



American College of  
Obstetricians & Gynecologists

**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 "**

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

**February 18, 2026**

**Senator Bailey, Representative Mathieson, and members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, Senator Bailey, Representative Mathieson, and members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services:**

**My name is Anne Marie van Hengel. I am a resident of Portland, Maine, and a board-certified Obstetrician-Gynecologist with over 30 years of clinical experience. I now focus my work on perinatal advocacy.**

**I am here today on behalf of the Maine Section of the American College of Obstetricians and Gynecologists, representing 186 members across our state.**

**Maine continues to experience an alarming acceleration in labor and delivery unit closures, particularly in rural communities. The reasons are complex—workforce shortages, financial strain, declining reimbursement, declining birth rate and regulatory pressures all contribute. But complexity does not justify a lack of transparency, process, or accountability.**

**As ACOG, we strongly support the intent behind this bill. We agree that when a birthing unit must close, there must be a meaningful transition period. A 120-day notice period should be the standard expectation.**

**At the same time, we recognize that rare and clearly defined circumstances may make a full 120-day notice impracticable—such as an abrupt and unavoidable loss of essential clinical staff, an immediate patient safety concern, or unforeseen financial insolvency that threatens overall hospital operations. In such cases, any abbreviated timeline should require documented justification and immediate engagement with DHHS to ensure that transition planning occurs as safely and transparently as possible.**

Outside of those limited exceptions, anything less than 120 days is insufficient. It creates unnecessary risk, destabilizes surrounding systems, and generates anxiety and mistrust within communities. A rushed closure is not merely disruptive—it is unsafe.

The 120-day period allows neighboring hospitals time to adapt, plan for increased patient volume, and ensure staffing and capacity adjustments are made thoughtfully rather than reactively. It gives emergency departments and EMS agencies time to receive appropriate obstetric training. It allows patients to transition care safely and deliberately.

It is unacceptable for communities to learn with minimal notice that a fundamental healthcare service is disappearing. Transparency, preparation, and accountability are not barriers to hospital administration—they are obligations to the patients and families we serve.

At the same time, we must acknowledge a larger truth: this bill addresses the moment of closure. It does not address the months—or even years—leading up to that moment.

Birthing units do not become unsustainable overnight. Financial strain, workforce shortages, and declining volume develop over time. Hospital leadership is aware of these vulnerabilities well before a formal notice is issued. If we wait until that notice is filed, we are already responding late in the process.

Our shared goal should not simply be to ensure that closures are handled safely—though that is critical—but to intervene early enough that closure may be prevented. Early engagement creates the possibility—though not the guarantee—of preserving services. Late engagement only manages the aftermath.

A mandatory 120-day notice period establishes a critical safeguard. Within that time frame, Maine's highly experienced perinatal outreach team—who have unfortunately already managed multiple closures—can bring their expertise, structured toolkit, and collaborative approach to support both the hospital and the affected community.

However, we would strongly encourage refining this approach to include an earlier trigger for collaboration.

When a hospital identifies that its birthing unit is at significant financial or operational risk, there should be a structured mechanism for confidential notification to DHHS. That notification should

activate a collaborative review process involving hospital leadership, obstetrics, emergency medicine, EMS, risk management, and the State's perinatal outreach team.

The purpose of that early engagement should be to explore sustainability strategies, regional partnerships, workforce support, telehealth integration, shared staffing models, or other mitigation pathways before closure becomes inevitable.

If, after thorough review, it is clear that the unit cannot be sustained, then the 120-day notice period should begin—subject only to limited, well-documented exceptions as previously described—allowing for safe transition planning, emergency department training, EMS coordination, and capacity planning at surrounding hospitals.

In other words, we should build a two-stage model:

First: proactive identification and collaboration while preservation is still possible.

Second: structured, accountable transition planning if closure proves unavoidable.

Our goal should not simply be to close units safely.

Our goal should be to prevent closures whenever possible—and when we cannot, to manage them responsibly, transparently, and with appropriate flexibility in truly exceptional circumstances.

LD 2189 is an important step. With refinement to encourage earlier collaboration and to allow carefully defined flexibility in rare situations, it can become part of a more comprehensive solution—one that protects patients, supports providers, and gives communities confidence that every option was explored before access to maternity care was lost.

Thank you for your consideration.

Anne Marie van Hengel MD FACOG

Treasurer/ Secretary MAine Section ACOG