

Safety must be evaluated not only within the hospital but across the community. Closing a rural labor and delivery unit shifts risk to patients, families, EMS, and surrounding hospitals by increasing travel time during labor and obstetric emergencies. Expectant mothers may alter medical decisions based on distance, including scheduling elective inductions or delaying evaluation, creating risks that would not exist with local access.

Miles has a longstanding history of providing safe, high-quality maternity care. Rural hospitals elsewhere have demonstrated that investment in workforce, facilities, and service redesign can substantially increase birth volume over time. Birth volume reflects not only community need but also investment, workforce stability, referral patterns, and public confidence.

Sources:

- <https://jama-network.com/journals/jama-healthforum/fullarticle/2790544>
- <https://ratings.leapfroggroup.org/facility/details/200002/mainehealth-lincoln-hospital-d-amariscotta-me>
- <https://www.cms.gov/about-cms/agency-information/omh/equity-initiatives/rural-health/09032019-maternal-health-care-in-rural-communities.pdf>
- <https://twinn-cities.umn.edu/news-events/rural-hospital-administrators-bellows-offering-obstetric-care>
- <https://www.commonwealthfund.org/publications/2025/oct/positive-outliers-how-rural-communities-maintain-access-labor-delivery>
- <https://www.google.com/url?q=https://legislature.maine.gov/testimony/resources/HCLFS20250507Keefe-Oates%2520133917499632691007.pdf&sa=D&source=docs&uist=1783707891652583&usq=AOVaw0118tevOSxq20XRbX1d44b>

Question published by MaineHealth:

What grants are available for rural health areas that would help support OB/GYN recruitment?

Community Response: Miles can build a sustainable rural maternity model through a combination of MaineHealth investment, community support, and state and federal workforce resources.

The solution should expand beyond a traditional OB/GYN-only model by building a collaborative care team that includes OB/GYN physicians, Family Medicine Obstetrics physicians, OB hospitalists, Certified Nurse Midwives, nurses, and other maternity care professionals.

Available opportunities include:

- **Federal rural maternity funding:** Rural maternity access is a national priority. MaineHealth has already participated in programs such as the Rural Maternity and Obstetrics Management Strategies (RMOMS) initiative and the Maine Rural Graduate Medical Education (MERGE) Collaborative. Additional HRSA and Rural Health Transformation Program funding can support workforce recruitment, training, and innovative care models.

- **Rural obstetrics fellowship development:** Funding could support a rural obstetrics fellowship to quickly train physicians for rural practice while building long-term workforce capacity.
- **Community investment:** Lincoln County has a strong history of supporting local healthcare through philanthropy. Community partnerships could help support recruitment, program development, and innovation.
- **Workforce incentives:** State and federal programs, including loan repayment, recruitment incentives, and rural workforce grants, can help attract and retain maternity care providers.

The challenge is not whether rural maternity care can be sustained. The opportunity is to use available resources to build a modern model suited to rural communities.

Sources:

- <https://www.maine.gov/dhhs/ruralhealth>
- <https://www.mainehealth.org/news/2025/01/mainehhealth-receives-hrsa-grant-enhance-rural-obstetric-training>
- <https://www.maine.gov/governor/mills/news/governor-mills-statement-rural-health-transformation-program-award-2025-12-29>

June 10, 2026: FAQ

Question published by MaineHealth:

You stated that only 32% of Lincoln County births occur at MaineHealth Lincoln Hospital, and that expectant mothers are choosing to deliver at other hospitals. Can you share any data on this?

Community Response: Birth volume is only one measure of maternity care. A 24/7 maternity service exists not only to perform deliveries, but to provide immediate assessment, monitoring, stabilization, and intervention when pregnancy-related complications arise. Many of the most time-sensitive situations are not captured by annual birth volume alone—they are measured by the ability to respond when a family needs care urgently by a practitioner trained in obstetrics emergencies, not emergency stabilization.

The statement that only 32% of Lincoln County births occur at MaineHealth Lincoln Hospital requires additional context. The figure is drawn from a snapshot of eight Lincoln County communities that historically have had high birth volumes, not the entirety of the county, and it does not explain why the remaining births occurred elsewhere. It should not be read as evidence that families simply prefer other hospitals, without accounting for the factors that shape maternity care decisions.

Out-of-county deliveries may reflect:

- appropriate referral of higher-risk pregnancies;
- provider and health system referral patterns;
- perceived safety and available services;
- insurance or logistical considerations; and
- uncertainty about the future stability of the local labor and delivery program.

MaineHealth has not provided the underlying data needed to interpret this statistic, including why Lincoln County residents delivered elsewhere. Without that information, the analysis risks confusing constrained choice with active preference. In a recent interview with LCTV, Dr. Andy Russ stated that one in five prospective patients at Miles had to go elsewhere due to a hospital policy requiring Vaginal Birth After Cesarean (VBAC) deliveries to occur in regional facilities. While we acknowledge this may be related to current insurance requirements, VBACs are routine not only for OB/GYNs but also for surgically trained Family Medicine Obstetrics fellows, and could be performed at Miles.

The data also demonstrates that Miles serves a broader regional population. MaineHealth has stated that of approximately 130 births in 2025, only about half are from Lincoln County (conflicting with their earlier statements), meaning many families from surrounding communities rely on Miles for maternity care. In the same media interview, hospital leadership suggested that residents of the island communities in the area tend to utilize Miles. In local patients' experience, independent, midwife-operated birthing centers transfer patients to Miles when a higher level of care is required. A sustainability analysis should therefore evaluate more opportunities to engage rural and home-centered patients to birth at Miles.

Research shows that rural maternity utilization reflects more than geographic availability; trust, continuity, workforce stability, and confidence in a service influence where families choose to deliver. When rural obstetric services are threatened or closed, families may

travel elsewhere because local options have changed, not because they prefer another hospital.

MaineHealth has acknowledged that closure has been considered for many years. Prolonged uncertainty may affect patient confidence and referral patterns, creating a feedback loop: uncertainty contributes to lower utilization, and lower utilization is then used as evidence that the service is no longer sustainable.

Following MaineHealth's reinvestment in Miles maternity services, such as updating the facilities and regaining Baby-Friendly Center designation, the program experienced year-over-year increases in births. This suggests that families' decisions about where to deliver are not fixed preferences, but can be influenced by confidence in the quality, stability, and experience of the local maternity service. Any analysis of demand should therefore consider how prior uncertainty, disinvestment, or reinvestment may have shaped birth volumes over time.

Before concluding that demand is insufficient, the community deserves a complete analysis that distinguishes patient preference from constrained choice and recognizes Miles' regional role in maternity care.

Sources:

- <https://pubmed.ncbi.nlm.nih.gov/37840011/>
- <https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.14248>
- <https://www.boothbayregister.com/article/lincolnhealth-re-designated-baby-friendly-birth-facility/116139>

Question published by MaineHealth:

What birth volume would you consider sustainable?

Community Response: There is no single number of births that determines whether a rural labor and delivery program is sustainable.

Sustainability depends on many factors, including staffing, reimbursement, community need, referral patterns, and health system investment. Birth volume alone does not capture the value of providing local access to emergency maternity care.

The better question is not, "How many births are enough?" It is, "What would it take to make this service sustainable?"

Other rural hospitals have strengthened maternity care by redesigning staffing, partnering across health systems, and investing in innovative care models. As Maine's largest health system, MaineHealth has the opportunity to do the same at Miles before concluding that closure is the only option.

Sources:

- <https://pubmed.ncbi.nlm.nih.gov/35977287/>
- <https://legislature.maine.gov/testimony/resources/HCIF520250507Keefe-Oates%20133917499632691007.pdf>
- <https://pmc.ncbi.nlm.nih.gov/articles/PMC13077149/>

Question published by MaineHealth:

What efforts have been made over the past five years to promote and market MaineHealth Lincoln Hospital's maternity program?

Community Response: Miles has increased births by more than 40% over the past five years, demonstrating that families are choosing the program and that growth is possible.

Community awareness of the Baby-Friendly designation, lactation services, positive birth experiences, and word-of-mouth likely contributed to this increase. In rural communities, families often rely heavily on trusted local experiences when choosing healthcare.

Before determining that demand is insufficient, MaineHealth should evaluate whether Miles received the modern outreach and community engagement needed to build awareness and trust. Today's families seek information through both traditional channels and peer experiences, and maternity programs must communicate clinical quality, safety, patient experience, and the benefits of local care.

Utilization responds to investment and engagement. A declining or increasing birth volume is not just a measure of demand; it is also a reflection of how a program is supported, communicated, and connected to its community.

Sources:

- <https://www.pressherald.com/2026/07/02/damariscotta-community-members-fight-to-keep-birthing-center-open/>
- <https://www.boothbayregister.com/article/lincolnhealth-miles-maternity-celebrating-20-years-being-baby-friendly/89306>
- <https://pmc.ncbi.nlm.nih.gov/articles/PMC10130839/>
- <https://healthcaresuccess.com/blog/branding/multi-generation-healthcare-branding-building-trust-across-age-groups.html>
- <https://lcnme.com/currentnews/community-members-share-testimony-about-lincoln-hospital-labor-and-delivery-unit/>

Question published by MaineHealth:

What were the projected costs of alternative staffing models, and were they shared with the local board and the steering committee?

Community Response: To date, the community has not seen a comprehensive analysis of the projected costs, benefits, and feasibility of alternative staffing models, nor is it clear whether those analyses were shared with the local board or steering committee.

The absence of that analysis matters, because the stakes reach beyond a single staffing decision. Closing another rural maternity unit will not solve the national crisis facing rural obstetric care. Miles has an opportunity to become a model for the future of rural maternity care. As part of Maine's largest integrated health system, it can serve as a site for innovation through team-based staffing, Family Medicine Obstetrics, Certified Nurse Midwives, tele-obstetrics, regional partnerships, and other workforce solutions.

The question is not only how to sustain the current model. It is how to redesign rural maternity care for the future. MaineHealth has the resources, expertise, and opportunity to lead that effort.

True to the spirit of our state motto, MaineHealth has an opportunity to step forward, not simply to preserve what exists, but to build what comes next. Miles Labor & Delivery is more than a service worth saving. It is a chance to reimagine rural maternity care and show what an anchor institution can do when it chooses innovation over retrenchment. Dirigo.

Sources:

- <https://row.northeastern.edu/story/needs-assessment-of-the-obstetric-workforce-in-maines-rural-hospitals/>
- <https://www.fhfi.gov/blog/insights/who-lives-in-rural-america/>
- <https://www.mckinsey.com/~/media/mckinsey/industries/healthcare%20systems%20and%20services/our%20insights/the%20next%20frontier%20in%20health%20care/the-next-frontier-of-health-care-delivery.pdf>
- <https://www.yorkhospital.com/about-us/maine-health-partnership>

Question published by MaineHealth:

Some patients have been told that the closure of labor and delivery services will happen in December. So why hold community forums?

Community Response: A better question is: Does the current timeline allow MaineHealth decision-makers, providers, patients and the community to be meaningfully engaged in mitigating concerns?

The prolonged uncertainty has also placed clinicians, staff, potential recruits, patients, and the community in a difficult position. Local leaders have cited fatigue with the ongoing "will they, won't they" discussion as one factor supporting closure. Yet that fatigue is itself a consequence of years of uncertainty. The ongoing focus on creating a "sustainable" level of births has likely eroded confidence and interest in the service.

Patients need transparency to make informed decisions about their care, and providers have an ethical responsibility to communicate honestly while maintaining trust. They should not be left wondering whether sharing information with patients is appropriate or risk criticism for being transparent. Clear, timely communication from leadership is essential - not only to reduce uncertainty, but to preserve trust between patients, providers, and the health system.

Sources:

- <https://onlinelibrary.wiley.com/doi/full/10.1111/jrh.12758>
- <https://www.urban.org/research/publication/provider-and-patient-perspectives-labor-and-delivery-unit-closures-rural-mex>

Question published by MaineHealth:

Are reproductive services on the chopping block?

Community Response: Lincoln County residents have reason to be concerned when Labor & Delivery services are reduced or eliminated. Maternity care is not a standalone service. It anchors women's healthcare across pregnancy, postpartum care, reproductive health, and the recruitment and retention of clinicians.

Closing Labor & Delivery at Miles would do more than change where babies are born. It would weaken the foundation of local women's healthcare and make it harder to sustain the full continuum of care that families rely on.

Rural communities across the country have seen that when obstetric units close, access challenges often extend beyond delivery. Longer travel distances, fewer local appointments, and difficulty recruiting clinicians can create a cycle of declining access.

Lincoln County families already balance transportation, work, childcare, and caregiving responsibilities. Pregnancy, birth, postpartum complications, and reproductive health needs do not always happen on a convenient schedule.

MaineHealth has an opportunity to strengthen women's healthcare in Lincoln County by investing in Miles as a regional model for rural maternity care. The community is asking for a commitment to expand and sustain access, not allow essential services to gradually disappear.

Sources:

- <https://onlinelibrary.wiley.com/doi/full/10.1111/irh.12758>
- <https://experts.umn.edu/en/publications/access-to-obstetric-services-in-rural-counties-still-declining-wi/>
- <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care>

Question published by MaineHealth:

What factors influence where families give birth?

Community Response: Research consistently shows that families choose where to give birth based on distance, provider recommendation, insurance coverage, perceived quality, continuity of care, and confidence in the maternity unit.

Distance is one of the strongest predictors of birthplace. When the nearest maternity unit is substantially farther away, most families choose the closest available hospital. This underscores the importance of maintaining good access. Referral patterns also influence delivery volumes, as higher-risk pregnancies are appropriately directed to regional centers with advanced capabilities.

Community confidence matters. Following Maine Health's reinvestment in Miles' Labor & Delivery unit, including the restoration of Baby-Friendly practices, annual birth volumes increased. This suggests that investments in quality, workforce, patient experience, and community trust can influence where families choose to deliver.

Birth volume is not something that merely happens to a hospital. It is shaped by the services a hospital offers, the confidence it inspires, the providers who refer patients there, and the investments made in maintaining a high-quality maternity program.

Home birth decisions are also influenced by proximity to emergency obstetric care. Research shows that respectful, coordinated care across hospitals, birth centers, and home birth settings is essential, particularly as maternity unit closures make timely obstetric consultation, emergency backup, and interfacility transfers more difficult.

Taken together, the evidence suggests that where families give birth is not determined by geography alone. It is influenced by the choices healthcare systems make. Investments in access, quality, workforce, and community trust can increase utilization, while reductions in services can accelerate the very declines used to justify further cuts.

Sources:

- <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0192523>
- <https://link.springer.com/article/10.1186/1472-6963-11-147>
- <https://digitalcommons.ilbrn.yu.edu/umaine.edu/mpm/vol34/iss2/7/>

Question published by MaineHealth:

Can you establish a float pool of OB/GYNs to provide on-call support?

Community Response: Maine Health already operates physician float pools in other specialties and maintains regional OB nursing float pools across multiple hospitals. It has also invested in regional obstetric workforce development through a federally funded HRSA

program. These existing models demonstrate that MaineHealth has experience coordinating providers across facilities when organizational priorities support it.

Given these existing regional staffing models, it is reasonable for the community to ask that MaineHealth pilot a regional OB/GYN staffing model before eliminating Labor & Delivery. Options could include shared call coverage, rotating physicians, Family Medicine Obstetrics providers, Certified Nurse Midwives, tele-obstetric support, or other innovative workforce approaches.

As Maine's largest integrated health system, MaineHealth possesses the organizational scale, clinical expertise, and geographic reach to design and evaluate new rural staffing models. The question is not whether innovation is possible. It is whether every reasonable innovation has been fully explored before concluding that closure is the only option.

Other health systems, both nationally and internationally, have implemented creative approaches to improving access to time-sensitive care, including physician response vehicles, enhanced prehospital physician support, telemedicine, regional workforce sharing, and collaborative staffing models. Rural maternity care deserves the same commitment to innovation.

The community is not demanding a guarantee that every model will succeed, only evidence that MaineHealth seriously weighed the alternatives before permanently closing a service that cannot easily be restored.

Sources:

- <https://www.careersatmainehealth.org/jobs/17546358-physician-hospital-medicine-float-pool>
- <https://www.mainehealth.org/news/2025/01/mainehealth-receives-hrsa-grant-enhance-r-ural-obstetric-training>
- <https://pubmed.ncbi.nlm.nih.gov/41563916/>

Question published by MaineHealth:

Can you require your medical staff to refer their OB/GYN patients to MaineHealth Lincoln Hospital?

Community Response: We do not suggest that all people who are pregnant in Lincoln County should give birth at Lincoln Hospital. Instead, providing obstetrics at Lincoln Hospital ensures women can continue to have autonomy in their birth location.

Preserving Labor & Delivery at Miles is about protecting that choice, not limiting it. Closing the unit would eliminate a local option and reduce access not only to hospital births, but also to safe home births and future community birthing centers.

Independent midwives and family physicians providing home births rely on a nearby hospital with obstetric services in case of emergency. Without local labor and delivery, fewer families will be able to safely choose home birth or other community-based maternity options.

Local labor and delivery makes every birth setting—hospital, home, or birth center—safely possible.

Sources:

- <https://apnews.com/article/1193f1a13210502c85431509cc4dc711>
- <https://themainemonitor.org/her-labor-turned-dangerous/>
- <https://themainemonitor.org/maternity-care-investigation-takeaways/>

Question published by MaineHealth:

Can the on-call dilemma be resolved by family medicine doctors receiving obstetric certification so they can accept on-call responsibilities?

Community Response: Yes. Family physicians with advanced obstetric training provide reliable on-call coverage and help sustain rural labor and delivery units. They manage routine births, perform cesarean sections, respond to obstetric emergencies, and collaborate with OB/GYN and maternal-fetal medicine specialists when higher-level care is needed.

FMOB-trained family physicians are credentialed hospital providers who receive standard insurance reimbursement for the services they provide. They expand, rather than replace, OB/GYN services and strengthen rural maternity systems through collaboration with specialists, emergency departments, and other qualified birth providers, including independent midwives, when consultation or transfer is needed.

Lincoln Hospital already has a family physician supporting the Miles Maternity Unit, providing a foundation for this approach. MaineHealth can combine FMOB-trained physicians with other rural obstetric providers and the existing emergency department team to create a sustainable coverage model. Since MaineHealth has stated that emergency services will remain available, the ER remains an important resource for stabilization, urgent care, and transfer when needed—using MaineHealth's own position that its ER coverage is sufficient to support, rather than replace, local obstetric care.

FMOB programs in rural states have helped address maternity workforce shortages by training physicians who continue practicing in rural communities. New England currently lacks a family medicine obstetrics fellowship with cesarean training, despite significant rural populations in Maine, Vermont, and New Hampshire.

Creating an FMOB pathway would do more than fill the immediate call schedule; it would build a long-term physician pipeline for rural maternity care, a focused investment rather than a short-term staffing patch.

Sources:

- <https://pmc.ncbi.nlm.nih.gov/articles/PMC12840823/#sec5-ijerph-23-00102>
- <https://themainemonitor.org/maternity-care-investigation-takeaways/>
- <https://pmc.ncbi.nlm.nih.gov/articles/PMC12969530>
- <https://www.essentialhealth.org/education-research/residencies-fellowships/family-medicine-obstetrics/compensation>
- <https://www.altru.org/careers/altru-family-medicine-residency/altru-family-medicine-obstetrics-fellowship>

Question published by MaineHealth:

Are current emergency department and primary care physicians trained in the event of emergency delivery?

Community Response: Emergency department and primary care physicians receive training in emergency stabilization, including obstetric emergency simulation. However, simulation training does not replace the experience of physicians who routinely provide obstetric care.

Physicians who complete OB/GYN residency and fellowship training, as well as family physicians who complete Family Medicine Obstetrics (FM/OB) fellowship training, receive specialized training in pregnancy, labor, delivery, and obstetric emergencies.

FM/OB physicians complement OB/GYN care by providing deliveries, cesarean sections, and emergency obstetric care while collaborating with specialists for higher-risk cases. Evidence from rural settings shows appropriately trained family physicians providing obstetric care achieve outcomes comparable to other qualified obstetric providers.

Closing obstetric services affects the entire regional healthcare system. MaineHealth Chief Health Improvement Officer Dr. Dora Anne Mills stated:

"You've got emergency rooms and EMS, emergency medical services, who are not used to obstetrical emergencies or having to handle them on their own. So, it stresses the health system out, and it also stresses the whole community. Well-being starts to go down, starts to deteriorate."

Maine EMS has identified risks associated with obstetric service closures, including:

- More planned home births with complications requiring hospital transfer
- More unplanned field births as patients travel farther for care
- More transfers when patients arrive at hospitals without obstetric services

Emergency training is essential, but it does not replace a local maternity care team with physicians who routinely provide obstetric care, including OB/GYN physicians and FM/OB-trained family physicians. Maintaining local obstetric expertise strengthens emergency readiness and reduces strain on the healthcare system.

Sources:

- <https://www.maine.gov/ems/sites/maine.gov/ems/files/inline-files/20250326-OB-Closure-Clinical-Bulletin-Final.pdf>
- <https://www.newscentermaine.com/article/news/health/hatten-thoulton-maine-hospital-labor-delivery-maine-monitor/97-b94e534e37-92d7-4117-50b2-7462021c6000>

- <https://www.marchofdimess.org/find-support/topics/miscarriage-loss-grief/maternal-death-and-pregnancy-related-death>

June 3, 2026: FAQ

Question published by MaineHealth:

Why is MaineHealth Lincoln Hospital reviewing its labor and delivery (obstetrics) program?

Community Response: Women's health is still too often treated as a "niche" service, historically underfunded and frequently among the first services considered for reduction. Maternity care deserts have been extensively studied and are becoming increasingly common in rural communities, where workforce shortages, changes in birth rates, and low Medicaid reimbursement combine to create the appearance of an "unsustainable" service line for hospital executives.

Distance insulates decision-makers from consequences. The trip to a prenatal appointment, the summer traffic on Route 1, the winter drive at night, the uncertainty of whether you will reach the hospital before labor progresses—none of these appear in a system-level analysis.

Birth volume is being treated as the decisive number. But it is only one metric, and a maternity service delivers much of its value before, during, and after a birth. The question should be not only "How many babies are born here?" but also "What care does this service provide before, during, and after those births?"

A rural maternity unit like Labor & Delivery at Miles provides:

- triage for pregnant patients with concerns;
- evaluation of bleeding, hypertension, decreased fetal movement, contractions, and other urgent symptoms;
- fetal monitoring;
- labor management;
- postpartum complications;
- newborn transition care;
- coordination with EMS and higher-level centers when needed;

- other urgent issues that may arise for an expectant family.

A maternity unit's value is not only the number of births completed, but the safety infrastructure available when unpredictable events occur. From the perspective of a large health system, it's a numbers game - workforce allocation, reimbursement, and operational efficiency. For rural families, it is a question of access to an essential public service during one of the most vulnerable moments of their lives.

The question is not simply why MaineHealth is reviewing Labor & Delivery. The question is why the burden of making rural maternity care "sustainable" continues to fall on the families who depend on it most.

Sources:

- <https://www.weforum.org/stories/2025/01/theres-a-womens-health-gap-heres-how-to-close-it/>
- <https://www.weforum.org/stories/all/women-health-investment-outlook-mapping-opportunity-mobilizing-investment/>
- <https://www.latimes.com/opinion/story/2024-05-31/caesarean-section-pregnancy-birth-women-healthcare-invisible-labor-rachel-somerstein>
- <https://www.beckershospitalreview.com/uncategorized/the-why-behind-increased-maternity-service-closures-and-what-can-be-done/>

Question published by MaineHealth:

Are changes being considered for financial reasons?

Community Response: Yes. MaineHealth has tied the future of Labor & Delivery in Lincoln County to birth volume and staffing costs rather than to community need or long-term access. That is fundamentally a financial analysis.

Although MaineHealth frames the potential closure as a workforce and sustainability issue, its own communications make clear that financial pressures are driving these decisions.

In a June 2026 systemwide email, CEO Dr. Andrew "Andy" Mueller described MaineHealth's ongoing financial challenges and its focus on reducing complexity, eliminating duplication,

managing labor expenses, and controlling shared-service costs. The message also sought to reassure staff:

"Some care team members have interpreted recent conversations about affordability and the cost of care as signs that our focus is mainly on workforce reductions or service cuts. While difficult decisions are sometimes necessary, that is not the main message."

The message describes service reductions as a secondary concern. Yet the potential closure of Miles Labor & Delivery is being weighed on the basis of birth volume and staffing cost, which is, by definition, a cost-driven service reduction. Affordability is the frame through which the future of local maternity care is being decided.

The financial impact of losing local maternity care will be borne primarily by Lincoln County families, not by the health system. MaineHealth is a multi-billion-dollar system with substantial administrative and philanthropic resources. MaineHealth's CEO received more than \$2.2 million in annual compensation, while local executives involved in these decisions earned approximately \$300,000 to \$500,000. The costs of closure, by contrast, fall on households with a median income of about \$70,000—in longer drives, missed work, childcare, and lodging.

Even Stroudwater Associates, a national consulting firm that specializes in helping rural hospitals improve their finances, warns that some Labor & Delivery units are recommended for closure based on inaccurate or incomplete financial analyses. Rather than assuming closure is inevitable, Stroudwater recommends more accurate financial modeling, workforce redesign, and regional partnerships to preserve local maternity care whenever possible.

This makes transparency essential. The community deserves to know the projected savings from closing Labor & Delivery, what alternative staffing models were evaluated, and whether the long-term costs to families, EMS, local employers, and the regional economy were included in that analysis.

Sources:

- "A Message from Andy: Continuing our Work to Build a Sustainable Future" dated June 29, 2026 - MaineHealth News <mhnews@mainehealth.org>
- <https://projects.propublica.org/nonprofits/organizations/10382340/202432199349300848/full>

- <https://projects.propublica.org/nonprofits/organizations/10238552/2025422693493011509/full>
- <https://equitablegrowth.org/research-paper/hospital-consolidation-matters/>
- <https://www.stroudwater.com/webinar/sustaining-rural-labor-delivery-programs-strategies-considerations/>

Question published by MaineHealth:

Why are birth volumes low at MaineHealth Lincoln Hospital?

Community Response: Lincoln County's maternity demand is not uniquely low, nor is the volume of births that occur at Lincoln Hospital. When adjusted for the number of women of childbearing age, Lincoln County's birth rate is comparable to the state average.

Births at Miles fell during a period of major healthcare restructuring in the county, not because families stopped needing care. It also reflects that the local community and patient autonomy in choosing where to receive care is affected by the actions of health institutions. The decrease in births at Miles despite the county numbers remaining stable raises important questions about how community trust, perceptions of local access, and confidence in the stability of healthcare services may have influenced where families chose to seek care. This is precisely the kind of question a sustainability analysis should answer, and it has not been asked.

Young families want to live and work here and start their family in the community they live their life in. A new generation of mothers may also have shifted their view of care at Miles, thanks in part to press coverage of the Birthing Center's 20th year as a Baby-Friendly designated center. People want to have choices, and have increasingly found Miles to be a premier regional option, particularly when information about its services is shared alongside improvements, such as advanced breastfeeding training.

Evaluating Miles services using qualitative methods alongside statistical analyses like birth volumes highlights our request: to take seriously the complexities of our local community.

Sources:

- <https://www.census.gov/quicks/facts/fact/table/lincolncountymaine/PST045224>

- https://www.maine.gov/dhhs/mecdc/sites/maine.gov/dhhs/mecdc/files/data/births2014_2023.pdf
- <https://www.sciencedirect.com/science/article/abs/pii/S026661382400247X>
- <https://lcnm.com/announcements/lincolnhealth-miles-campus-maternity-marks-20-baby-friendly-years/>
- <https://www.wiscassetnewspaper.com/article/more-healthcare-changes-ahead-local-hospitals/756>

Question published by MaineHealth:

Why is MaineHealth Lincoln Hospital unable to recruit an OB/GYN provider?

Community Response: Recruiting OB/GYNs is difficult nationwide, but modern rural maternity care no longer depends on a single provider type. If MaineHealth measures sustainability using only OB/GYN recruitment, it is relying on an outdated workforce model.

Federal rural maternity initiatives support collaborative teams that include OB/GYNs, Family Medicine Obstetrics physicians (FMOBs), Certified Nurse Midwives, laborists, regional call-sharing, and tele-obstetrics. Professional organizations, including the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Family Physicians (AAFP), and the American College of Nurse-Midwives (ACNM), support collaborative, rural maternity care models that allow low-risk patients to receive care close to home while ensuring higher-risk pregnancies have timely access to specialized regional care when needed.

MaineHealth's Chief Medical and Transformation Officer, Dr. Adrian Moran, has acknowledged that expecting clinicians to be onsite five days a week is no longer realistic and that health systems must redesign coverage to meet today's workforce.

The community is asking whether MaineHealth evaluated these modern staffing models before recommending closure. Recruitment is not simply about filling a traditional OB/GYN position. It is about building a sustainable workforce that preserves safe, local maternity care.

Sources:

- <https://www.commonwealthfund.org/publications/2021/sep/restoring-access-maternity-care-rural-america>

- <https://www.hrsa.gov/rural-health/grants/rural-community/mmoms>
- <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/02/head-th-disparities-in-rural-women>
- <https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all/family-centered-maternity-care.html>
- <https://www.beckershospitalreview.com/quality/hospital-physician-relationships/the-most-difficult-physician-specialties-to-recruit/>

Question published by MaineHealth:

Why is this review happening now?

Community Response: MaineHealth is the dominant hospital system across southern and much of Midcoast Maine. The Miles Birthing Center is one of the few remaining rural maternity units within a critical access hospital in Maine. As health systems grow larger and more centralized, decisions about service lines become increasingly driven by system-wide operational and financial considerations rather than the unique needs of local communities. Obstetric services, which often face workforce challenges and lower reimbursement, are frequently among the first services evaluated for "sustainability."

The timing of this review has significant practical consequences. The process occurs during a period when:

- The Maine Legislature is out of session.
- Local businesses are operating during their busiest tourism season.
- Families are occupied with graduations, vacations, camps, and other summer commitments.
- Many residents, community leaders, and policymakers are away on summer travel.

By announcing the review at the end of May, holding listening sessions in early June, and scheduling a final decision for August 6, the process concludes before the Legislature reconvenes and while many community members face the greatest barriers to participating. The compressed timeline substantially limits opportunities for public engagement, legislative oversight, and the collaborative development of alternatives.

Sources:

- <https://www.boothbayregister.com/article/lincolnhealth-re-designated-baby-friendly-birth-facility/116139>

- <https://www.porh.psu.edu/ob-services-a-leading-money-loser-for-hospitals/>
- <https://www.kff.org/medicaid/a-look-at-rural-hospital-closures-and-implications-for-access-to-care/#4941d6fb-45bf-4590-a8cc-7f7e123012cd>
- <https://www.beckershospitalreview.com/uncategorized/st-andrews-hospital-in-maine-to-close-er/>
- <https://www.boothbayregister.com/article/community-waits/1407>

Question published by MaineHealth:

Will a closure of labor and delivery services lead to other service closures?

Community Response: Yes. The closure of labor and delivery services often creates a chain of effects that makes additional closures and reductions in staffing more likely, especially in rural hospitals. Expectant mothers may begin traveling to the regional hospital where they will give birth in order to establish care with these providers, leading to fewer local outpatient visits for labs, imaging, and wellness checks. Women tend to manage family healthcare appointments; labor and delivery services are frequently a doorway to pediatric and primary care.

Labor and delivery closures also impact a hospital's ability to recruit and retain care providers. Obstetricians, family physicians who deliver babies, anesthesiologists, pediatric providers, nurses, and surgical staff may relocate if they can no longer practice the full scope of their work, and recruiting replacements becomes more difficult.

Question published by MaineHealth:

Are patients concerned about travel time when delivering?

Community Response:

Yes. Labor begins whenever it begins, and babies will not wait for Wiscasset traffic to clear. Births happen during snowstorms, ice storms, holiday weekends, rush hour, and in the middle of the night; pregnancy does not run on a predictable schedule, which is exactly why proximity to maternity care matters.

During MaineHealth's June community listening sessions, former patients, expectant parents, and other residents repeatedly raised concerns about longer travel times. Those concerns were not meaningfully reflected in MaineHealth's response or in their analysis.

The consequences of that distance reach beyond any single patient. EMS capacity in Lincoln County varies with season, weather, staffing, and tourism, and it is already stretched. A woman in active labor who needs long ambulance transport to a regional maternity hospital ties up a crew, and that ambulance may then be unavailable for a cardiac arrest, a serious crash, a boating accident, or another emergency elsewhere in the county.

That strain intensifies in season. Lincoln County serves far more than its year-round population; during peak tourism months, thousands of additional visitors depend on the same roads, hospitals, and EMS agencies. Long-distance obstetric transports add to a system that already operates with limited resources.

Maintaining local maternity care is therefore about more than convenience. It protects access for pregnant women while preserving emergency response capacity for everyone else who lives in, works in, or visits Lincoln County.

For rural communities, travel time is not measured only in miles. It is measured in risk, reliability, and whether emergency resources remain available when every minute matters.

Sources:

- <https://pubmed.ncbi.nlm.nih.gov/22905951/>
- <https://pmc.ncbi.nlm.nih.gov/articles/PMC7266083/>
- <https://ambulance.org/2021/05/25/study-rural-hospital-closures-strain-community-ambulance-services/>
- <https://www.ruralhealthinfo.org/topics/emergency-medical-services>

Question published by MaineHealth:

How would travel time increase if MaineHealth Lincoln Hospital no longer offered delivery services?

Community Response: Travel times for families would increase significantly, and longer distances create real risks for mothers and babies. Research links increased travel time with higher rates of maternal and newborn complications, delayed access to emergency obstetric care, and more out-of-hospital births.

Studies show that when travel time exceeds about 30 minutes, the risk of an unplanned out-of-hospital birth more than doubles. Maine is already seeing this challenge. Between 2018 and 2023, out-of-hospital births increased by 41 percent, rising from 228 to 321 births.

For rural families, travel does not begin the moment labor starts or a complication appears. Families must arrange childcare, leave work, drive in winter weather or heavy traffic, and decide when it is time to seek care. These delays matter, especially during emergencies where minutes can affect outcomes.

Some families would also face the added stress and risk of emergency ambulance or LifeFlight transport. Being transferred during labor, after delivery, or with a newborn in distress creates additional physical and emotional trauma for families already facing a medical crisis. Delays while waiting for transport or traveling longer distances may also contribute to complications that could have been addressed earlier with local obstetric care.

Traveling for maternity care also shifts costs onto households—additional driving, childcare, missed work, lodging, and transportation. These can add hundreds to thousands of dollars over the course of a pregnancy and postpartum period, and they fall hardest on families with the fewest resources to absorb them.

Access to maternity care is not only about distance. It is about whether mothers and babies can reach appropriate care safely, calmly, and in time when every minute matters.

Sources:

- <https://www.statnews.com/2017/02/16/pregnant-women-rural-america/>
- <https://pubmed.ncbi.nlm.nih.gov/33779982/>
- <https://themainemonitor.org/maternity-care-investigation-takeaways/>
- <https://lifeflight.me/patient-story-stacie-newman/>

Question published by MaineHealth:

What is the timeline for completing the assessment and presenting suggestions?

Community Response: MaineHealth has shared limited details, but the community understands that the MaineHealth Board of Trustees plans to make a final decision on

August 6. It remains unclear whether the assessment findings and alternative recommendations will be shared publicly before that decision. The community has not been offered a meaningful opportunity for dialogue.

A decision of this importance requires a process built on transparency, trust, and partnership.

We urge MaineHealth to delay a final decision and engage clinicians, patients, community leaders, elected officials, researchers, and philanthropic partners in a regional planning process. As a healthcare anchor in Damariscotta, MaineHealth has an opportunity to work with the community to develop solutions that protect access to rural maternity care.

A delay of 18 to 36 months would allow time to evaluate emerging state and federal rural maternity initiatives, pursue funding opportunities, test innovative staffing models, strengthen recruitment efforts, and determine whether a sustainable future for Labor & Delivery exists.

In July 2027, the Miles Labor & Delivery Unit is expected to celebrate its 30th anniversary as a nationally recognized rural maternity program. We ask MaineHealth to honor that legacy by choosing partnership and investment over an irreversible cut.

Sources:

- <https://www.ruralhealthinfo.org/toolkits/maternal-health/4/implementation>
- <https://us.noharm.org/sites/default/files/documents-files/7383/Anchored-by-health-care-Strategies-for-health-systems-HCWH.pdf>
- <https://www.boothbayregister.com/article/lincolnhealth-miles-maternity-celebrating-20-years-being-baby-friendly/89306>

Question published by MaineHealth:

Will current staff lose their jobs if a closure decision is made?

Community Response:

While ending obstetric services may not immediately lead to layoffs, it would have significant workforce and community impacts.

Existing employees may be offered other roles, but eliminating Labor & Delivery could increase turnover among physicians, nurses, Certified Nurse Midwives, and other clinicians who value full-scope rural care. Reducing the ability to provide comprehensive family care may make recruitment and retention more difficult and weaken the mission that attracts providers to Lincoln Hospital.

Miles has consistently hosted two Tufts Maine Track students each year and has remained eligible because it provides obstetric training. If the maternity unit is closed, Lincoln Hospital would no longer qualify, eliminating an important pathway for training and recruiting future rural physicians.

The impact extends beyond hospital staffing. Local maternity care helps attract families and healthcare professionals, strengthens community relationships, and supports the long-term health of the region.

The question is not only whether current employees keep their jobs. It is whether Lincoln Hospital remains the kind of rural hospital where clinicians build careers and families choose to call home.

Sources:

- <https://www.mitemainehealth.org/uploads/1291704-25-MH-MedED-UME-Recruitment-LIC-8.5x11-Handout-v4-1.pdf>
- <https://rhrc.umn.edu/publication/state-variations-in-the-rural-obstetric-workforce/>
- <https://pubmed.ncbi.nlm.nih.gov/20004606/>
- <https://themaine-monitor.org/maternity-care-investigation-takeaways/>
- https://scholar.google.com/scholar_lookup?journal=Can.%20J.%20Rural%20Med.&title=%E2%80%9CYou%20don%E2%80%99t%20know%20what%20you%E2%80%99ve%20got%20till%20it%E2%80%99s%20gone%E2%80%9D:%20The%20role%20of%20maternity%20care%20in%20community%20sustainability&author=C.%20Miewald&author=M.C.%20Klein&author=C.%20Ulrich&author=D.%20Butcher&author=S.%20Eftekhar&volume=16&publication_year=2011&pages=7-12&

Appendix - Tables

Appendix A - MaineHealth Executive Compensation

Executive / Key Employee	Role	Reported Compensation	Other Compensation	Total Reported Package
Andrew T. Mueller, MD	CEO & President	\$2,222,049	\$55,268	\$2,277,317
Matthew R. Sanborn, MD	Physician	\$1,479,719	\$61,694	\$1,541,413
Robert Ecker, MD	Chief – Neurosciences	\$1,462,063	\$96,908	\$1,558,971
Jeffrey Sanders	Former Maine Medical Center President	\$1,364,442	\$34,150	\$1,398,592
Dougald MacGillivray, MD	Physician	\$1,295,020	\$110,813	\$1,405,833
Albert G. Swallow III	CFO / Board Treasurer	\$1,275,516	\$128,689	\$1,404,205
Lugene Inzana	Former Officer / Associate CFO	\$887,523	\$61,476	\$948,999
Joel Botler, MD	Former Regional CMO	\$855,473	\$92,847	\$948,320
Beth Kelsch	General Counsel / Board Secretary	\$752,576	\$96,015	\$848,591
Lisa Beaulé, MD	VP Physician & APP Services	\$594,453	\$101,835	\$696,288

Sources:

- <https://projects.propublica.org/nonprofits/organizations/10238552/202542269349301509/full>

Appendix B - MaineHealth President x Lincoln Health Top Officials x LC

Person	Role	Approx. Total Compensation	Compared to Median Lincoln County Household Income
Andrew T. Mueller, MD	MaineHealth CEO & President	~\$2.3 million	~30×
Cindy Wade	LincolnHealth President / Executive Leadership	~\$500,000+ (reported through related compensation sources)	~7×
Tim Fox, MD	LincolnHealth Physician	~\$465,000	~6×
Andrew Russ, MD	LincolnHealth Physician	~\$389,000	~5×
Average Lincoln County resident (per capita income)	Individual income average	~\$45,600/year	1×
Median Lincoln County household	Typical household income	~\$76,900/year	1×

Comparison	Amount
MaineHealth CEO total reported package	~\$2.28 million
Top 10 listed executives/key employees combined	~\$13.4 million
Lincoln County median household income	~\$76,875/year
Lincoln County per capita income	~\$45,631/year

Sources:

- <https://projects.propublica.org/nonprofits/organizations/10382340/202432199349300848/full>
- <https://www.census.gov/quickfacts/fact/table/lincolncountymaine/IPE120224>
- <https://projects.propublica.org/nonprofits/organizations/10238552/202542269349301509/full>

Appendix C - Timeline of St. Andrews Hospital transition to an outpatient facility and community concerns:

2010:

- Reductions in staff, cost-cutting measures, discussions of consolidations, at both St. Andrews and Miles.
- Noted as the last year of high birth volume before annual declining numbers until 2018.

2011:

- Internal review of St. Andrews Hospital services began amid broader questions about sustainability and service alignment.

2012:

- **April:** Outpatient surgical services ended as Lincoln County Healthcare continued evaluating the future configuration of services.
- **July:** Lincoln County Healthcare announced plans to end inpatient services and close the emergency department at St. Andrews.
- **August:** MaineHealth Board of Trustees approved the changes, resulting in St. Andrews no longer qualifying as a hospital.
- **September–December:** Significant community response followed; a task force was formed, and community members requested additional time to evaluate alternatives.

2013:

- **January–September:** Community members and local leaders continued efforts to delay or reconsider the transition.

- **October:** St. Andrews ceased operating as a hospital; emergency and inpatient services were consolidated at Miles.

Sources:

- https://www.boothbayregister.com/print_boothbay_register/article/how-did-we-get-here/2087
- <https://www.mainehealth.org/mainehealth-lincoln-hospital/about-mainehealth-lincoln-hospital/mainehealth-lincoln-hospital-labor-and-delivery-assessment>

Appendix D Decline in Miles births beginning after 2010 - which coincided with the Lincoln Hospital controversy in Boothbay.

Birth volumes during the evaluation and eventual transition of St. Andrews Hospital away from hospital status (2010-2013)

Year	Deliveries at Miles	Lincoln County resident births (LCRB)	Approx. % of LCRB at Miles
2010	212	297	71.40%
2011	162	263	61.60%
2012	126	271	46.50%
2013	112	250	44.80%

Sources:

- <https://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records>

Appendix E - Federal rural funds and insurance reimbursement support various practitioners other than solely OB/GYNs, allowing for new workforce mix to provide L&D:

There is not one universal national staffing ratio that says "X number of OB/GYNs, midwives, or nurses are required for Y number of births." Potential staffing setups:

Model	Available Workforce Pool	Example Rural L&D Staffing Model	Workforce Impact
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OB/GYN physicians	~60,000 practicing OB/GYNs	Full-spectrum obstetrics, surgery, high-risk care	Highly trained but a smaller, competitive workforce; rural recruitment is difficult
Provider type	Approximate U.S. workforce	Role in maternity care	Relevance to rural L&D

Appendix F - Obstetrics Workforce Snapshot

- Sources:**
- <https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/08/levels-of-maternal-care>
 - <https://www.aamc.org/data-reports/workforce>
 - <https://www.aafp.org/about/policies/all/cesarean-delivery-family-medicine.html>
 - <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries>

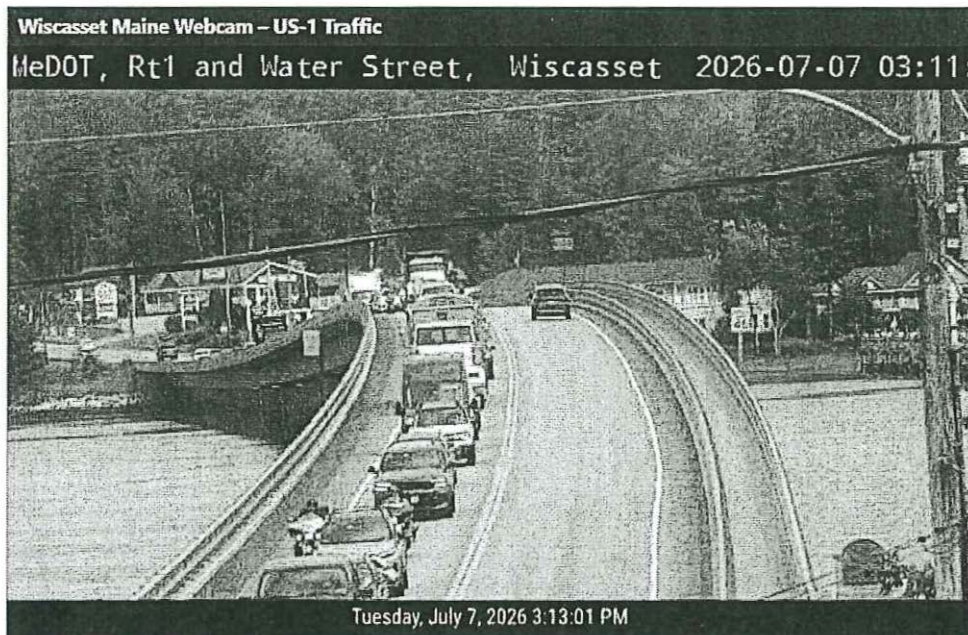
OB/GYN-only model	OB/GYN + Family Medicine (FM-OB) Obstetrics	OB/GYN + FM-OB + Certified Nurse Midwives (CNM)	OB/GYN + Laborist + CNM model
OB/GYN physicians only	OB/GYNs + family physicians trained in obstetrics	OB/GYNs + FM-OBs + CNMs	OB/GYN specialists + dedicated labor physicians + CNMs
1-2 OB/GYNs expected to cover deliveries, call, emergencies	OB/GYN provides specialty backup; FM-OB physicians provide deliveries and continuity care	Team-based care with CNMs managing appropriate low-risk births and physicians supporting higher-risk care	Laborist covers in-house deliveries/call; CNMs provide low-risk care; OB/GYN provides specialty backup
Smallest recruitment pool; high call burden; vulnerable if one physician leaves	Expands physician pool significantly, especially in rural areas	Larger workforce pool; improved flexibility; supports low-risk birth volume	Reduces individual call burden and improves recruitment

Family Medicine physicians	~130,000+ practicing family physicians	Primary care; some provide full-scope OB including deliveries	Critical rural maternity workforce; family physicians are often the only delivering physicians in some rural hospitals
Family Medicine physicians providing OB	A smaller subset, estimated in the thousands	Low-risk births, prenatal care, postpartum care, some C-sections if trained	One of the most important expansion opportunities for rural maternity care
Certified Nurse Midwives (CNMs)	~14,000+ CNMs	Prenatal care, low-risk births, postpartum care, collaboration with physicians	Expands low-risk maternity workforce and supports team-based models
Laborists	No fixed national count	Hospital-based OB coverage, often shift-based	Helps reduce call burden and makes rural practice more attractive

Sources:

- <https://www.aafp.org/about/policies/birth-equity-pos-paper>
- <https://pmc.ncbi.nlm.nih.gov/articles/PMC10549447/>
- <https://www.aafp.org/medical-school-residency/fellowships/directory/family-medicine-obstetrics.html>

Appendix G - Typical traffic volume daily through Wiscasset - open road to Damariscotta, traffic jam towards Midcoast Hospital.



Source:

- <https://maine-webcams.com/maine-traffic-cameras/rt1-wiscasset-maine-webcam/>

Appendix H - Approximate increase in expenses per pregnancy on individual/family if L&D closed

For families in Lincoln County, traveling to a regional hospital for labor & delivery care can add significant expenses, including:

- **Travel costs:** Additional miles for prenatal appointments, ultrasounds, lab work, triage visits, delivery, and postpartum follow-up.
- **Vehicle expenses:** Fuel, maintenance, tires, and vehicle wear from repeated long-distance trips.
- **Lost wages and time away from work:** Parents and partners may need to use paid time off or lose income to attend appointments, delivery, or hospital visits.
- **Childcare costs:** Additional childcare may be needed for appointments, emergencies, or hospital stays.
- **Family travel costs:** Partners, grandparents, and support people may face repeated trips to provide support before and after birth.
- **Meals, parking, and possible lodging:** Longer stays or frequent visits can create additional out-of-pocket expenses.

Estimate approximately **\$2,000 to \$4,500 in additional costs per pregnancy** in increased expenses due to more distant care facilities.

Source: Community Members.

* *Testimony of former Representative Les Fossel on Maternal Health Services and the proposed closure of the Lincoln Hospital Birthing & Delivery Services August 27, 2026*
Senator Bailey, Representative Mathieson, and Esteemed Members of the Health Coverage, Insurance & Financial Services Committee I am Les Fossel, a recovering politician.

Maine House (Republican, 2008-12)

Insurance & Financial Services	Created the Joint Select Committee on Healthcare Reform Joint Select Committee on Healthcare Costs (not funded)
Health & Human Services	Authored the Electronic Health Records law (with Shenna Bellows)
Moderate Caucus Co-Chair	The largest caucus in the 115th Maine Legislature
MERI Rating	Regularly cited as one of the most fiscally conservative legislators

Politics I served as Lincoln County GOP Chair or State Committeeman for over 15 years

My Healthcare background

Past Senior Underwriter, Special Risk Health, Hartford Insurance Group (3 yrs)

Executive Director, Heart Association of Eastern CT. (2 yrs)

Board, Lincoln health (15 yrs)

Now Vice Chair, Lincoln County Dental (9 yrs): Serves low income dental patients www.lcdental.org
Chair, Eldercare Network of Lincoln County (8 yrs): Low income frail elders www.eldercarenetwork.org
Treasurer, Healthcare for All Maine (6 yrs): Healthcare Referendum www.healthcareforallmaine.org
Board, Governance, Volunteers of America NNE: Serves low income at risk Mainers www.voanne.org

My family's Background

Brother Jon chaired Unum

Brother Michael (PHD, MD Stanford) Chairs Telocyte, is a leading researcher on aging (see attachment),
Sister in law Dottie board chair Madison Valley Medical Center (12 yrs)

Uncle Mart owned Unimed, a pharmaceutical company

Cousin Eric was a full professor at Harvard Medical School.

Grandfather George Sioux Falls, SD hospital administrator

I am Lincoln County's largest contractor - and pay for healthcare. www.oldhouserestoration.com

I was the only employer on Lincoln Health's board.

The Lincoln Health Board majority is wealthy recent retirees from away.

The long term resident Lincoln Health Board members voted to keep our Birthing Center.

I resigned from the Lincoln Health board because:

I don't believe in secret votes on non-personnel or legal matters for 501c3s.

False information was presented to secure the vote.

All the votes of the volunteer Maine Health boards were based on false information presented by the Maine Health administration, I pointed that out to them privately in May '26 and repeated that warning many times to no avail. Since this false information was created by Maine Health's central office it is clear that they had a predetermined outcome. In fact, their chief lobbyist was contacting members of the Lincoln Health board to influence their vote.

If Maine Health spent as much money on saving our birthing center as they have on slick PR to justify their closure, then the problem would be solved & we wouldn't be wasting time here.

Lincoln County has among the highest percentage of millionaires among US counties.

Lincoln County ties with Washington County with the lowest wage incomes in Maine (Maine is 42nd in the US).

Lincoln Hospital was ranked the safest hospital in America 7 years ago by Consumer Reports. Despite that, the health statistics for Lincoln Residents are mediocre at best.

Maine Health is focused on treatment, because that's where the money is.

Community health focused on prevention is the future we must adopt.

A key to community health is having a robust pregnancy and birthing center.

As with politics, all health is local.

Our single payer healthcare referendum will collect over 100,000 signatures.

When it goes on the ballot in 2027 it is very likely to pass overwhelmingly.

Maine Health's healthcare treatment model is both unaffordable and outdated - it kills.

Thank you for giving me the opportunity to testify. I welcome your questions.

(136)

6 Year Maine Births

Les Fossel 7/22/26

County	2019 Births		2020 Births		2021 Births		2022 Births		2023 Births		2024 Births	
All Lincoln County Births	246	100%	234	100%	254	100%	257	100%	284	100%	231	100%
Actual Lincoln Hospital Births	92	37%	111	47%	111	44%	101	39%	132	46%	132	57%
Lincoln Hospital if 7 in 10	76	30%	73	30%	79	30%	80	30%	88	30%	72	30%

Prepared by Maine Department of Health and Human Services,

Maine Center for Disease Control and Prevention, Data, Research, and Vital Statistics, 12/04/2025.



Why are birth volumes low at MaineHealth Lincoln Hospital?



Several factors contribute:

- The median age in Lincoln County is 51, the oldest in Maine and among the oldest in the country, according to the US Census Bureau.
- Nearly 7 of 10 expectant parents in Lincoln County are choosing to deliver at hospitals other than MaineHealth Lincoln Hospital.

Les Fossel

Business Owner

Restoration Resources, Maine's premier historic house restoration company, founded in 1975 with 14 staff members (with over 200 total years of experience) and \$2.9 million in sales. His work has been featured in *DownEast Magazine*, *Money Magazine* and many other publications.

Awards

- 2023 Greater Portland Landmarks "Preservation Award for Falmouth's Bucknam Tavern"
- 2019 Sagadahoc Preservation "Preservation of the City of Bath"
- 2017 Maine Preservation "Honor Award for Elijah Kellogg Church"
- 2010 Burnt Island Lighthouse, Southport
- 2008 "Long term commitment to providing broad ranging preservation education"
- 2007 Maine Preservation for "Outstanding contribution as Vice President"
- 2001 "Excellence in restoration carpentry and the building preservation trades"

Education

Les has taught generations of Mainers the preservation trades. Beginning at the University of Southern Maine, he's taught over 2,000 Realtors, assessors, appraisers, & inspectors. He regularly lectures to local, state and national groups. Les was in the Rho class of Leadership Maine. He created Maine Preservation's summer internship program for master's degree students. Through Adult Education programs, he has taught field courses for over 1,000 owners of old houses since 1989.

Current community service

- Wiscasset & Quebec Railroad*: Treasurer (a founder). Narrow Gauge Railroad Museum www.wfry.org
- Lincoln County Dental*: Vice Chairman. Serves low income dental patients www.lcdental.org
- Eldercare Network of Lincoln County*: Chairman. Serves low income elderly www.eldercarenetwork.org
- ClimateWork Maine*: Board. Development Committee. Fights climate change www.climateworkmaine.org
- Maine Preservation*: Advisory, Governance & Real Estate Committees www.maine Preservation.org
- Healthcare for All Maine*: Treasurer (a founder). Healthcare Referendum www.healthcareforallmaine.org
- Braver Angels/Building Bridges Maine*: Program committee, Fights extremism www.buildingbridgesmaine.org
- Greater Portland Landmarks*: Advisory Trustee www.portlandlandmarks.org
- Volunteers of America NNE*: Board, Governance. Serves vulnerable Mainers www.voanne.org

Legislative service ('08-12)

- | | |
|--------------------------------|--|
| Moderate Caucus Co-Chair | Became the largest caucus in the 115 th Maine Legislature |
| Judiciary | Compromise legislation on takings of land by government |
| Government Oversight | Reformed of the Maine Turnpike Authority |
| Insurance & Financial Services | Created the Joint Select Committee on Healthcare Reform |
| Health & Human Services | Authored the Electronic Health Records law |
| Congressional Reapportionment | Authored the law |

Les graduated from Lake Forest College with a degree in Sociology/Anthropology. Les and his wife Merry (they met in high school) live in an 1815 Alna Cape with 3 barns (with 27 kw of solar panels, 4 heat pumps, & 3 EV trucks, a greenhouse, and 39 acres with a large organic garden, pasture, & hayfield. Together they have 4 children and 5 grandchildren.

Mail: Restoration Resources PO Box 525 Alna, ME 04535. **Phone:** Les Fossel (207) 586-5680. **Email:** fossel@oldhouserestoration.com **Website** www.oldhouserestoration.com **Video:** https://youtu.be/UJ_zSDk3mzg



Matthea Elisabeth Larsen Daughtry
President of the Senate

THE MAINE SENATE
132nd Legislature

3 State House Station
Augusta, Maine 04333

**Testimony of Senate President Mattie Daughtry
Before the Joint Standing Committee on Health Coverage, Insurance and Financial Services Regarding
Rural Maternity Care and Labor and Delivery Services
August 27, 2026**

Senator Bailey, Representative Mathieson, and distinguished members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, my name is Mattie Daughtry. I represent Senate District 23, which includes Brunswick, Chebeague Island, Freeport, Harpswell, Pownal, and part of Yarmouth, and I have the honor of serving as President of the Maine Senate.

Thank you for holding this hearing and, more importantly, thank you to everyone who came here today to share their experiences with maternity care in Maine.

For the past several months, I have stood alongside families, health care workers, local leaders, and people from across Lincoln County fighting to keep labor and delivery services at the Miles campus of Lincoln Hospital. We wrote letters, signed petitions, rallied, and asked questions. People shared some of the most intimate stories of their lives: difficult pregnancies, emergency deliveries, and babies born safely at Miles. They shared those stories because they believed they might help save this service for the next family who needs it.

On Aug. 6, despite all of that, the MaineHealth Board of Trustees voted to close the Miles Family Birth Center.

I remain deeply, deeply angered and disappointed by that decision. But what happened at Miles has once again forced us to confront something that is so much larger than one hospital or one community. **Maine has a maternity care crisis, and we cannot continue addressing it one closure at a time.**

As we all know, Miles is not the first labor and delivery unit we have lost and across Maine, maternity units have been closing for years. Each closure comes with its own explanation: staffing shortages, declining birth rates, changing patient patterns, and the difficulty of maintaining around-the-clock coverage.

Those challenges are very real. Running a hospital in rural Maine is difficult, and providing 24-hour maternity care is especially difficult. But difficult cannot become synonymous with disposable. There are many essential services we maintain because their value cannot be captured by how many people need them on an average Tuesday. We do not decide whether a fire department is necessary based only on how many houses caught fire last year. Its value is in knowing that when a house does catch fire, someone will be there. Labor and delivery care carries that same responsibility.

Pregnancy does not always follow a schedule. Labor does not wait for good weather, convenient staffing, or an open bed an hour away. A complication does not care whether a family has reliable transportation, whether Route 1 is backed up in August, or whether there is a snowstorm in February.

And that is why the question before us cannot simply be whether an individual hospital can make the numbers

work.

The question has to be: **What level of maternity care does Maine believe every family should be able to access, how close should that care reasonably be, and what are we willing to do as a state to make that possible?**

Because this is also a question about the survival and future of rural Maine, and the preservation of our way of life.

We spend a lot of time in this building talking about our aging population and workforce shortages. We talk about attracting young people to Maine, keeping the young people who grew up here, and making it possible for families to put down roots in our rural communities. But the reality is that families need housing they can afford. They need child care, and schools, and good jobs. And they ultimately need to know that when they decide to have a child, safe care will be within reach. At its core, that is why the loss of Miles feels and is so much bigger than the closure of one unit.

What I watched happen in Lincoln County was extraordinary. The community refused to accept that losing maternity care was simply inevitable. And so they organized. They learned hospital finances and staffing models. We saw nurses, physicians, EMS professionals, parents, business owners, and community leaders come forward. They all brought ideas to the table and asked to be partners in finding a solution and they fought for the ability of the next generation to be born in the community they call home.

The outcome was not what we wanted. But their work cannot end with Miles. It has to be the beginning of a statewide movement. Today, we have an opportunity to stop reacting hospital by hospital and community by community and begin building a strategy for maternity care in Maine; something that will require us asking hard questions.

How do we recruit and retain obstetricians, nurses, midwives, anesthesiology professionals, and the other health care workers necessary to maintain these services? What innovative staffing and regional partnership models are working elsewhere, and what would it take to make them work here? What role should the state play when an essential service is at risk of disappearing? How do we measure access, not simply by miles on a map, but by what those miles mean in February weather, during summer traffic, for a family without reliable transportation, or during an obstetric emergency? And how do we make sure communities have a meaningful voice before decisions about essential services become irreversible?

We should also recognize that no single person sitting in this room has all of those answers. This conversation needs our hospitals as well as the nurses and doctors who know what it takes to safely provide this care. It needs EMS professionals who understand exactly what additional travel time can mean during an emergency. It needs policymakers, insurers, educators, and people working every day to solve Maine's health care workforce challenges. Most importantly, it needs the people who live in the communities affected by these decisions. Everyone, and I truly mean everyone, needs to have a seat at the table.

MaineHealth has committed not to close another labor and delivery unit within its system for two years, but we cannot sit idly by with trust and treat those two years as a reprieve and simply wait for the clock to run out. We need to treat it as a deadline to build a long-term vision for maternity care in Maine before another community finds itself fighting, with only weeks or months of notice, to save the place where its babies are born.

The people of Lincoln County fought incredibly hard for Miles, and they deserved a different outcome, as did every single community in our state that has lost access to birthing services. Maine rural communities cannot simply become another place on the map where babies used to be born.

Thank you, and I look forward to working with this committee on what comes next.

TABLE 2: Live Maine Births by Facility

Facility	CY 2024	CY 2023	CY 2022	CY 2021	CY 2020	CY 2019
Delivered At Home	330	321	324	307	274	227
Northern Sun (Topsham) - R		4	9	6	9	6
The Birth House (Bridgton) - R		7	12	5	9	12
Holly #7 (Bangor)		40	39	9	15	11
Soft Corner Midwifery (Bath) - R		2				
Women First (Machias) - R		1				
Free-Standing Birth Center	75					
Bridgton Hospital (2021) - R		1	1	27	58	60
Northern Maine Medical Center (2023) - R		14	46	45	53	43
St Mary's Regional (2022)		1	246	482	504	542
Rumford Community(2023) - R		8	55	84	80	95
York Hospital (2023)		187	291	265	271	324
Millinocket Regional (1998) - R	1	0	1	2	2	
Calais Regional (2018) - R	1	0	1	1	1	2
MH Waldo - R	125	109	97	123	119	137
Houlton Regional - R	82	90	88	107	103	119
Mt Desert Island - R	33	59	67	42	62	64
Northern Light -Inland Hospital - R	208	268	270	270	296	307
MH Franklin - R	256	281	240	222	237	229
MH Lincoln - R	132	132	101	111	111	92
MH Stephens - R	233	204	225	151	147	163
MH Mid Coast - R	475	528	506	532	464	569
MH Pen Bay - R	201	202	234	211	225	248
MH Maine Medical Center Biddeford/Sanford	437	436	476	441	417	505
MH Maine Medical Center Portland	3330	3236	3313	3157	3055	2942
Central Maine Medical	735	855	746	525	559	568
Cary Medical Center - R	214	201	194	195	196	204
Mayo Regional - R	113	104	112	108	108	85
Redington-Fairview - R	112	118	103	119	125	125
Down East Community - R	83	112	141	183	153	177
MaineGeneral Alford Center for Health - R	1003	1050	1033	1058	980	1015
Northern Light-A.R. Gould - R	190	177	155	212	166	175
Northern Light-Mercy Hospital	725	670	682	632	669	638
Northern Light -Eastern Maine Medical Center	1591	1587	1721	1669	1607	1625
Northern Light-Maine Coast Hospital - R	259	186	170	184	211	193
Total deliveries	11,587	11,737	12,198	11,962	11,296	11,511

Source: Maine Center for Disease Control, Office of Data, Research, and Vital Statistics, Communication with Terry Bryant, May 2025.

Note: R following the hospital name indicates a rural hospital using federal HRSA definition of rural. Gray-shaded area indicates facilities that have closed maternity units as of Dec. 2025.

Five rural Maine maternity hospitals have fewer than 200 annual births (MH Lincoln, Mayo Regional, Redington-Fairview, Down East Community, and NLH A.R. Gould), and five more hover just above that (MH Franklin, MH Stephens, MH Pen Bay, Cary Medical Center, and NLH Maine Coast) (Table 2).

Alternative reimbursement models (such as add-on payments, standby reimbursement, or local government ownership of the hospital) could help ensure rural hospitals maintain their maternity units.

Add-on payments. State and federal policies related to Medicaid reimbursements are critical to the survival of



Richard A. Bennett
Senator, District 18

THE MAINE SENATE
132nd Legislature

3 State House Station
Augusta, Maine 04333

**Joint Standing Committee on Health Coverage, Insurance and Financial
Services**

Hearing on Labor and Delivery Unit Closures

August 26, 2026

Senator Bailey, Representative Mathieson, and honorable members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services: I am Senator Rick Bennett of Oxford.

Thank you for convening this hearing on labor and delivery unit closures.

We cannot accept a Maine where families lose access to health care when they need it most. Maternity care matters and is worth fighting for.

The families who are losing this care are being asked to shoulder the burden of a failing system. The strength of a state is measured in many ways. One of them is whether families can count on care when they need it most.

The closure of the birthing center at Lincoln Hospital will mark the twelfth such closure in the last decade.

My heart is with the families affected by the recently announced closure – and rural communities around the state – who no longer have access to nearby health care.

Our first moments welcoming a new baby should not be filled with fear. These precious moments deserve to be filled with the excitement, love, care, and joy that having a baby brings.

My wife Karen and I live in rural Maine. We drove the hour to Portland for our daughter's birth. For our son, we didn't have that luxury. It quickly became clear that we couldn't make the drive – that Nate wasn't going to wait for us to make it to Portland. Thankfully, we did have a hospital nearby, and an OB was able to meet us there – though he arrived after us. Had we not had maternity services at the local hospital, Nate surely would have been born on the side of 95.

And I heard similar stories when I joined the listening session at Great Salt Bay Community School. I heard from so many young families, their own stories, their fears. Their hopes for the future.

And the resounding agreement that access to maternity care is essential to Maine families, the future of our state.

Now, this committee is looking for solutions. Here are my thoughts.

We have been hearing from providers that staffing is an issue. The Legislature had an opportunity to fund the Doctors for Maine's Future program this last session, and it failed to do so. This program has proven to be successful, and the State must continue to support it.

The State must also pay providers on time, and at the appropriate rate. It is unconscionable that health providers are needing to take out a line of credit while they wait for the state to pay our bills.

And it is about making sure the people most affected – the families, providers, and communities – are heard clearly. Today's hearing is an important step, but it cannot be the last time we engage with these communities.

Because once care disappears from a community, the impact is far reaching.

It shapes whether people feel confident staying in the area, raising children there, and putting down roots.

Access to maternity care is part of what makes a community livable and sustainable. We deserve that for every part of Maine.

The strength of a state is measured in many ways. One of them is whether families can count on care when they need it most.

Thank you.

Public Comment from Hannah Pingree to the
Joint Standing Committee on Health Coverage, Insurance and Financial Services

Thursday, August 27, 2026

Senator Bailey, Representative Mathieson and members of the Health Coverage, Insurance and Financial Services, My name is Hannah Pingree and I am from North Haven. Previously, I served as Director of the Governor's Office of Policy Innovation and the Future, Speaker of the Maine House of Representatives, a state legislator, Co-Chair of the Health and Human Services Committee, and a chair of my local school board. I am also a parent of two teenage kids. It is with that experience that I provide this public comment for this special committee hearing in the wake of the recent MaineHealth decision impacting Lincoln County and related to the broader issues facing families seeking access to health care services across our rural state.

MaineHealth's vote to close labor and delivery services at Miles Memorial Hospital is a devastating decision for families in Lincoln County and a stark reminder that Maine cannot continue to treat the loss of local maternity care as inevitable.

A baby doesn't always wait for good weather, a long drive to a hospital an hour away, or the right doctor or midwife to be available. But across Maine, more families are being asked to bet on all three.

In the last decade, we've lost twelve hospital-based birthing units. Nine of those closures have come in just the past few years. Rural Mainers whose closest hospital does not have a birthing unit now drive more than 45 minutes on average to reach a hospital that delivers babies.

This is not just a health care problem — it's a safety issue for moms and babies, and an economic issue for communities across Maine.

I know personally what it means to plan around distance and weather. I live on an island twelve miles off the coast of Rockland, an hour-long ride on the state ferry and another ten minutes to the nearest hospital. Before both of my children were born, I moved off-island for a few weeks so I wouldn't be stuck on the wrong side of the bay when labor began.

I was lucky. I had somewhere to stay and a job that gave me the flexibility to do it. Not every family does. A safe place to deliver a baby close to home should not depend on luck or good weather. It should be something Maine families can count on.

That is why I called for a statewide moratorium on labor and delivery closures for one full year after the next governor takes office. That demand from myself and so many others wasn't

enough to save Lincoln. But it's not too late for the next hospital on this list. We need time to find real alternatives before another community loses essential care.

And, just as urgently, with the loss of delivery units across our state, moms and babies will face greater risks and worse health outcomes. Our challenge is not just about stopping the next closure, but improving the health outcomes for families now facing a much longer trip for deliveries and care.

That work starts with money. Maine is receiving approximately \$150 million a year from Washington's \$50 billion Rural Health Transformation Fund, but federal rules limit direct provider payments to 15 percent of each state's award. That does little for a rural hospital struggling to afford and recruit the doctors, midwives and nurses it needs.

Our congressional delegation and federal health officials need to hear from all elected officials that that cap has to come off, so these resources can actually reach the providers our rural hospitals depend on.

This state also needs a statewide maternity care summit — hospital leaders, doctors, midwives, state officials, legislators and families in the same room — to find real solutions: shared staffing, expanded midwifery care, telemedicine, mobile health units, new reimbursement models. The next Legislature and the next governor need to convene that work together, in the first months of the next term, before we lose another unit and to improve the health outcomes of families who now are traveling longer distances for care.

The people of Lincoln County have been asking a hard question: What happens if you can't be born here, and you can only die here? It doesn't have to be that way. But, as you know, that is now the case in several rural counties in Maine.

When an ambulance and its crew spend hours transporting a woman in labor, they are unavailable for the next heart attack, car accident or emergency. Hospitals farther away absorb patients they were never meant to serve alone. And young families deciding where to put down roots ask whether their community has a hospital nearby when they need it.

This isn't a problem the next governor can solve alone, and it isn't one this Legislature can solve alone either. It's going to take both, working together with Maine's providers and health systems, starting now — not after the next campaign, but before the next community loses what Lincoln just lost.

A thriving Maine needs thriving rural communities. Maine does not have to accept the loss of maternity care as inevitable. This is a policy choice and we must make a different one.

McCarthyReid, Colleen

From: Candace Crocker <pc4candie@gmail.com>
Sent: Thursday, August 27, 2026 12:49 PM
To: McCarthyReid, Colleen
Subject: Rural maternity units, specifically Miles (aka Lincoln) Maternity

ALERT This email looks suspicious and may have been automatically generated. Be careful as this is likely spam. If you disagree, mark as Safe/Phishing using the Outlook Add-In. Powered by CyberSentriq.

This message originates from outside the Maine Legislature.

As a MaineHealth employee, I strive to be thoughtful, ethical, and professional—I do not represent my employer in any way in this email. I am an RN at a Maine Birth Center facing an uncertain future after 27 dedicated years to this unit as our unit has been made aware that we will close on December 18 and all laboring patients will “transition” to another facility several towns away.

I am also a school nurse part time so I see the financial strain up close, that our families face, as I’m sure you do as well. This is why, as a nurse, I have some questions.

There are several things I’ve been thinking about that I believe deserve much more consideration before this “transition” occurs.

First, **what is the actual financial impact on patients?**

The proposed model seems to create the possibility of patients moving through multiple points of care for a single episode.

For example, a pregnant patient could present to the proposed perinatal/postnatal center at my current facility. She could undergo an NST, laboratory testing, and potentially an examination to determine her labor status. If she then develops elevated or severe-range blood pressures, she may need to be sent to our facility's emergency room for evaluation and treatment, potentially including IV labetalol or magnesium sulfate. If she then requires transfer to the other hospital, there could be another EMS charge, another hospital encounter, and another set of hospital charges. If she stabilizes and is ultimately discharged on an oral medication such as nifedipine rather than being admitted for delivery, she could potentially repeat this process multiple times during the remainder of her pregnancy.

I realize that the exact clinical pathway and billing would depend on the circumstances, but this raises a bigger question:

Has MaineHealth actually calculated what the closure will mean financially for patients who need evaluation or emergency care but don't ultimately deliver?

Some of our patients have no insurance or are under insured. How do we account for this?

And if the new model creates multiple additional encounters, facility fees, ambulance charges, emergency department charges, laboratory charges, and other out-of-

pocket expenses, **what plan does MaineHealth have to offset those additional costs for patients?**

If MaineHealth is describing the new model as an equivalent or safe replacement for local maternity care, I think the financial burden placed on the patient needs to be part of that analysis—not simply the financial cost to the health system.

Second, I think we need to talk about continuity and philosophy of care.

Lincoln and Mid Coast are both part of MaineHealth, but they don't necessarily have identical approaches to childbirth.

Our patients have chosen Lincoln in part because of the type of care they receive here—the amount of time spent with them, the education they receive, the emphasis on physiologic birth, labor support, breastfeeding, skin-to-skin, shared decision-making, and avoiding unnecessary intervention when it is clinically appropriate.

If patients receive prenatal/perinatal education and then are transferred to a completely different clinical environment, **how will MaineHealth ensure continuity in the philosophy and expectations of care?**

What happens if the education a patient receives at the local facility differs from the policies, practices, or clinical approach she encounters at the receiving facility?

How will patients know what to expect?

How will their birth preferences and informed choices follow them?

And perhaps most importantly, how will MaineHealth ensure that patients aren't placed in a situation where they feel that the only way to move care forward is through interventions they weren't expecting or weren't adequately counseled about?

I'm not suggesting that the other facility provides poor care. I'm asking how MaineHealth intends to preserve continuity of patient-centered care when it is moving patients from one model of maternity care to another?

I also think there are some very important questions about what happens after December 18 when a pregnant patient presents unexpectedly to Lincoln Hospital.

What exactly is the emergency plan?

Who will provide the care?

What happens with a precipitous delivery, shoulder dystocia, postpartum hemorrhage, eclampsia, cord prolapse, or a baby requiring resuscitation?

What happens if an ambulance isn't immediately available, Mid Coast is on diversion, or winter weather significantly delays transport?

And what happens financially and emotionally to the patient and family when they are repeatedly moved

between outpatient care, the ER, EMS, and then the receiving hospital?

I also think there are important questions about what alternatives were considered before deciding that closure was the only sustainable option, and whether every reasonable staffing and coverage model was truly explored—I do not feel there was adequate attempts to advertise for Lincoln, only for Mid Coast and Pen Bay.

I don't want to assume that I know the legal answers to any of this.

I care deeply about our patients, our community, and the people I work with. I also care about maintaining my professionalism and being able to continue doing my job.

There are so many layers to this decision that I don't think have been adequately explored yet. The question isn't simply where babies will be delivered. It's what happens to the mother and baby before, during, and after that delivery—and what the financial, clinical, emotional, and logistical consequences are for families.

Who will provide counsel and support to the mothers who expected to birth their babies at miles? Some have had multiple children at miles and now are forced to deliver their next baby elsewhere. This is traumatic and disappointing for families, to leave their familiar environment at their most vulnerable time.

The fact that mainehealth so unapologetically is willing to dismiss 16 fully trained, specialized nurses from their

roles and their staff is so disheartening. Many of us have certifications and dedicated hours specifically geared towards obstetrics, postpartum and newborn care as well as lactation and maternal infant education.

I'm asking, is there a way to delay or preferably, stop all together, this rushed plan to cease services the local communities were promised? How can such a large "leader in healthcare" so haphazardly choose to close without plans in place for their staff and patients? If those plans are in place, shouldn't the public be allowed to see this considering they have continued to accept pregnant women into their practice?

What will happen if patients choose to deliver at Pen Bay instead of Mid Coast as I presume will be the case considering the traffic bottleneck of Wiscasset?

Is Pen Bay ready for an influx of possibly 130 patients—really 260 or more considering each mother and baby counts and needs proper care? Has anyone at the leadership level at MaineHealth who don't work directly with patients thought any of this through?

Thank you for your time and consideration. The fact that this closure has become so broad and could help other maine facilities remain open is the only thing that gives me peace about all of this.

Sincerely,
Candace Crocker
(BSN RN IBCLC NCSN)

