PA 23-147—sSB 986
Public Health Committee
Appropriations Committee

AN ACT PROTECTING MATERNAL HEALTH

SUMMARY: This act makes various unrelated changes affecting maternal and infant health. Principally, it:

1. creates a new license category administered by the Department of Public Health (DPH) for freestanding birth centers, and starting January 1, 2024, prohibits anyone from establishing or operating a birth center without this license (§§ 1-9);
2. prohibits DPH from issuing or renewing a maternity hospital license starting January 1, 2024, and repeals this licensure program on July 1, 2025 (§§ 7 & 17);
3. establishes an Infant Mortality Relief Program within DPH to review medical records and other data on infant deaths (i.e., those occurring between birth and one year of age) and sets related requirements on record access, information sharing, and confidentiality (§§ 10 & 12);
4. establishes an Infant Mortality Review Committee within DPH to conduct a comprehensive, multidisciplinary review of infant deaths to reduce health care disparities, identify associated factors, and make recommendations to reduce the deaths (§§ 11 & 12);
5. requires DPH, within available resources, to establish an 18-member Doula Advisory Committee to develop recommendations on doula certification requirements and standards for recognizing training programs that meet the certification requirements (§§ 13 & 18);
6. establishes a voluntary doula certification program administered by DPH and, starting October 1, 2023, prohibits an uncertified person from using the title "certified doula" (§ 14);
7. requires the DPH commissioner to create a midwifery working group to study and make recommendations on advancing choices for community birth care (i.e., planned home birth or birth at a birth center) and the role of community midwives in addressing maternal and infant health disparities (§ 15); and
8. requires the Office of Early Childhood (OEC) commissioner, within available appropriations, to develop and implement a statewide universal nurse home visiting services program for all families with newborns living in the state (§ 16).

The act also makes technical and conforming changes.

EFFECTIVE DATE: October 1, 2023, except the provisions on (1) birth center licensure fees, certificate of need exemption, statutory definitions, and nurse-midwives practice take effect January 1, 2024; (2) the doula advisory committee,

doula certification, the midwifery working group, and the universal nurse home visiting services program take effect July 1, 2023; and (3) repealing the maternity hospital licensure program take effect July 1, 2025.

§§ 1-9 & 17 — BIRTH CENTER LICENSURE

The act creates a new DPH-administered license category for freestanding birth centers. Starting January 1, 2024, it prohibits a person, entity, firm, partnership, corporation, limited liability company, or association from establishing, conducting, operating, or maintaining a birth center unless it gets this license. The act also expressly prohibits an outpatient clinic, except in an emergency, from providing birth center services as part of its ambulatory medical services without a birth center license.

Also starting on this date, the act prohibits the DPH commissioner from granting or renewing a maternity hospital license. It then repeals the maternity hospital licensure program on July 1, 2025. (The one facility that currently holds this license will, presumably, transfer to the new birth center license.)

The act also makes various conforming changes, such as authorizing the Office of Health Strategy's Health Planning Unit to collect patient-level outpatient data from birth centers (§ 5) and requiring birth centers to report adverse events to DPH (§ 6).

Definitions

Under the act, a "birth center" is a freestanding DPH-licensed facility that provides perinatal, labor, delivery, and postpartum care during and immediately after delivery to those presenting with a low-risk pregnancy and healthy newborns for generally less than 24 hours. It is not a licensed hospital or attached to or located in a licensed hospital.

A "low-risk pregnancy" is an uncomplicated, single-fetus pregnancy with vertex presentation (i.e., positioned head-first) that is at low risk of developing complications during labor and delivery, as a licensed provider, acting within his or her scope of practice, determines through an evaluation and examination.

The act also makes a conforming change by adding "birth center" to the statutory definition of health care "institution." In doing so, the act extends to these centers statutory requirements for health care institutions on things like workplace safety committees, patient record access, HIV-related information disclosure, and smoking prohibitions.

Licensure Application

Under the act, birth centers must (1) be accredited by the Commission for the Accreditation of Birth Centers on or before the effective date of their licensure and (2) maintain accreditation when they are licensed. If a birth center loses accreditation, it must immediately notify the DPH commissioner and stop providing birth center services to patients until the commissioner authorizes it to

reinstate services.

Before issuing a license, the DPH commissioner must review and approve the information the birth center submitted to the Commission for Accreditation of Birth Centers, including information relating to the birth center's (1) plan for ongoing risk assessment and adherence to patient eligibility criteria, as determined by the commission, while delivering birth center services to a patient and (2) policies and procedures for a patient's prenatal, intrapartum, or postpartum transfer if the patient no longer meets the eligibility criteria.

Licensure Fees

Under the act, DPH must license and inspect birth centers every two years. Birth centers must pay an initial and renewal license fee of $940 per site and $7.50 per bed.

Emergency Plan

The act requires birth centers to have a written plan to get services for their patients from a licensed hospital if there is an emergency or other condition that pose a risk to the patient's health and require the patient's transfer to a hospital.

Patient Transfers

If a patient receiving birth center services no longer presents with a low-risk pregnancy, or otherwise fails to meet the Commission for Accreditation of Birth Centers' patient eligibility criteria, the act requires the birth center to ensure the patient's care is transferred to a licensed health care provider capable of providing the patient with the appropriate level of obstetrical care.

The act also requires licensed hospitals with an emergency department, other than a children's hospital, to work cooperatively with birth centers to coordinate care for patients who require services in the event of an emergency or other condition that poses a risk to the patient's health and requires their transfer to a hospital.

Under the act, children's hospitals with an emergency department must work cooperatively with birth centers to coordinate the care of neonatal patients that require the patient's transfer to a children's hospital.

Nurse-Midwife Practice

Prior law required nurse-midwives to practice within a health care system and have a clinical relationship with obstetrician-gynecologists that provide for consultation, collaborative management, or referral as indicated by the patient's health status. The act requires nurse-midwives to instead practice either within a health care system or a birth center in the same manner.

Under existing law, unchanged by the act, nurse-midwives must provide (1) care consistent with the Accreditation Commission for Midwifery Education's

standards and (2) information about, or referral to, other providers or services if the patient asks or requires care that is not in the nurse-midwife's scope of practice.

Certificate of Need

The act exempts birth centers enrolled as a Connecticut Medical Assistance Program (i.e., Medicaid and the State Children's Health Insurance Program) provider from the state's certificate of need (CON) requirements until June 30, 2028. By law, health care facilities must generally apply for and receive a CON from the Office of Health Strategy's Health Systems Planning Unit when proposing to (1) establish a new facility or provide new services, (2) change ownership, (3) purchase or acquire certain equipment, or (4) terminate certain services.

The act also requires the Office of Health Strategy (OHS) executive director, in consultation with the DPH commissioner and within available appropriations, to study whether this CON exemption for birth centers should be extended. In conducting the study, the executive director must collect data from birth centers on the following:

1. the number of deliveries performed at each birth center and the number of patient transfers or referrals to other care settings, and the reasons for them;
2. the number and percentages of patients who are self-pay or are covered by private or public insurance (e.g., Medicaid);
3. patient demographic information, including race, ethnicity, and preferred language;
4. geographic locations of birth centers and catchment areas;
5. financial assistance and uncompensated care provided by each birth center; and
6. any other information the executive director deems necessary.

The executive director must report on the study to the Public Health Committee by July 2, 2027.

Regulations

The act requires the DPH commissioner to adopt regulations to implement the licensure, including provisions on facility administration, staffing requirements, infection control protocols, physical plant requirements, accommodating participation of support people the patient chooses, limitations on anesthesia and surgical procedures, operating procedures for determining patients' risk status at admission and during labor, reportable events, medical records, pharmaceutical services, laundry services, emergency planning, and requirements for professional and medical liability insurance for facilities and health care providers.

Under the act, the commissioner may implement policies and procedures to administer the license while adopting them into regulations. However, she may only do this if she notifies her intent to adopt regulations in the eRegulations System within 20 days after the implementation date. These policies and procedures remain in effect until the final regulations are adopted.

§§ 10 & 12 — DPH INFANT MORTALITY REVIEW PROGRAM

The act establishes an Infant Mortality Relief Program within DPH to review medical records and other relevant data on infant deaths. Under the act, this review must include information from birth and death records and medical records from health care providers and facilities to make recommendations on reducing health care disparities and identify gaps in, or problems with, health care or service delivery to reduce infant deaths.

Record Access and Information Sharing

Under the act, pharmacies and health care providers and facilities must give the DPH commissioner or her designee, upon the commissioner's request, access to all medical and other records, including prenatal records, associated with infant death cases under the program's review.

The act allows the commissioner or her designee to give the Infant Mortality Review Committee (see § 11 below) information she determines it needs to make recommendations on infant death prevention.

Death Certificates

The act requires the Office of the Chief Medical Examiner and funeral directors and licensed embalmers who complete a death certificate for an infant death to report the death to DPH in a way the commissioner sets.

Child Fatality Review Panel

The act requires the DPH commissioner to notify the existing child fatality review panel about an infant death if the program reviews an infant death and determines that it occurred in out-of-home care or due to unexpected or unexplained causes.

The act expressly provides that it does not limit or alter the authority of the Office of the Child Advocate or the child fatality review panel to investigate or make recommendations about a child's death.

By law, the child fatality review panel reviews the death of a child who was placed in out-of-home care or whose death was unexpected or unexplained to (1) develop prevention strategies to address identified trends and risk patterns and (2) improve service coordination for children and families (CGS § 46a-13*l*).

Confidentiality

Under the act, the information the commissioner or her designee obtains for the program and all information DPH gives to the Infant Mortality Review Committee (see § 11 below) (1) is confidential and not subject to disclosure, (2) is not admissible as evidence in a court or agency proceeding, and (3) must be used solely for medical or scientific research purposes (CGS § 19a-25).

§§ 11 & 12 — INFANT MORTALITY REVIEW COMMITTEE

The act creates an Infant Mortality Review Committee within DPH to conduct a comprehensive, multidisciplinary review of infant deaths to reduce health care disparities, identify factors associated with infant deaths, and make recommendations to reduce these deaths.

Members

The act allows the committee's membership to vary, as needed, depending on the infant death under review, but it may include the following members:

1. a licensed physician specializing in obstetrics and gynecology, designated by the American College of Obstetrics and Gynecology's Connecticut chapter;
2. a community health worker, designated by the Commission on Women, Children, Seniors, Equity and Opportunity;
3. a licensed pediatric nurse, designated by the Connecticut Nurses Association;
4. a licensed clinical social worker designated by the National Association of Social Workers' Connecticut chapter;
5. the chief medical examiner, or his designee;
6. a Connecticut Hospital Association member representing a pediatric facility;
7. a representative of the UConn-sponsored Health Disparities Institute;
8. a licensed physician practicing neonatology, designated by the Connecticut Medical Society;
9. a licensed physician assistant (PA) or advanced practice registered nurse (APRN) designated by an association representing PAs or APRNs in Connecticut;
10. the child advocate, or her designee;
11. the commissioners of children and families, early childhood, mental health and addiction services, and social services, or their designees; and
12. any additional members the committee co-chairs determine would be beneficial.

Leadership and Meetings

Under the act, the DPH commissioner, or her designee, and a representative designated by the American Academy of Pediatrics' Connecticut chapter, co-chair the committee. The co-chairs must convene a committee meeting when the commissioner requests it.

Infant Mortality Reviews

The act allows the committee, when conducting an infant mortality review, to consult with relevant experts to evaluate information and findings it obtains from

the Infant Mortality Review Program (see above) and make recommendations on preventing infant deaths.

In its review, the committee must include available infant death reports and recommendations from the existing child fatality review panel to recommend ways to reduce health care disparities and identify gaps in, or problems with, delivering health care and services to reduce infant deaths.

Confidentiality

Under the act, all information DPH gives the committee or an expert with whom the committee consults (1) is confidential and not subject to disclosure, (2) is not admissible as evidence in a court or agency proceeding, and (3) must be used solely for medical or scientific research purposes (CGS § 19a-25).

Report

Within 90 days after completing an infant mortality review, the act requires the committee, in consultation with the Office of the Child Advocate, to report its findings and recommendations to the DPH commissioner in a way that meets the confidentiality requirements.

§§ 13 & 18 — DOULA ADVISORY COMMITTEE

Duties

The act requires the DPH commissioner, within available resources, to establish a Doula Advisory Committee within DPH. The committee must develop recommendations on (1) requirements for initial and renewal doula certification, including training, experience, and continuing education, and (2) standards for recognizing doula training program curricula that satisfy the doula certification requirements.

The advisory committee must also establish a Doula Training Program Review Committee to (1) continuously review doula training programs and (2) give DPH a list of doula training programs in the state that meet the advisory committee's requirements.

Membership

Under the act, the DPH commissioner or her designee is the advisory committee's chairperson. Additional members include (1) the commissioners of early childhood, mental health and addiction services, and social services, or their designees, and (2) 14 members appointed by the DPH commissioner or her designee, as follows:

1. seven doulas actively practicing in the state;
2. one licensed nurse-midwife with experience working with a doula;
3. one acute care hospital representative, appointed in consultation with the

Connecticut Hospital Association;
4. one representative of an association representing hospitals and health-related organizations in the state;
5. one licensed health care provider specializing in obstetrics with experience working with a doula;
6. one representative of a community-based doula training organization;
7. one representative of a community-based maternal and child health organization; and
8. one member with expertise in health equity.

Repealer

The act repeals a provision in PA 22-58 that required DPH, within available resources, to establish a similar 18-member Doula Advisory Committee.

§ 14 — DOULA CERTIFICATION

The act establishes a DPH-administered voluntary doula certification program and related requirements. Starting October 1, 2023, it prohibits someone from using the title "certified doula" unless they obtain the certification. But it does not prohibit an uncertified doula from providing doula services, so long as they do not use the title "certified doula."

Under the act, a "doula" is a trained, nonmedical professional who provides physical, emotional, and informational support, virtually or in person, to a pregnant person and any family or friends supporting them, before, during, and after birth.

Doula Advisory Committee and Training Program Review Committee

The act requires DPH's Doula Advisory Committee (see § 13 above) to advise the DPH commissioner or her designee on doula services matters, including (1) access and promotion of education and resources for pregnant persons, and family and friends supporting them; (2) recommendations to improve access to doula care; and (3) furthering interagency efforts to address maternal health disparities.

It also requires the advisory committee's Doula Training Program Review Committee (see § 13 above) to (1) conduct an ongoing review of doula education and training programs and (2) give the commissioner or her designee a list of approved doula education and training programs that meet the advisory committee's certification requirements. This committee must also (1) ensure that its list of approved programs includes training in core doula competencies and (2) make recommendations on certified doula continuing education requirements to the commissioner.

The act requires the advisory committee to annually decide whether to renew or disband in a manner the commissioner or her designee determines.

Certification Application

Under the act, a doula seeking certification must apply to DPH on forms the commissioner sets and pay an application fee of $100.

The application must include the following information:

1. proof that the applicant is at least 18 years old;
2. two reference letters from families or professionals with direct knowledge of the applicant's experience as a doula that verify the applicant's training or experience; and
3. evidence that the applicant (a) completed an approved doula training program or a combination of approved programs or (b) attests that, in the five years preceding the application date, he or she provided doula services to at least three families and trained in at least four core competencies the Doula Training Program Review Committee identified.

The act prohibits the commissioner from issuing a certificate to an applicant with pending professional disciplinary action or an unresolved complaint.

Certification Renewal and Continuing Education

The act requires doulas to renew their certification every three years and pay a $100 renewal fee.

Under the act, DPH must adopt continuing education requirements for certified doulas, which the Doula Training Program Review Committee must provide. Certification renewal applicants must give DPH evidence of meeting the continuing education requirements.

Certification by Endorsement

The act allows the DPH commissioner to grant certification by endorsement to a doula who presents satisfactory evidence that he or she is certified as a doula in another state or jurisdiction with certification requirements substantially similar to Connecticut's requirements for at least two years before the certification application date.

Disciplinary Action

The act authorizes the DPH commissioner to take several disciplinary actions against a certified doula, such as suspending or revoking the doula's certification, limiting his or her practice, and imposing a civil penalty of up to $25,000 (see CGS § 19a-17). The commissioner may take these actions for a certified doula's failure to conform to accepted professional standards, including the following:

1. fraud or deceit in obtaining or seeking reinstatement of certification;
2. engaging in fraud or material deception in his or her professional services or activities;
3. negligent, incompetent, or wrongful conduct in professional activities;
4. aiding or abetting the use of the title "certified doula" by an uncertified person;
5. physical, mental, or emotional illness or disorder resulting in an inability to

conform to accepted professional standards; or

6. drug abuse or excessive drug use, including alcohol, narcotics, or chemicals.

Under the act, the commissioner may also order a certified doula to have a reasonable physical or mental examination if the doula's physical or mental capacity to safely practice is the subject of an investigation. The commissioner may also petition the Superior Court in Hartford to enforce an order or action she takes. The act requires the commissioner to give the doula notice and an opportunity to be heard on any contemplated disciplinary action.

§ 15 — MIDWIFERY WORKING GROUP

The act requires the DPH commissioner to create a midwifery working group to study and make recommendations on (1) advancing choices in care for community birth (i.e., planned home birth or birth at a birth center) and (2) direct entry midwives' role in addressing maternal and infant health disparities. Under the act, a "direct entry midwife" is a person trained in planned out-of-hospital births other than a nurse-midwife, including certified midwives, certified professional midwives, community midwives, and traditional midwives. A "certified midwife" is someone with a graduate degree in midwifery who passed a national certification examination administered by the American Midwifery Certification Board.

Under the act, the study must include the following:

1. improvements in birthing care quality and safety, including those addressing racial disparities in maternal and infant health outcomes;
2. regulation, licensure, or certification of direct entry midwives and certified midwives not otherwise licensed to practice midwifery in Connecticut; and
3. advancements of interprofessional coordination of birthing care, including community birth.

The working group must annually decide whether to renew or disband in a manner the DPH commissioner or her designee determines.

Members

The act requires the DPH commissioner to appoint the working group members, which must at least include the following:

1. a DPH commissioner designee and one Department of Social Services (DSS) representative,
2. at least six direct entry midwives practicing in Connecticut,
3. one certified nurse-midwife with experience working with direct entry midwives,
4. one certified midwife representing an entity that certifies midwives,
5. one doula serving communities of color,
6. one representative of families or a community-based organization with an interest in maternity care,
7. one representative of a community organization furthering health equity,
8. representatives of associated maternity care professions, and
9. one representative of the Connecticut Hospital Association.

Report

The act requires the working group, starting by February 1, 2024, to annually report its findings and recommendations to the DPH commissioner and the Public Health Committee.

§ 16 — UNIVERSAL NURSE HOME VISITING PROGRAM

The act requires the OEC commissioner to develop a statewide program offering universal nurse home visiting services to all families with newborns living in the state to support parental health, healthy child development, and strengthen families. She must do this within available appropriations and in collaboration with the DSS and DPH commissioners and the OHS executive director.

When developing the program, the commissioners and executive director must (1) consult with insurers that offer health benefit plans in the state, hospitals, local public health authorities, existing early childhood home visiting programs, community-based organizations, and social service providers and (2) maximize available federal funding.

Under the act, "universal nurse home visiting" is an evidence-based nurse home visiting model in which a licensed registered nurse with specialized training provides in-home services to families with newborns.

Program Services

The program must provide universal nurse home visiting services that are evidenced-based and designed to improve outcomes in one or more of the following areas:

1. child safety or child health and development,
2. family economic self-sufficiency,
3. maternal and parental health,
4. positive parenting or parent-infant bonding,
5. reducing child mistreatment or family violence, and
6. any other appropriate area the commissioners and executive director establish in writing.

Under the act, the program's services must be voluntary and have no negative consequences for a family that does not participate. Services may be offered in every community in the state and to all families with newborns based on the full extent of available provider capacity.

The services must also allow families to choose up to a certain number of additional visits, consistent with an evidence-based model; provide information and referrals to address each family's identified needs; and include the following:

1. an evidence-based assessment of the physical, social, and emotional factors affecting a family receiving these services;
2. at least one visit during a newborn's first three months or other time frame the commissioners and executive director deem appropriate that is consistent with an evidence-based model; and

3. a follow-up visit within three months, or another time frame the model establishes, after the last visit.

Medicaid State Plan Amendment or Waiver

The act authorizes the DSS commissioner to seek federal Centers for Medicare and Medicaid Services approval for a Medicaid state plan amendment or waiver for universal nurse home visiting services coverage. The commissioner must do this in a time frame and manner to ensure that this coverage does not duplicate any other applicable federal funding.

Program Data

The act requires the OEC commissioner, in collaboration with the DSS and DPH commissioners and OHS executive director, to collect and analyze program data to (1) assess the program's effectiveness in meeting its goals and (2) collaborate with other state agencies to develop protocols for sharing the data, including doing so in a timely manner with primary care providers that provide care to families with newborns receiving program services.