



Right for Vermont Foundation

September 9, 2026

RE: Proposed Rule 26P029 — Licensure of Freestanding Birth Centers

Dear Commissioner and Rulemaking Staff,

Right for Vermont Foundation submits this comment on proposed rule 26P029 governing the licensure of freestanding birth centers. We write in strong support of the underlying goal of S.18, to expand maternity care choice in Vermont, and we urge the Department to revise the proposed rule so that it does not undo, through licensing costs and compliance burdens, the access that the legislature just voted to create.

The Stakes Are Real and Immediate

Vermont families are losing access to maternity care. Copley Hospital [closed its Morrisville birthing center](#) last November, ending a service the community had relied on since 1933. Brattleboro Memorial Hospital's board has [voted to close its birthing center](#) within six to nine months. If that closure proceeds, Windham and Windsor County families will have no in-state option and will need to cross into New Hampshire or Massachusetts to give birth.

Against that backdrop, the legislature passed [S.18](#) to create a licensing pathway for freestanding birth centers and to exempt them from Vermont's certificate-of-need process (the primary reason Vermont has never had a single freestanding birth center, [unlike every other state in the Northeast](#)). Under this new pathway, a group of midwives, several formerly of Copley, are now working to open the [Green Mountain Birth Center](#) in Waterbury. Whether that effort, and others like it, will succeed will depend heavily on the rule the Department finalizes.

A Rule Should Not Rebuild the Barrier the Legislature Just Removed

Freestanding birth centers are meant to offer a lower-cost, lower-intervention alternative to hospital maternity wards for low-risk pregnancies. One federal study found average Medicaid savings of [over \\$2,000 per birth center delivery](#) compared to hospital delivery. That value proposition depends on birth centers being able to operate at a cost structure significantly below a hospital. A licensing rule that imposes hospital-grade fixed costs on a completely different and smaller-scale model will simply price out the providers S.18 was designed to enable.

We ask the Department to reconsider three specific provisions before finalizing this rule:

1. Mandatory CABC accreditation, maintained indefinitely, is not necessary for licensure.

Only seven states require Commission for the Accreditation of Birth Centers (CABC) accreditation as a condition of state licensure. CABC accreditation reviews governance, finances, staffing, facilities, clinical protocols, emergency planning, hospital partnerships, and quality improvement — the same ground the state's own inspection covers. CABC's fees are also rising sharply: as of September 1, 2026, the registration fee climbs to \$6,000, the one-year review fee to \$4,000, and the recurring monthly fee to \$350 per location. Layering a mandatory, indefinitely maintained, private accreditation on top of state licensure adds cost without adding a commensurate safety benefit, and that cost will ultimately either be borne by patients, or prevent centers for opening in the first place.

2. Stacking a full state inspection on top of CABC accreditation is redundant.

Four states allow CABC accreditation to substitute for a state inspection precisely because the accreditation review already covers the relevant ground. Vermont's proposed rule instead requires both, in full. If the Department believes CABC's review is rigorous enough to mandate, it should be rigorous enough to also satisfy the state's own inspection requirement, rather than requiring providers to fund and pass two overlapping reviews. Offering CABC accreditation in lieu of a state inspection would alleviate bureaucratic costs and save taxpayers money.

3. Blanket 24-hour on-site, two-provider staffing requirements should be replaced with 24-hour on-call coverage by one licensed clinician.

The proposed rule requires “24-hour staffing coverage by licensed maternity-care providers” at every facility, with one provider present at every birth and a second available in the building, regardless of caseload. CABC's own standards do not require this — they scale staffing to actual demand (routine, high-volume, or emergency), requiring one clinical provider in-house during active labor and one trained support or nursing staffer. A new birth center may see only a handful of patients per week, and fixed, round-the-clock, on-site staffing is a cost that does not shrink with a smaller caseload. Because birth centers are small by design, that cost lands disproportionately harder per patient than it would at a hospital, and it functions as a de facto barrier to entry for exactly the small, independent providers S.18 was meant to enable.

We recommend the Department require 24-hour on-call coverage rather than 24-hour on-site staffing, with one licensed clinician required in the room for a birth rather than two. On-call coverage still guarantees a licensed provider is reachable and able to respond at any hour, which is what patient safety requires; it does not require the center to carry the fixed cost of physically staffing an empty building overnight on the chance a patient arrives. Similarly, requiring *one* licensed clinician in attendance at the birth itself (consistent with CABC's own demand-based standard) rather than a second provider present in the building at each labor and birth, would keep the safety bar intact while sizing the staffing requirement to the actual scale of a freestanding birth center.

Questions We Ask the Department to Answer Before Finalizing This Rule

- Is every requirement in this rule actually necessary for patient safety, or are they duplicative protections that will price providers out of the market?

- Why mandate CABC accreditation when it is not a national requirement and most states do not require it for licensure?
- Why require blanket 24-hour staffing when CABC itself scales staffing to demand?
- Could Vermont achieve the same safety outcomes through a more flexible, cost-proportionate set of requirements?

Conclusion

The legislature removed certificate-of-need review because it recognized that regulatory barriers, not lack of demand, were the reason Vermont had never had a freestanding birth center. A licensing rule that reimposes barriers through costly accreditation requirements, duplicative inspections, and inflexible staffing mandates would defeat the purpose of S.18. We urge the Department to revise 26P029 so that Vermont families losing access to hospital-based maternity care gain a viable, affordable alternative.

Thank you for the opportunity to comment.

Respectfully,

Clara Morrison

Executive Director

Right for Vermont Foundation