FINAL PROPOSED RULE # 26-P029

Final Proposed Filing - Coversheet

Instructions:

In accordance with Title 3 Chapter 25 of the Vermont Statutes Annotated and the "Rule on Rulemaking" adopted by the Office of the Secretary of State, this filing will be considered complete upon filing and acceptance of these forms with the Office of the Secretary of State, and the Legislative Committee on Administrative Rules.

All forms shall be submitted at the Office of the Secretary of State, no later than 3:30 pm on the last scheduled day of the work week.

The data provided in text areas of these forms will be used to generate a notice of rulemaking in the portal of "Proposed Rule Postings" online, and the newspapers of record if the rule is marked for publication. Publication of notices will be charged back to the promulgating agency.

PLEASE REMOVE ANY COVERSHEET OR FORM NOT REQUIRED WITH THE CURRENT FILING BEFORE DELIVERY!

Certification Statement: As the adopting Authority of this rule (see 3 V.S.A. § 801 (b) (11) for a definition), I approve the contents of this filing entitled:

Birth Center Licensing Rule

Dawn O'Toole _____ , on 10/13/26

(signature) (date)

Printed Name and Title:
Dawn O'Toole, Chief Operating Officer, Agency of Human Services

RECEIVED BY: _____

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
- ☐ Environmental Impact Analysis
- ☐ Strategy for Maximizing Public Input
- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)
- ☐ ICAR Minutes
- ☐ Copy of Comments
- ☐ Responsiveness Summary

1. TITLE OF RULE FILING:
Birth Center Licensing Rule

2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
26P029

3. ADOPTING AGENCY:
Agency of Human Services - Vermont Department of Health

4. PRIMARY CONTACT PERSON:
(A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE).

Name: Meg McCarthy, Policy Advisor

Agency: Agency of Human Services - Vermont Department of Health

Mailing Address: 280 State Drive, Waterbury, VT 05671

Telephone: 802-904-9319 Fax:

E-Mail: ahs.vdhrules@vermont.gov

Web URL *(WHERE THE RULE WILL BE POSTED)*:
https://www.healthvermont.gov/laws-regulations/laws/rules-public-comment

5. SECONDARY CONTACT PERSON:
(A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON).

Name: Jessica Schifano, Policy Director

Agency: Agency of Human Services - Vermont Department of Health

Mailing Address: 280 State Drive, Waterbury, VT 05671

Telephone: 802-798-6756 Fax:

E-Mail:

6. RECORDS EXEMPTION INCLUDED WITHIN RULE:
(DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE, EXEMPTING IT FROM INSPECTION AND COPYING?) No

IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

7. LEGAL AUTHORITY / ENABLING LEGISLATION:
   (THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).

   3 V.S.A. § 801(b)(11), 18 V.S.A. § 2359

   EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:

   18 V.S.A. § 2359 states, "The Department of Health shall adopt rules in accordance with 3 V.S.A. chapter 25 as needed to carry out the purposes of this chapter."

   3 V.S.A. §801(b)(11) states "Adopting authority" means,for agencies that are attached to the Agencies of Administration, of Commerce and Community Development,of Natural Resources, of Human Services, and of Transportation, or any of their components, the secretaries of those agencies; for agencies attached to other departments or any of their components, the
8. commissioners of those departments.
9. THE FILING HAS CHANGED SINCE THE FILING OF THE PROPOSED RULE.
10. THE AGENCY HAS INCLUDED WITH THIS FILING A LETTER EXPLAINING IN DETAIL WHAT CHANGES WERE MADE, CITING CHAPTER AND SECTION WHERE APPLICABLE.
11. SUBSTANTIAL ARGUMENTS AND CONSIDERATIONS WERE RAISED FOR OR AGAINST THE ORIGINAL PROPOSAL.
12. THE AGENCY HAS INCLUDED COPIES OF ALL WRITTEN SUBMISSIONS AND SYNOPSES OF ORAL COMMENTS RECEIVED.
13. THE AGENCY HAS INCLUDED A LETTER EXPLAINING IN DETAIL THE REASONS FOR THE AGENCY'S DECISION TO REJECT OR ADOPT THEM.
14. CONCISE SUMMARY (**150 WORDS OR LESS**):

    This rule sets forth the standards that apply to the licensing of birth centers in Vermont.

    This rulemaking establishes the process by which a birth center can apply for a license in Vermont.

15. EXPLANATION OF WHY THE RULE IS NECESSARY:

This rulemaking is necessary for compliance with 18 V.S.A. § 2359 that requires the Department of Health (Department) to "adopt rules in accordance with 3 V.S.A. chapter 25 as needed to carry out the purposes of this chapter."

16. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

The establishment of this rule is not arbitrary because the rule is tailored to comply with the specific requirements of 18 V.S.A. § 2359 that requires the Department to adopt rules to establish the process by which a birth center can apply for a license in Vermont.

17. LIST OF PEOPLE, ENTERPRISES AND GOVERNMENT ENTITIES AFFECTED BY THIS RULE:

Entities establishing, maintaining, or operating birth centers, the Vermont Department of Health, and the Department of Disabilities, Aging, and Independent Living (DAIL).

18. BRIEF SUMMARY OF ECONOMIC IMPACT (150 WORDS OR LESS):

This rulemaking establishes a licensing and regulatory program for birth centers within the Department of Health, as required by statute (18 V.S.A. § 2359). There are only minimal economic impacts anticipated for the Agency of Human Services and for the entities establishing, maintaining, or operating birth centers from this Rule.

19. A HEARING WAS HELD.

20. HEARING INFORMATION

(THE FIRST HEARING SHALL BE NO SOONER THAN 30 DAYS FOLLOWING THE POSTING OF NOTICES ONLINE).

IF THIS FORM IS INSUFFICIENT TO LIST THE INFORMATION FOR EACH HEARING, PLEASE ATTACH A SEPARATE SHEET TO COMPLETE THE HEARING INFORMATION.

Date: 9/11/2026

Time: 09:00 AM

Street Address: 280 State Drive, Waterbury, VT

Zip Code: 05671-8300

URL for Virtual:

Date:
Time: AM
Street Address:
Zip Code:
URL for Virtual:

Date:
Time: AM
Street Address:
Zip Code:
URL for Virtual:

Date:
Time: AM
Street Address:
Zip Code:
URL for Virtual:

21. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING):

KEYWORDS (PLEASE PROVIDE AT LEAST 3 KEYWORDS OR PHRASES TO AID IN THE SEARCHABILITY OF THE RULE NOTICE ONLINE).

birth center
birth
midwives
license
health care
labor
maternity care
prenatal
postpartum

Adopting Page

Instructions:

This form must accompany each filing made during the rulemaking process:

Note: To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with proposed and final proposed filings. Filing an annotated paragraph or page of a larger rule is not sufficient. Annotation must clearly show the changes to the rule.

When possible, the agency shall file the annotated text, using the appropriate page or pages from the Code of Vermont Rules as a basis for the annotated version. New rules need not be accompanied by an annotated text.

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1. TITLE OF RULE FILING:
   Birth Center Licensing Rule
2. ADOPTING AGENCY:
   Agency of Human Services – Vermont Department of Health
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):

   - **AMENDMENT -** Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment if the rule is replaced with other text.
   - **NEW RULE -** A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

   This filing is **A NEW RULE** .

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE)*:

Interagency Committee on Administrative Rules (ICAR) Minutes

Date/Time: July 13, 2026, 2:00 PM

Location: Virtually via Microsoft Teams

Members Present: Chair Nick Kramer, Heidi Moreau, Patrick Murphy, Earl Fechter, John Kessler, Russ McCracken, Stephen Brown, Jennifer Mojo

Members Absent: n/a

Minutes By: Chrissy Gilhuly

- 2:00 p.m. meeting called to order.
- Review and approval of minutes from the June 8, 2026, meeting.
- No additions/deletions to agenda. Agenda approved as drafted.
- No public comments made.
- Presentation of Proposed Rules with recommended changes on pages to follow.

1. Agency of Natural Resources: Department of Forests Parks and Recreation (ANR-FPR) – Rules Governing the Activity of Primitive Camping on State Forest and State Park Lands
   - The Primitive Camping Rule governs how the public can camp in a primitive manner on state lands, without paying a fee or benefiting from infrastructure or services. The rule was first promulgated in 1993. Over the last 30+ years, primitive camping practices in Vermont have evolved, creating challenges that the current rule is not well equipped to regulate, specifically around rule enforcement, campfires and wildland fire risk, and jurisdiction of the rule across state lands managed by FPR, F&W, and DEC.

2. Agency of Human Services: Department of Health (AHS-VDH) – Birth Center Licensing Rule
   a. This rule sets forth the standards that apply to the licensing of birth centers in Vermont. This rulemaking establishes the process by which a birth center can apply for a license in Vermont.

3. Agency of Human Services: Department for Children and Families (AHS-DCF) – Rules for Afterschool Childcare Programs
   a. The amended rule reorganizes, renumbers, and replaces the existing rule, which governs the licensing and operation of afterschool child care

programs (ASP). Among other things, the rule governs the licensing process, the administration and operation of ASPs, and employee qualifications. The rule also contains several provisions governing health, safety, and nutrition. Furthermore, the rule addresses parent visits and notifications.

4. Agency of Human Services: Department for Children and Families (AHS-DCF) – Rules for Center Based Child Care and Preschool Programs
    a. The amended rule reorganizes, renumbers, and replaces the existing rule, which governs the licensing and operation of center based childcare and preschool programs (CBCCPP). Among other things, the rule governs the licensing process, the administration and operation of CBCCPPs, and employee qualifications. The rule also contains several provisions governing health, safety, and nutrition. Furthermore, the rule addresses parent visits and notifications.

5. Agency of Natural Resources: Department of Fish and Wildlife (ANR-DFW) - 10 App. V.S.A. § 7 Bear Management Rule
    a. The proposed rule amendments eliminate the consecutive "early" and "late" seasons to create one bear season extending from September 1st through the last day of the regulated deer season. The proposed rule would require the purchase of a bear tag to take a bear during the season and would allow for the taking of a second bear within specified Wildlife Management Units (WMU) upon Board approval. The rule prohibits the intentional taking of sows with cubs. Additionally, the rule clarifies bear dog permit requirements and makes technical and grammatical corrections.

6. Office of the Attorney General – Prohibited Data and Design Products
    a. This Rule implements 9 V.S.A. § 2449f of Act 63, an act relating to an age-appropriate design code. The Rule establishes standards governing prohibited data processing and design practices affecting covered minors, including practices that contribute to compulsive use, impair autonomy or decision-making, or otherwise violate statutory requirements. The Rule provides definitions, interpretive standards, rebuttable presumptions, and illustrative examples to assist covered businesses in complying with the Act while maintaining flexibility regarding implementation. The Rule is intended to protect covered minors while providing regulated entities with greater clarity regarding their obligations under Vermont law.

7. Office of the Attorney General – Age Assurance Privacy
    a. This Rule implements 9 V.S.A. § 2449g of the Vermont Age-Appropriate Design Code Act. The Rule establishes standards governing age assurance for covered minors, including requirements relating to selection of age assurance methods, graduated escalation, proportionality, data minimization, accuracy, privacy protections, fallback mechanisms, appeals, and compliance. The Rule emphasizes flexible, technology-

neutral approaches that require covered businesses to use the least intrusive age assurance process or technique reasonably available while protecting the privacy of covered minors. The Rule also establishes standards governing the collection, retention, use, and disclosure of age assurance data and provides guidance to assist covered businesses in complying with the statutory requirements of 9 V.S.A. § 2449g.

- Next scheduled meeting is August 10, 2026, at 2:00 p.m.
- 3:52 p.m. meeting adjourned.

To receive this information in an alternative format or for other accessibility requests, please contact:

Agency of Administration
ADM.Secretary@vermont.gov, 802-828-3322

DRAFT

Proposed Rule: Agency of Natural Resources: Department of Forests Parks and Recreation (ANR-FPR) – Rules Governing the Activity of Primitive Camping on State Forest and State Park Lands

Presented By: Oliver Pierson, Director of Forestry

Motion made to accept the rule by Stephen Brown, seconded by Earl Fechter, and passed unanimously, except for Jennifer Mojo, who abstained, with the following recommendations:

1) **Cover Sheet**
    a. #8: Spell out acronyms
    b. #11: Correct spelling of the word ‘primitive’

2) **Economic Impact Analysis**
    a. #3: Consider adding costs and benefits to this section

DRAFT

Proposed Rule: Agency of Human Services: Department of Health (AHS-VDH) – Birth Center Licensing Rule

Presented By: Meg McCarthy, Policy Advisor

Motion made to accept the rule by Russ McCracken, seconded by Patrick Murphy, and passed unanimously, except for Heidi Moreau, who abstained, with the following recommendations:

1) **Cover Sheet**
    a. #16: Keywords, 'labor' appears twice

DRAFT

Proposed Rule: Agency of Human Services: Department for Children and Families (AHS-DCF) – Rules for Afterschool Childcare Programs

Presented By: Philip Back, Attorney and Beth Maurer, Director of Licensing

Motion made to accept the rule by Patrick Murphy, seconded by Stephen Brown, and passed unanimously, except for Heidi Moreau, who abstained.

DRAFT

Proposed Rule: Agency of Human Services: Department for Children and Families (AHS-DCF) – Rules for Center Based Child Care and Preschool Programs

Presented By: Philip Back, Attorney and Beth Maurer, Director of Licensing

Motion made to accept the rule by Russ McCracken, seconded by Patrick Murphy, and passed unanimously, except for Heidi Moreau, who abstained, with the following recommendations:

1) **Cover Sheet**
    a. #12: Explain impact about lost subsidy payments to providers. General statement about what would be lost.
2) **Economic Impact**
    a. #8: Add something about radon; positive impact

DRAFT

Proposed Rule: Agency of Natural Resources: Department of Fish and Wildlife (ANR-DFW) - 10 App. V.S.A. § 7 Bear Management Rule

Presented By: Hannah Smith, General Counsel and Jackie Comeau, Bear Project Leader

Motion made to accept the rule by Heidi Moreau, seconded by Stephen Brown, and passed unanimously, except for Heidi Jennifer Mojo, who abstained, with the following recommendations:

1) **Cover Sheet**
    a. #7: Small typo, extra to in quoted language

2) **Environmental Impact**
    b. #6: Small typo, the ‘g’ and ‘n’ are reversed in the word ‘hunting’
    c. #8: Include positive impact to the bear population

3) **Public Input Maximization Plan**
    a. #3: Small typo, extra ‘n’
    b. Dates for at least two public hearings will be added prior to filing with the Secretary of State

DRAFT

Proposed Rule: Office of the Attorney General – Prohibited Data and Design Products

Presented By: Sarah Aceves, Assistant Attorney General, Public Protection Division

Motion made to accept the rule by John Kessler, seconded by Jennifer Mojo, and passed unanimously, with the following recommendations:

1) **Proposed Cover Filing Sheet**
   a. Add Charity Clark's title
   b. #4: Include a secondary contact person
   c. #8: Insert the date of 2025 for Act 63
   d. #16: Add keywords

2) **Public Input Maximization Plan**
   a. There will be two public hearings, possibly three, that will be scheduled imminently

DRAFT

Proposed Rule: Office of the Attorney General – Age Assurance Privacy

Presented By: Sarah Aceves, Assistant Attorney General, Public Protection Division

Motion made to accept the rule by Russ McCracken, seconded by Earl Fechter, and passed unanimously, with the following recommendations:

1) **Proposed Cover Filing Sheet**
   a. Add Charity Clark's title
   b. #4: Include a secondary contact person
   c. #8: Insert the date of 2025 for Act 63
   d. #8: State up front what age assurance does
   d. #16: Add keywords

2) **Public Input Maximization Plan**
   a. There will be two public hearings, possibly three, that will be scheduled imminently

DRAFT

280 State Drive – Center Building
Waterbury, VT 05671-1000

OFFICE OF THE SECRETARY
TEL: (802) 241-0440
FAX: (802) 241-0450

JENNEY SAMUELSON
SECRETARY

TODD W. DALOZ
DEPUTY SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

MEMORANDUM

TO: Sarah Copeland Hanzas, Secretary of State

FROM: Jenney Samuelson, Secretary, Agency of Human Services

DATE: June 29, 2026

SUBJECT: Signatory Authority for Purposes of Authorizing Administrative Rules

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I hereby designate Dawn O'Toole, Chief Operating Officer, Agency of Human Services as signatory to fulfill the duties of the Secretary of the Agency of Human Services as the adopting authority for administrative rules as required by Vermont's Administrative Procedures Act, 3. V.S.A § 801 et seq.

CC: Dawn O'Toole via Dawn.OToole@vermont.gov

Economic Impact Analysis

Instructions:

In completing the economic impact analysis, an agency analyzes and evaluates the anticipated costs and benefits to be expected from adoption of the rule; estimates the costs and benefits for each category of people enterprises and government entities affected by the rule; compares alternatives to adopting the rule; and explains their analysis concluding that rulemaking is the most appropriate method of achieving the regulatory purpose. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Rules affecting or regulating schools or school districts must include cost implications to local school districts and taxpayers in the impact statement, a clear statement of associated costs, and consideration of alternatives to the rule to reduce or ameliorate costs to local school districts while still achieving the objectives of the rule (see 3 V.S.A. § 832b for details).

Rules affecting small businesses (excluding impacts incidental to the purchase and payment of goods and services by the State or an agency thereof), must include ways that a business can reduce the cost or burden of compliance or an explanation of why the agency determines that such evaluation isn't appropriate, and an evaluation of creative, innovative or flexible methods of compliance that would not significantly impair the effectiveness of the rule or increase the risk to the health, safety, or welfare of the public or those affected by the rule.

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1. TITLE OF RULE FILING:

   Birth Center Licensing Rule

2. ADOPTING AGENCY:

   Agency of Human Services - Vermont Department of Health

3. CATEGORY OF AFFECTED PARTIES:

   LIST CATEGORIES OF PEOPLE, ENTERPRISES, AND GOVERNMENTAL ENTITIES POTENTIALLY AFFECTED BY THE ADOPTION OF THIS RULE AND THE ESTIMATED COSTS AND BENEFITS ANTICIPATED:

   DAIL: There is a small anticipated cost to DAIL from this rulemaking. This rulemaking requires DAIL to inspect birth centers for compliance with birth center regulations and verify ongoing compliance. DAIL will also be required to receive and respond to

complaints and initiate investigations and corrective actions. While the requirements associated with a birth center are new, these responsibilities, generally, are ones familiar to DAIL, as they complete similar responsibilities for other health care facility licensing programs (i.e., Hospitals, Ambulatory Surgical Centers, Psychiatric Residential Treatment Facilities for Youth) currently established in the Department of Health and have the existing staff and infrastructure to carry out these responsibilities.

Vermont Department of Health: There is a small anticipated cost to VDH from this rulemaking since it requires the Department to implement the licensing scheme for birth centers.

Entities establishing, maintaining, or operating birth centers: There is an anticipated cost to the entities establishing, maintaining, or operating birth centers, to meet the following requirements of the Rule: 1) completing the application and renewal process and paying the fees to obtain licensure from the Department of Health; 2) maintaining compliance with relevant regulations; 3) establishing a complaint process and annually reporting complaint data to the Department of Health; 4) preparing documents and paying the fees to obtain accreditation from the Commission for the Accreditation of Birth Centers (CABC); and 5) maintaining patient records. The CABC accreditation fees are $6,000 for initial registration and $350 per month continuing. The Department of Health licensure fee is $250 for an initial license, renewal of a license, or a change of ownership, as required by 18 V.S.A. § 2353. However, these are all minimum requirements that are necessary to obtain a license from the Department of Health, as established by statute (18 V.S.A. § 2359).

4. IMPACT ON SCHOOLS:

INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON PUBLIC EDUCATION, PUBLIC SCHOOLS, LOCAL SCHOOL DISTRICTS AND/OR TAXPAYERS CLEARLY STATING ANY ASSOCIATED COSTS:

There is no anticipated direct impact to schools.

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

   Because there is no anticipated direct impact to schools, alternatives to this rule have not been considered.

6. IMPACT ON SMALL BUSINESSES:
   INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

   There is no anticipated impact to small businesses.

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

   Because there is no anticipated impact to small businesses, no evaluation is necessary.

8. COMPARISON:
   COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING SEPARATE REQUIREMENTS FOR SMALL BUSINESS:
   There are no alternatives to this rule, this rulemaking is necessary for compliance with 18 V.S.A. §2359 that requires the Department "to adopt rules pursuant to 3 V.S.A. chapter 25 to carry out the purposes of this section."

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   The Department has provided the relevant information above based on the assessment of the potential impacts.

Environmental Impact Analysis

Instructions:

In completing the environmental impact analysis, an agency analyzes and evaluates the anticipated environmental impacts (positive or negative) to be expected from adoption of the rule; compares alternatives to adopting the rule; explains the sufficiency of the environmental impact analysis. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Examples of Environmental Impacts include but are not limited to:

- Impacts on the emission of greenhouse gases
- Impacts on the discharge of pollutants to water
- Impacts on the arability of land
- Impacts on the climate
- Impacts on the flow of water
- Impacts on recreation
- Or other environmental impacts

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1. TITLE OF RULE FILING:

   Birth Center Licensing Rule

2. ADOPTING AGENCY:

   Agency of Human Services - Vermont Department of Health

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*

   No anticipated impact.

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*

   No anticipated impact.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*

   No anticipated impact.

6. RECREATION: *EXPLAIN HOW THE RULE IMPACTS RECREATION IN THE STATE:*

   No anticipated impact.

7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   No anticipated impact.
8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   No anticipated impact.
9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   The estimate is based on information available to the Department.

Public Input Maximization Plan

Instructions:

Agencies are encouraged to hold hearings as part of their strategy to maximize the involvement of the public in the development of rules. Please complete the form below by describing the agency's strategy for maximizing public input (what it did do, or will do to maximize the involvement of the public).

This form must accompany each filing made during the rulemaking process:

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1. TITLE OF RULE FILING:

   Birth Center Licensing Rule

2. ADOPTING AGENCY:

   Agency of Human Services - Vermont Department of Health

3. PLEASE DESCRIBE THE AGENCY'S STRATEGY TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE, LISTING THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:

   The Department has met with and/or sent a draft of the pre-rulemaking rule to the parties listed below, and received comments from them.

4. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

   The following have been consulted and included in proposed rule development discussions, and will be notified when the rule is available for public comment. Additionally, a public hearing will be held, and the rule will be posted on the Department of Health website.

   The Department of Disabilities, Aging and Independent Living

   The Board of Medical Practice

   The Office of Professional Regulation

   Midwives advisory board and advisory committee

- The Department of Health's Family and Child Health Division
- The Commission for the Accreditation of Birth Centers
- Vermont Birth Center Coalition
- Green Mountain Birth Center
- Vermont Medical Society
- Vermont Association of Hospitals and Health Systems

Incorporation by Reference

THIS FORM IS ONLY REQUIRED WHEN INCORPORATING MATERIALS BY REFERENCE. PLEASE REMOVE PRIOR TO DELIVERY IF IT DOES NOT APPLY TO THIS RULE FILING:

Instructions:

In completing the incorporation by reference statement, an agency describes any materials that are incorporated into the rule by reference and how to obtain copies.

This form is only required when a rule incorporates materials by referencing another source without reproducing the text within the rule itself (e.g., federal or national standards, or regulations).

Incorporated materials will be maintained and available for inspection by the Agency.

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1. TITLE OF RULE FILING:

   Birth Center Licensing Rule

2. ADOPTING AGENCY:

   Agency of Human Services - Vermont Department of Health

3. DESCRIPTION (*DESCRIBE THE MATERIALS INCORPORATED BY REFERENCE)*:

   Section 4.1 refers to the American Association of Birth Centers Standards for Birth Centers as published on October 17, 2017.

   Section 4.2 refers to the Commission for the Accreditation of Birth Centers (CABC) Indicators for Compliance with Standards for Birth Centers Reference Edition 2.3.

4. FORMAL CITATION OF MATERIALS INCORPORATED BY REFERENCE:

   American Association of Birth Centers. (2017). Standards for birth centers. https://www.birthcenters.org/birth-center-standards

   Commission for the Accreditation of Birth Centers. (2023). CABC indicators of compliance with standards for birth centers (Reference Edition

2.3). https://birthcenteraccreditation.org/go-get-cabc-indicators/

5. OBTAINING COPIES: *(EXPLAIN WHERE THE PUBLIC MAY OBTAIN THE MATERIAL(S) IN WRITTEN OR ELECTRONIC FORM, AND AT WHAT COST)*:

   These references are all available for free on publicly accessible websites.

6. MODIFICATIONS (*PLEASE EXPLAIN ANY MODIFICATION TO THE INCORPORATED MATERIALS E.G., WHETHER ONLY PART OF THE MATERIAL IS ADOPTED AND IF SO, WHICH PART(S)ARE MODIFIED)*:

   No modifications; these materials are incorporated in their entirety.

Run Spell Check

State of Vermont
Department of Health
280 State Drive
Waterbury, VT 05671-8300
802-863-7200
HealthVermont.gov

Agency of Human Services

To: Rep. Trevor Squirrell, Chair of the Legislative Committee on Administrative Rules

From: Meg McCarthy, Policy Advisor for the Vermont Department of Health

Re: Birth Center Licensing Rule

Date: October 1, 2026

Following the filing of the rule for public comment, the Health Department made the following changes to the proposed rule based on comments received from stakeholders:

1. Section 5.1.2. was amended to include a missing word:

   5.1.2 No person shall represent itself as a "birth center" or use the term "birth center" in its title or in its advertising, publications, or other form of communication unless the person has been licensed as a birth center in accordance with 18 V.S.A. Chapter 53 and this rule.

2. Section 5.1.3 was amended to delete extraneous words:

   5.1.3. Every Vermont birth center license shall expire one year from the date of issuance ~~of each year~~ unless otherwise revoked.

3. Section 5.2.3.6 was amended to clarify that the written plan shall be shared with the emergency medical transport services *serving the birth center*:

   5.2.3.6. A written plan for access to and use of emergency medical transport services that includes evidence of work to develop a collaborative relationship through meetings and drills. The written plan shall be shared with the emergency medical transport services serving the birth center.

4. Section 5.2.3.7. was amended to clarify that the written plan shall also be shared with the emergency medical transport services serving the birth center:

5.2.3.7. A written plan for consultation with physicians and other health care providers, and for emergency transfer of an infant or a patient to an appropriate health care facility that includes a health care facility with 24/7 obstetric services and includes evidence of work to develop a collaborative relationship through meetings and drills. The written plan shall be shared with the health care facilities and emergency medical transport services serving the birth center.

5. Section 5.2.5 was amended to decapitalize the word "rules" for consistency:

5.2.5. If the birth center is determined to be substantially in compliance with the standards in these ~~R~~rules and applicable statutes, the Department may issue a license.

6. Section 5.5.3 was amended to use the defined term "birth center":

5.5.3. New owners shall apply to the Department for a new license as required in Section 5.2. New owners shall not operate a birth~~ing~~ center until they obtain a license from the Department.

7. Section 5.7.3.1. was amended to use the word "Section" in lieu of "rule" for consistency:

5.7.3.1. At a hearing, a birth center shall have the opportunity to respond to the Department's findings and reasons included in the notice sent pursuant to Section ~~Rule~~ 5.7.2 and to present evidence and argument regarding the same.

8. Section 5.7.3.2. was amended to use the word "Section" in lieu of "rule" for consistency:

5.7.3.2. The Department shall have an opportunity to present evidence and argument to support its findings and reasons included in the notice sent pursuant to ~~Rule~~ Section 5.7.2 and to respond to a birth center's response made in accordance with ~~Rule~~ Section 5.7.3.1.

9. Section 6.1.3. was amended to clarify that the birth center must notify the Department if they fail to obtain accreditation:

6.1.3. If the birth center fails to obtain accreditation, loses its accreditation, or has its accreditation restricted, the birth center must immediately notify the Department and its patients.

10. Section 6.1.5.2. was amended to decapitalize the word "rules" for consistency:

6.1.5.2. Require a corrective action plan in accordance with these ~~R~~rules; and

11. Section 6.2.4. was amended to add the words "labor and delivery" for consistency with statute at 18 V.S.A. §2359(4):

6.2.4. Risk Factors, Risk Criteria: A birth center shall not provide labor and delivery services to patients who have risk factors or risk criteria which, when present, would preclude the patient from being considered a low-risk patient, and make the patient ineligible for a birth center birth. Birth centers shall ensure ongoing risk assessments are conducted.

12. Section 6.2.4.1. was amended to add the words "labor and delivery" for consistency with statute at 18 V.S.A. §2359(4):

6.2.4.1. Risk factors or risk criteria that preclude a patient from receiving labor and delivery services at a birth center include, but are not limited to:

13. Section 6.2.4.1.9. was amended to include "and":

6.2.4.1.9. Gestation less than 36 weeks and 0 days, or greater than 42 weeks and 0 days; and

14. Section 6.2.4.1.10. was amended to clarify that other risk factors established by the CABC would also preclude a patient from receiving labor and delivery services at a birth center:

6.2.4.1.10. Other risk factors or risk criteria established by the birth center, the CABC, or the Department.

15. Section 6.2.5.4. was amended to clarify the meaning of "coverage":

6.2.5.4. The birth center shall ensure 24-hour staffing coverage by licensed maternity care providers and appropriate support staff, meaning 24-hour telephone consultation and provider availability to the patients of the birth center.

16. Section 6.2.5.5. was amended to ensure consistency with CABC accreditation standards:

6.2.5.5. The birth center shall ensure at least one licensed maternity care provider is present at each labor and birth. ~~A second person who is a licensed provider must be immediately available in the building at each labor and birth.~~ Another staff person who has certification of current training in neonatal and adult resuscitation shall be present at each labor and birth.

17. Section 6.2.6. was amended to clarify that a birth center does not need to have agreements for emergency transport or emergency transfer, but if the

birth center does have these agreements, they must be provided to the Department:

> 6.2.6. Collaboration, Transfer and Services Policies: In addition to plans for emergency transport and emergency transfer of clients and newborns, a birth center shall have policies and procedures in place for collaboration with hospitals, agencies, other facilities, and individuals to provide services to patients. These policies and procedures must be provided to the relevant service providers and the Department, along with any agreements with these entities a birth center may have pursuant to these policies and procedures, if applicable, and must include:

18. Section 6.2.7. was amended to decapitalize the word “state” for consistency:

> 6.2.7. Pharmaceuticals: A birth center shall comply with ~~S~~state and federal laws regarding obtaining, storing, possessing, prescribing, administering, and dispensing drugs, as that term is defined in 26 V.S.A. § 2022(6).

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Agency of Human Services

Public Comment Response Summary

Birth Center Licensing Rule

The Department of Health (Department) held a public hearing on September 11, 2026, in Waterbury, Vermont, for the proposed Birth Center Licensing Rule and accepted written comments on the proposed rule between August 3 and September 18, 2026.

The following is a summary of the 14 written comments received from the public, as well as the comments provided during the public hearing. The Department has provided a response to each comment. Comments of a similar or consistent nature have been consolidated and responded to accordingly.

Outcome Data

1. **Comment**: One commenter stated that the rule should include an expectation or requirement that birth centers report the outcomes and complications associated with both child birth and the immediate postpartum window, on a regular basis (i.e. annually), and that these data be available to state approved investigators for examination, analysis and public dissemination. Another comment asked whether physicians periodically review birth center records.

   Response: The legislature required the Department to adopt rules based on the national birth center standards published by the American Association of Birth Centers (AABC). These standards, as well as the Commission for the Accreditation of Birth Centers (CABC) Indicators for Compliance with Standards for Birth Centers, were are adopted by reference in the rule.

   The AABC Standards and CABC Indicators for Compliance require birth centers to collect and analyze all outcome data compared to national benchmarks, including but not limited to antepartum attrition and referral rates, pre-admission and post-admission intrapartum transfer rate, spontaneous vaginal, operative vaginal and cesarean birth rates including intrapartum

transfers, utilization rates for available methods of intrapartum pain management, episiotomy, third and fourth degree laceration rates, postpartum maternal and neonatal transfer rates and maternal, fetal and neonatal mortality rates. Birth center records, including outcome data, are subject to inspection by the Department at all times. There is no required physician review of birth center records.

Further, the AABC Standards and CABC Indicators for Compliance require that each birth center participate in a recognized national perinatal data registry which regularly reports birth center outcomes to the public and stakeholder groups (see AABC Standard 7.B.4 and CABC Indicator 7B.4).

Birth Center Definition and Use of Term "Birth Center"

2. **Comment**: One commenter asked whether the definition of "birth center" in the rule will preclude hospital based perinatal units from using the term "birth center," and whether this will be clarified in the rule. Another commenter states that there are many hospitals using the term "birth center" and "birthing center" for their labor and delivery units within the hospital and the commenter wants to ensure that there is clear public awareness about what services are offered in freestanding birth centers vs. hospital labor and delivery units, referred to as "birth or birthing centers". The commenter recommends adding the term "birthing center" to Section 5.1.2 of names that cannot be used unless licensed by 18 V.S.A. Chapter 53 and this rule in order to reduce public confusion.

   Response: In 18 V.S.A. §2351(1) the legislature defined "birth center" as excluding "a facility that is a hospital, is part of a hospital, or is owned by a hospital; a facility that is an ambulatory surgical center; or the residence of the individual giving birth." In 18 V.S.A. §2352(d) the legislature stated "No person shall represent itself as a "birth center" or use the term "birth center" in its title or in its advertising, publications, or other form of communication unless the person has been licensed as a birth center in accordance with the provisions of [Title 18 Chapter 53]." The rule definition at Section 3.1 is consistent with the statutory definition and was not amended to include the term "birthing center." The Department does not have the authority to expand the statutory prohibition under 18 V.S.A. 2352 through rules. Statute and the rule are clear about which entities can use the term "birth center."

3. **Comment**: One commenter noted that the definition of "birth center" in Section 3.1 of the rule does not include "A facility that is a hospital, is

part of a hospital, or is owned by a hospital, although a birth center may be located on the grounds of a hospital." The commenter noted that birth centers may be owned by a hospital while remaining operationally distinct from acute care obstetrical services. The commenter noted that freestanding birth centers are defined by their model of care rather than ownership structure and may be located either on or off hospital grounds. The commenter stated that excluding facilities solely on the basis of hospital ownership may not accurately reflect current practice or the established definition of freestanding birth center. The commenter recommends reconsidering this exclusion or clarifying that ownership alone does not determine whether a facility qualifies as a birth center.

Response: In 18 V.S.A. §2351(1), the legislature defined "birth center" as not including "a facility that is a hospital, is part of a hospital, or is owned by a hospital; a facility that is an ambulatory surgical center; or the residence of the individual giving birth." The definition further states that "A birth center may be located on the grounds of a hospital." The rule definition at Section 3.1 is consistent with the statutory definition. The Department does not have the authority to modify the provisions regarding hospital ownership in 18 V.S.A. §2351(1) through rules.

Other Definitions

4. **Comment**: One commenter stated that the definition of "licensed maternity care provider" at Section 3.6 of the rule is unclear and suggests deleting the phrase "and who may be the primary attendant during the perinatal period" from the definition to ensure the definition more clearly includes nurses and other licensed providers whose scope of practice encompassed perinatal and newborn care. The commenter also notes that the definition of "licensed provider" in Section 3.8 is limited to professionals whose scope of practice includes serving as the primary birth attendant, which may create inconsistency between the two definitions.

   Response: The rule definition at Section 3.6 is consistent with the statutory definition of "licensed maternity care provider" in 18 V.S.A. §2351(5).

5. **Comment**: One commenter states that the definition of "midwifery" should be included in the rule. The commenter states that midwifery care is at the center of birth center care and it is important that the rules for birth centers acknowledge what midwifery is when defining how birth centers will function. The commenter recommends adding the proposed definition: "Midwifery" means the provision of care, support and education to healthy people during the childbearing cycle, including normal pregnancy, labor, childbirth and the postpartum

period. Such care occurs in collaboration and consultation with other health care providers, and can appropriately occur at home, in birth centers, or in medical facilities. Midwifery care includes the care of the newborn, support of the family unit, and gynecologic health and wellness care, in accordance with the professional scope and standards of practice of the profession's certifying or licensing body.

Response: "Midwifery" is already defined in Vermont state statute at 26 V.S.A. §4181. Creating a separate and different definition for the same term in the Rules would create confusion and could lead to inconsistency in the application of laws. Additionally, incorporating the existing statutory definition in this rule would narrow the scope of activities that may be conducted at a birth center, as the statutory definition reflects the scope of practice for licensed midwives whereas birth centers may provide birth services beyond the licensed midwife scope of practice (e.g., Certified Nurse Midwife services). The Birth Center Licensing Rule and the CABC accreditation standards elucidate the meaning of "midwifery" in the context of birth centers. The Department is relying on the language in the rule, in professional scopes of practice, and in the CABC accreditation standards rather than creating a new or duplicative definition of midwifery in this rule.

Accreditation and Inspection

6. **Comment**: One commenter noted that Section 5.4 indicates that CABC accreditation is required for license renewal, which suggests that a birth center may be initially licensed without accreditation and may operate for up to one year prior to demonstrating accreditation. The commenter suggested clarifying expectations in the event that accreditation is denied since a birth center denied accreditation would be unable to reapply for one year following a denial, which may have implications for continued operation and license renewal. The commenter states that additional clarification regarding licensure status following an accreditation denial would strengthen implementation of these provisions and avoid uncertainty for both regulators and birth centers.

   Response: Section 5.7.1 makes it clear that the Department may condition, deny, suspend, or revoke a birth center license if it finds that there has been a substantial failure to comply with the requirements established in this rule or applicable statutes. This includes the requirement to obtain CABC accreditation. If, during the first year of licensure, the birth center fails to obtain CABC accreditation, the Department may require a corrective action plan, or it may condition, suspend, or revoke the birth center's license, and will deny renewal of the license if accreditation has not been achieved.

The Department has added language to Section 6.1.3. of the rule to clarify that if a birth center fails to obtain accreditation, it must immediately notify the Department.

7. **Comment**: Three commenters stated that mandatory CABC accreditation is not necessary for licensure. One commenter stated that only seven states require CABC accreditation as a condition of state licensure and CABC accreditation reviews the same items as the state. The commenter noted that CABC's fees are rising sharply and 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. One commenter notes that requiring both state licensure and Commission for the Accreditation of Birth Centers (CABC) accreditation while also implementing extensive staffing and compliance measures will make it considerably more expensive for a small, independent birth center to open and remain in operation. One commenter suggests allowing birth centers to seek CABC accreditation in lieu of any state inspections or other licensure requirement, to prioritize safety, while streamlining the licensure process.

   Response: The legislature required the Department to adopt rules based on the national birth center standards published by the American Association of Birth Centers (AABC). While the AABC Standards set national standards, the CABC accreditation process provides detailed criteria, indicators of compliance, and unacceptable practices based on the best available evidence for maternity care to ensure that the AABC Standards are met and maintained by birth centers. The CABC accreditation process is recognized for evidence-based care and best practices for low-risk births.

   In licensing other health care facilities, the Department also relies on national third-party standards developed to protect the safety of patients using those facilities (e.g., Centers for Medicaid and Medicare Services Conditions of Participation for hospitals and ambulatory surgery centers). For birth centers, CABC is the national expert in freestanding birth centers and midwifery care. In requiring CABC accreditation for state licensure, the Department is balancing the interests of facilitating access to birth center care with safety and quality for the patients using birth centers.

   The birth center advocates consulted during the development of the proposed rulemaking indicated that they planned to pursue CABC accreditation and that accreditation would not be a barrier to opening a birth center.

8. **Comment**: One commenter states that stacking a full state inspection on top of CABC accreditation is redundant. Another commenter states that in other states where CABC Accreditation is required for licensure, the state does not perform routine inspections, and the state does not need to make duplicative inspections of birth centers. A commenter states that 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. Another commenter asks the Department to consider removing routine inspections by the Department, as CABC will be conducting regular inspections as part of the accreditation process.

   Response: Birth centers must be licensed before operating in Vermont, per 18 V.S.A. §2352(a). Birth centers cannot obtain accreditation from the CABC until they have been in operation for at least 3 to 4 months, and thus a birth center must be licensed and operating before they receive a rigorous, on-site review from the CABC. As such, Vermont's initial inspection, required by 18 V.S.A. §2354, for purposes of a birth center's initial licensing, must be sufficient in scope and depth to ensure that birth centers are prepared to provide patients with safe care in a sanitary setting and that the state can issue a license to operate.

   Once a birth center has been inspected and accredited by the CABC (within the first year of licensure in Vermont), the CABC would subsequently only inspect the birth center every 3 years as part of the re-accreditation process. The Department has authority from statute to inspect a birth center at all times (18 V.S.A. 2357(b). The State of Vermont has an interest in being able to inspect birth centers to review compliance with Vermont statutes and rules that are not included in the CABC requirements, as well as review of continued compliance with CABC requirements that have been incorporated into the rule. The intention of the Department's inspections is to supplement, rather than duplicate, the CABC inspections. Inspections by the state will ensure that the birth center continues to be compliant with the Birth Center Licensing Rule requirements in addition to CABC requirements, and that the birth center's license can be renewed annually and between CABC inspections. Further, state inspections would be conducted as needed, in response to complaints received about a licensed birth center.

   In developing the proposed rule, the Department met with representatives from other state birth center licensing programs that require CABC accreditation for licensure (Illinois, Connecticut, Louisiana, and Minnesota). The Department confirmed that most states do conduct inspections of

birth centers to confirm compliance with their regulations prior to licensure, on a periodic basis to ensure continued compliance, and in response to complaints. Only Minnesota does not require a state inspection for licensure.

The Department has updated Section 5.3.1 to clarify that the Department or its designee may conduct inspections of licensed birth centers, including but not limited to inspections in response to complaints or grievances, as necessary.

9. **Comment**: A commenter, referring to the incorporation by reference of the AABC Standards as published on October 17, 2017 and CABC Indicators for Compliance Reference Edition 2.3 and "any further revisions or amendments thereof" in proposed rule Sections 4.1 and 4.2, states that private accreditation can support quality and accountability, but future changes made by a private organization should not automatically alter the practical requirements for Vermont licensure without state review and an appropriate public process. The commenter recommends that the rule incorporate only the identified editions and that future revisions should become applicable in Vermont only after the Department has evaluated them and completed any notice, public comment, and rulemaking requirements that apply.

   Response: The Department is aware of and attentive to changes in AABC Standards and the CABC Indicators for Compliance and will review and evaluate any proposed changes. The Department has also included in Sections 4.1 and 4.2 of the rule language that limits the incorporation of any new AABC standards or CABC indicators that are inconsistent with the rule.

   Further, the Department has the authority to modify its rules at any time if updates are inconsistent with statutory intent or not protective of public health, and the public may petition the Department to modify a rule at any time.

Transfer and Transportation Agreements or Plans

10. **Comment**: One commenter states that they strongly support the language in Section 5.2.3.6 of the rule emphasizing collaboration between birth centers and emergency medical transport services through meetings and drills, which reflects how relationships between these organizations are developed and maintained in practice.

    Response: During the drafting of the preliminary rule, the Department heard from several commenters that requiring a written agreement between a birth center and emergency medical transport services would be a barrier to opening a birth center, and that requiring a written plan for access to and use of emergency medical transport services with

evidence of work to develop a collaborative relationship through meetings and drills was a more realistic standard.

11. **Comment**: Two commenters, referring to the language in proposed rule Section 6.2.6, state that signed agreements with transfer hospitals, physicians, or emergency services are not required by CABC accreditation. The commenter suggests that the rule language "along with any agreements with these entities" implies that there may be signed agreements. The commenter asks the Department to clarify in rule that this statement in no way requires that the birth center enter into signed agreements with consultative and transfer physicians or hospitals. One commenter states that the rule implies that a birth center needs formal agreements with facilities and providers related to collaboration and transfer, which seems contrary to the clear intent of the language.

    Response: The Department has added language to Section 6.2.6 of the rule to clarify that agreements must only be provided if applicable. Agreements are not required by this rule, but the rule also does not prohibit agreements. A birth center does not need to have agreements for emergency transport or emergency transfer, but if the birth center does have these agreements, they must be provided to the Department.

12. **Comment**: One commenter states that the language in Section 6.2.3.9.1. of the rule, "Services offered and performed by the birth center are subject to these rules and statutes governing birth centers, regardless of whether the services are provided in a shared or adjacent space," is unclear and that added clarification would be helpful regarding how this is applied in shared or adjacent spaces. The commenter requests confirmation that the rule applies only to services provided under the birth center's scope of operation, and not to independent providers who are not affiliated with or operating as part of the birth center. Another commenter suggests removing this section because the shared and adjacent clinic space is not only to be used for low-risk planned birth center patients, but is also inclusive of patients who are receiving midwifery care at the birth center clinic, but who are not planning a birth center birth and may have risk factors appropriate for co-managed care. The commenter states that this section could be interpreted as limiting the ability for care provided by midwives in the clinic space. Risk criteria guidelines should only be applied to the birth center birthing space.

    Response: If the licensed birth center offers and provides services in the birth center or in adjacent spaces that are part of the birth center (e.g., owned by same organization and held out to the public as part of

the birth center), these services are subject to the Birth Center Licensing Rule. If there is a separate entity that is not part of the licensed birth center and is not held out to the public as part of the birth center offering services in a separate space or a space adjacent to the birth center, then those services would not be subject to the Birth Center Licensing Rule.

The Department has added language to Sections 6.2.4 and 6.2.4.1 of the rule to be consistent with statute at 18 V.S.A. §2359(4) and to clarify that the risk factors/risk criteria would preclude a patient from receiving labor and delivery services from a birth center, but not other services such as prenatal or post-partum care. Any services provided to patients with the risk factors or criteria must be within the professional's scope of practice.

13. **Comment**: One commenter asked whether there is a certain distance a birth center must be from a hospital, whether EMS is involved in conversations around birth centers, and whether, in the event of an emergency, EMS can respond adequately for either the mother or the newborn.

    Response: The proposed rules do not require that a birth center be located within a certain distance of a hospital. However, the birth center would be required to have policies and procedures in place for emergency transfer and transport of a newborn to a newborn nursery or neonatal intensive care nursery and emergency transfer or transport of a patient to an appropriate hospital when additional care is necessary, including at least one hospital with 24/7 obstetric services. This includes evidence of work to develop a collaborative relationship with emergency medical transport services and health care facilities through meetings and drills. These policies and procedures would need to account for transfer time and distance to the hospital.

14. **Comment**: One commenter states that a contract with a transportation entity seems unnecessary, and that if the Department determines that a contract with a transportation entity is necessary for a Vermont Birth Center to be licensed then transport entities, across the state of Vermont, need to also be required, by VT Law, to have and hold contracts with Vermont Birth Centers in reciprocity.

    Response: The proposed rule does not require a birth center to contract with a transportation entity.

15. **Comment**: One commenter states that they strongly support the requirement contained in Sections 5.2.3.7 and 6.2.6.3 that transfer plans include a plan to transfer to a hospital that offers 24/7 obstetric services. While depending on the circumstances, OB services may not be needed, the rule should require that transfer plans need to include at least one hospital with

24/7 obstetric services. Emergency department care alone is often not sufficient for a complex obstetric transfer.

Response: The Department agrees that requiring a birth center to have a plan for transfer to a hospital that offers 24/7 obstetric services is important.

16. **Comment**: Two commenters suggest that the transfer plan to a hospital with 24/7 labor and delivery access (required in proposed rule Section 5.2.3.7) be shared with the EMS services serving the birth center so they are aware who their local/regional partners are – as EMS may have different rules where patients need to be sent based on distance and level of medical emergency.

    Response: The Department has made this suggested change to Section 5.2.3.7.

17. **Comment**: One commenter noted that they support Sections 5.2.3.6, 5.2.3.7 and 6.2.6 as drafted, requiring that birth centers provide a written plan regarding transfer to a potential transport provider or receiving health care provider ahead of time, so that the provider knows that they are a potential receiving provider. The commenter states that this written communication in advance of a transfer between the birth center and other providers advances the fundamental goal of ensuring that the providers are aware of their roles and expectations and can facilitate timely communication and support when transfer is needed.

    Response: The Department agrees that having written plans regarding transfer is important to facilitate those transfers if and when needed.

Risk Factors or Risk Criteria

18. **Comment**: Remarking on Section 6.2.4.1.10, a commenter recommends adding a reference to the CABC in this provision, as the language as written refers only to the criteria established by the birth center or the Department, and including the CABC would better align this section with nationally recognized accreditation standards and ensure consistency with established clinical and operational guidelines.

    Response: The CABC Indicators of Compliance are incorporated by reference in Section 4.2 of the rule, so any standards set by CABC would be required of birth centers. But the Department has added language to Section 6.2.4.1.10 to clarify that any risk factors or risk criteria established by the birth center, the Department, or the CABC would be included.

19. **Comment**: A commenter recommended revising the language in Section 6.2.4.1 concerning risk factors that would preclude a patient from receiving services at a birth center. Regarding the language in Sections 6.2.4.1.1. and 6.2.4.1.2, ("more than one cesarean birth" and "classical uterine scar") to state "any uterine scar other than a low transverse incision" since there are other types of uterine incisions that also contraindicate a trial of labor after cesarean (TOLAC). Another commenter stated that the rule's exclusion criteria should include any previous cesarean section.

    Response: The risk factors/criteria listed in rule Section 6.2.4.1, including evidence of more than one cesarean birth and classical uterine scar, are taken directly from the CABC Indicators for Compliance, Indicator 5.1.f. However, the list of risk factors or risk criteria in rule Section 6.2.4.1 is not exhaustive. It also includes other risk factors or risk criteria established by the birth center or the Department, as well as any established by the CABC. In developing additional risk factors for their own birth center, practitioners may rely on their professional expertise, professional scope of practice, and site-specific considerations.

20. **Comment**: A commenter recommended revising the language in Section 6.2.4.1 concerning risk factors that would preclude a patient from receiving services at a birth center. Regarding Section 6.2.4.1.3. ("BMI greater than defined limits"), commenter states that clarification is needed regarding where these limits are established. The commenter notes that CABC Indicators reference "defined limits" meaning limits set by the birth center's own policies and procedures. Another commenter states that the proposed rule does not state those limits, identify who defines them, or provide the evidence supporting them. The commenter recommends that the Department state the precise threshold in the rule, identify the evidence supporting that threshold, explain how the threshold relates to specific maternal or neonatal outcomes, and allow an individualized clinical assessment when appropriate, rather than making BMI alone an automatic exclusion.

    Response: The risk factors/criteria listed in rule Section 6.2.4.1 are taken directly from the CABC Indicators for Compliance Indicator 5.1.f which lists risk factors inconsistent with a birth center's eligibility criteria. However, the list of risk factors or risk criteria in rule Section 6.2.4.1 is not exhaustive. It also includes other risk factors or risk criteria established by the birth center or the Department, as well as any established by the CABC. So the BMI limits could be defined by the birth center, the Department or the CABC. In developing additional risk factors for their own birth center, practitioners may rely on their professional expertise, professional scope of practice, and site-specific considerations.

21. **Comment**: One commenter states that Section 6.2.4.1 of the rule should rely on the current CABC Indicators and AABC standards as the framework for birth center eligibility and risk assessment. The commenter states that the list of risk criteria listed in this section may cause confusion, as it is not comprehensive, and referring to the established and frequently updated risk criteria from CABC and AABC will provide more relevant and comprehensive guidelines. The commenter states that the risk criteria should not be determined by the Department of Health, as they are not experts in up-to-date birth center care and perinatal research and guidelines.

    Response: Vermont statute at 18 V.S.A. § 2359 requires the Department to promulgate rules that, at a minimum, include provisions regarding "the scope of services that may be provided at a birth center, including risk factors that preclude a patient from receiving labor and delivery services at a birth center." The risk factors/criteria listed in Section 6.2.4.1 are taken directly from the CABC Indicators for Compliance Indicator 5.1.f which lists risk factors inconsistent with a birth center's eligibility criteria. The language in Section 6.2.4.1 of the rule also incorporates any additional risk criteria included in future updates of the AABC Standards and CABC Indicators for Compliance.

22. **Comment**: One commenter notes that Section 6.2.4.1 states that disqualifying conditions "include, but are not limited to" those listed. Section 6.2.4.1.10 also permits "other risk factors or risk criteria established by the birth center or the Department." The commenter states that this language allows eligibility for birth-center care to be restricted through criteria that are not stated in the rule and have not undergone public review. The commenter recommends that the Department specify the circumstances in which additional risk criteria may be applied, require those criteria to be evidence-based and documented, and subject any new categorical exclusion established by the Department to the appropriate public rulemaking process.

    Response: The Department needs to maintain flexibility to respond to real time needs and any potential risks to the public or patients. If, based on evidence, the Department determines that including additional risk factors or risk criteria is necessary to protect public health, then the Department would collaborate with licensees, subject matter experts, the AABC and CABC, and the public, and provide notice and opportunity for feedback. Similarly, the AABC and CABC use experts, data, and assessments to determine if it is appropriate to add a new risk factor or risk criteria to its Standards or Indicators of Compliance. The Department is aware of and attentive to changes in AABC Standards and the CABC Indicators for Compliance and will review and evaluate any proposed changes. The Department has the

authority to modify its rules at any time if updates are inconsistent with statutory intent or not protective of public health. Additionally, the public may petition the Department to modify a rule at any time.

23. **Comment**: One commenter, commenting on language in the proposed rule section 6.2.4., states that birth centers should have the ability to accept as patients people who cannot deliver in the birth center, if appropriate for other care during the prenatal or postpartum period in consultation and collaboration with a provider at the hospital. The commenter states that in rural communities or locations where maternity care services are available at a distance, birth centers may provide some prenatal or postpartum care, labs, or visits to higher risk patients between care appointments at the hospital where the patient will deliver. These patients may be called “prenatal care only” or “co-managed patients” who will give birth at the hospital. Another commenter states that Section 6.2.4 should be changed to clarify that a birth center shall not provide “birth services” to patients who have risk factors or risk criteria…, etc.` The commenter states that some patients may be seen in collaboration with high-risk providers, such as OBGYNs and MFM doctors, who plan to deliver at the hospital but will be receiving prenatal and postpartum care at the birth center. This change in wording will ensure those patients can receive co-managed care from the midwives at the birth center.

    Response: The Department has added language to Sections 6.2.4 and 6.2.4.1 of the rule to be consistent with statute at 18 V.S.A. §2359(4) and to clarify that the risk factors/risk criteria would preclude a patient from receiving labor and delivery services from a birth center, but not other services such as prenatal or post-partum care. Any services provided to patients with the risk factors or criteria must be within the professional’s scope of practice.

24. **Comment**: One commenter supports section 6.2.4 as drafted, outlining the risk factors and risk criteria that preclude a patient from receiving care from a birth center. As currently drafted, the rule is consistent with risk factors listed by CABC at Indicator. 5.1.f.

    Response: The Department agrees that this section of the rule is consistent with the risk factors listed by CABC in Indicator 5.1.f, but has added language to Sections 6.2.4 and 6.2.4.1 of the rule to be consistent with statute at 18 V.S.A. §2359(4) and to clarify that the risk factors/risk criteria would preclude a patient from receiving *labor and delivery* services from a birth center, but not other services such as prenatal or post-partum care.

Staffing



25. **Comment**: A commenter has concerns with the provision in Section 6.2.5.5. of the rule, stating that allowing the second provider to be “immediately available in the building” rather than physically present in the room is not consistent with CABC indicators and does not reflect safe practice. “Immediately available” does not provide the same level of readiness as having two qualified individuals present in the room during labor and birth. A provider located elsewhere in the building must still be notified and physically arrive, creating an inherent delay in response. The commenter recommends revising this requirement to reflect that two qualified individuals, meaning individuals fully trained in neonatal resuscitation, should be present for the birth to ensure client safety and alignment with established standards.

    Response: CABC Indicator 3.5. requires that two staff currently trained in neonatal resuscitation and adult cardiopulmonary resuscitation must be present at each birth, and CABC Indicators 3.4 requires that a clinical provider be in-house at all times during the intrapartum course. The Department has made edits to Section 6.2.5.5. of the rule to clarify that one licensed maternity care provider and one staff person who has certification of current training in neonatal and adult resuscitation must be present at each labor and birth.

    Section 6.2.5.3 requires all licensed providers on staff to have certification of current training in neonatal and adult resuscitation. “Licensed provider” is inclusive of “licensed maternity care provider”, meaning that the licensed maternity care provider required by Section 6.2.5.5. will qualify as one of the individuals with neonatal and adult resuscitation training and fulfill the CABC indicator.

26. **Comment**: One commenter stated that the requirement that a second licensed provider remain immediately available during labor and birth unnecessarily increases the cost of opening and operating a freestanding birth center. Another commenter states that the term “licensed provider” is confusing here and does not fit with the required staffing of accredited birth centers. Does licensed provider mean a second licensed midwife? Or an RN? Many birth centers operate with trained Birth Assistants to assist the midwife, who are not currently licensed. They are also trained in CPR and NRP and all other skills needed to assist the licensed midwife at birth. They may also be RNs but are not always nurses. AABC Standards and CABC Indicators state that there must be 2 people at every birth who are trained in adult CPR and NRP, but they do not require the second person to be a licensed person. Most birth center guidelines do not require that two midwives attend each birth or that a second midwife be in the building during each labor

and birth. This would be burdensome and difficult to manage with staffing patterns at birth centers.

Response: The Department has updated Section 6.2.5.5. of the rule to require that at least one licensed maternity care provider be present at each labor and birth, and to clarify that a second staff person who has certification of current training in neonatal and adult resuscitation must be present at each labor and birth.

CABC Indicator 3.5. requires that two staff currently trained in neonatal resuscitation and adult cardiopulmonary resuscitation must be present at each birth. The licensed maternity care provider counts as one of the two staff who have certification of current training in neonatal and adult resuscitation, because licensed maternity care providers are required to have this training by Section 6.2.5.3 of the rule. The other staff person present at the labor and birth need not be a licensed provider, but must have certification of current training in neonatal and adult resuscitation.

The Department believes this requirement is protective of patient health and safety and is consistent with CABC requirements.

27. **Comment**: Three commenters commented on the proposed 24-hour staffing requirement, stating that this is particularly concerning for many of Vermont's small communities because it imposes round-the-clock coverage regardless of whether patients are present. This adds significant labor costs even though the rule otherwise requires staffing patterns to be consistent with a center's size and patient load. A commenter stated that the blanket 24-hour on-site, two-provider staffing requirements should be replaced with 24-hour on-call coverage by one licensed clinician. One commenter states the statement in proposed rule section 6.2.5.4. has the potential for misunderstanding and should be reworded to add 24-hour "on-call staffing coverage by licensed maternity care providers and appropriate support staff." It is not feasible for freestanding birth centers to provide in-house staffing 24-hours per day. One commenter recommends 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.

Response: Section 6.2.5.4 of the proposed rule does not require 24-hour on-site staffing for birth centers; it requires 24-hour staffing coverage by licensed maternity care providers and appropriate support staff. The Department has amended Section 6.2.5.4 to clarify that this obligation can be fulfilled through telephone consultation and licensed maternity care provider availability, mirroring the requirement in CABC Indicators of Compliance Indicator 1.C.1.h.

Pharmaceuticals

28. **Comment**: One commenter stated that while the pharmaceutical provisions in the proposed rule appropriately require compliance with state and federal law, they do not address the minimum emergency medications necessary for the provision of safe birth center care, and recommend that the Department clarify in rule the expectations regarding emergency medications required for maternal and neonatal stabilization, including medications necessary to support neonatal resuscitation when indicated before arrival of emergency transport personnel. The commenter notes that the formulary for licensed midwives in Vermont's Administrative Rules for Midwives (table on page 25) does not address the requirement that birth center staff be able to manage neonatal resuscitation according to the current American Health Association and American Academy of Pediatrics Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular care. The Vermont Administrative Rules for Midwives allow epinephrine 1:1,000 for allergic reactions, adult concentration, but do not include the neonatal resuscitation concentration of 1:10,000.

Response: Birth centers will need to meet CABC requirements to maintain accreditation and retain their license under the Birth Center Licensing Rule. The CABC accreditation requirements and this rule require two staff currently trained in neonatal resuscitation at each birth, one of whom must be a licensed maternity care provider.

Practitioners also need to stay within their current professional scope of practice. As you note, licensed midwives do not have the neonatal resuscitation concentration for epinephrine in their formulary in the current Vermont Administrative Rules for Midwives.

There are different ways for a birth center operated by a licensed midwife to achieve compliance with the CABC standards and stay within their scope of practice, such as an engagement with another licensed maternity care provider (e.g., certified nurse midwives or physicians) who can

delegate authority for the neonatal resuscitation epinephrine concentration of 1:10,000 to a licensed individual with the appropriate education, training, or licensure to administer. Licensed midwives must engage with the Office of Professional Regulation to update the formulary in the Vermont Administrative Rules for Midwives to allow them to independently administer the neonatal resuscitation epinephrine concentration of 1:10,000.

Fetal Monitoring

29. **Comment**: One commenter asked why continuous fetal monitoring is expressly prohibited in the rule. The commenter stated that this tool could be helpful in determining if a patient needs to be transferred to a different level of care. Continuous electronic fetal heart monitoring is a screening tool that can provide information to add to the clinical picture and decision making. The commenter stated that while it would likely rarely be used or even indicated in low risk labors, it seems prudent to have the tool available to providers rather than expressly prohibited.

    Response: Per statute (see 18 V.S.A. § 2351(1)), the primary purposes of a birth center are to provide midwifery care, low-risk deliveries, and newborn care immediately after delivery. The legislature required the Department to adopt rules based on the national birth center standards published by the AABC including defining the scope of services that may be provided at a birth center, including risk factors that preclude a patient from receiving labor and delivery services at a birth center (see 18 V.S.A. § 2359). The prohibition against continuous fetal monitoring in the rule is based on those AABC standards (see standard C.1.j), as well as the CABC Indicator 1 C.1.j, which prohibit fetal monitoring beyond intermittent auscultation. The AABC standards and CABC indicators for compliance are evidence-based and widely recognized benchmarks for low-risk deliveries.

Physician Oversight

30. **Comment**: One commenter asked whether there is physician oversight of birth centers.

    Response: 18 V.S.A. chapter 53 does not require physician oversight of a birth center, nor do the proposed rules. 18 V.S.A.§ 2352(b) states that a birth center may be independently owned and operated by a licensed maternity care provider or any other person who complies with the

requirements of this chapter. “Licensed maternity care provider” is defined in 18 V.S.A.§ 2351(5) as “a licensed provider whose professional scope of practice, as established under Vermont law, includes preconception, prenatal, labor, birth, and postpartum care and early care of a newborn and who may be the primary attendant during the perinatal period,” and does not limit the ownership and operation of a birth center to physicians.

Rulemaking Process

31. **Comment**: One commenter asked why this rule was being promulgated, whether VT already had birth centers and whether this work was connected to a recommendation from the Green Mountain Care Board. The commenter asked whether these rules were an attempt to reduce the cost of OB care and whether any modeling used to predict these savings could be shared.

    Response: This rule is being promulgated pursuant to legislation signed into law in Vermont in 2025 (Act 19 of 2025, codified in 18 V.S.A. chapter 53) requiring the Department of Health to adopt rules that set the requirements for operating and licensing a birth center. The law directs the Department to base those requirements on the national birth center standards published by the American Association of Birth Centers. There are currently no birth centers operating in Vermont that are not otherwise part of a hospital.

    The Department has not conducted any financial modeling concerning birth center care.

32. **Comment**: One commenter asked whether obstetrician-gynecologists and pediatric physicians have been involved in the creation of the proposed regulations.

    Response: While obstetrician-gynecologists and pediatric physicians were not directly engaged during the preliminary rule drafting process, the preliminary draft of the rule was shared with the Vermont Medical Society and the Vermont Association of Hospitals and Health Systems, and the proposed rule was again shared with these organizations during the public comment period.

33. **Comment**: The commenter states that, as an obstetrician-gynecologists physician who has worked collaboratively with nurse midwives and nurse practitioners, they do not support the idea of a free-standing birth centers since even very low risk patients can quickly become critically ill or compromised.

Response: In Act 19 (2025), the legislature required that the Department of Health issue licenses to freestanding birth centers that apply for a license and meet requirements for operation that the Department of Health adopts via rulemaking. The question of whether free standing birth centers should be allowed in Vermont has already been decided by the legislature and is outside the scope of this rulemaking.

34. **Comment**: One commenter states that the administrative filing states that "only minimal economic impacts" are anticipated and that "[t]here is no anticipated impact to small businesses." It consequently concludes that no small-business compliance evaluation is necessary. The commenter states that those conclusions warrant further examination, and that if the cumulative requirements make operation financially or practically impossible, Vermont could establish a birth-center licensing framework without preserving a viable path for birth centers to exist. The commenter recommends that the Department publish a more complete analysis of these costs.

Response: Thank you for the comment. The Department stands by its assessment of the economic impacts of the rulemaking in which we provided the costs of licensing and accreditation, which would apply to any business or entity choosing to pursue a birth center license. The costs of the rule, described in the analysis of the economic impact, are the result of balancing patient safety and quality with cost and access.

AABC
AMERICAN ASSOCIATION OF BIRTH CENTERS

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EXECUTIVE DIRECTOR
Kate E. Bauer, MBA

September 17, 2026

Vermont Department of Health
280 State Drive
Waterbury, VT 05671-8300
AHS.VDHRules@vermont.gov

Re: Birth Center Licensing Rule

Dear Vermont Department of Health

Thank you for this opportunity to submit comments on your pending Birth Center Licensing Rule. We appreciate the work the Department of Health is doing to ensure licensure and access to high-quality birth center care for people in Vermont.

AABC Standards and CABC Indicators are evidence-based and use the latest information from research studies and documented clinical experience to set safety and clinical management standards for birth center operations. For those concerned about the cost of accreditation, the AABC Foundation offers scholarships for those seeking first time accreditation.

AABC offers comments on three sections of the proposed rule. These comments are offered for clarification and concern that the proposed requirements may fall outside the AABC Standards and CABC Indicators and may lead to confusion or barriers to the operation of birth centers in the State of Vermont. Our comments refer to sections 5.3, 6.2.4, 6.2.5, and 6.2.6.

5.3 **Inspections** and Corrective Actions

Comment: In other states where CABC Accreditation is required for licensure, the state does not perform routine inspections. In Minnesota, for example, the site visits of the accrediting organization are reported to the state under an agreement between CABC and the state. As a result, the state does not need to make duplicative inspections of birth centers.

6.2.4. "Risk Factors, Risk Criteria : A birth center shall not provide services to patients who have risk factors or risk criteria which, when present, would preclude the patient from being considered a low-risk patient, and **make the patient ineligible for birth center birth** ."

Comment: Birth centers should have the ability to accept as patients people who cannot deliver in the birth center, if appropriate for other care during the prenatal or postpartum period in consultation and collaboration with a provider at the hospital.

In rural communities or locations where maternity care services are available at a distance, birth centers may provide some prenatal or postpartum care, labs, or visits to higher risk patients between care appointments at the hospital where the patient will deliver. These patients may be called "prenatal care only" or "co-managed patients" who will give birth at the hospital.

Does this section preclude care before or after pregnancy being provided at the birth center to co-managed patients? A sentence could be added with the explanation that "In collaboration with a Maternal Fetal Medicine specialist or OB/Gyn at a hospital, patients may have some care at the birth center in their community to avoid driving long distances for every appointment."

6.2.5 Staffing

6.2.5.4 "The birth center shall ensure **24-hour staffing coverage** by licensed maternity care providers and appropriate support staff."

Comment: This statement has the potential for misunderstanding and should be reworded to add 24-hour "on-call staffing coverage by licensed maternity care providers and appropriate support staff." It is not feasible for freestanding birth centers to provide in-house staffing 24-hours per day. Accredited birth centers provide staffing with on-call scheduling, so personnel are available by phone and readily available to come to the birth center to provide in-person care whenever needed.

6.2.5.5 "A second person **who is a licensed provider** must be immediately available in the building at each labor and birth."

Comment: The term "licensed provider" is confusing here and does not fit with the required staffing of accredited birth centers. Does licensed provider mean a second licensed midwife? Or an RN? Many birth centers operate with trained Birth Assistants to assist the midwife, who are not currently licensed. They are also trained in CPR and NRP and all other skills needed to assist the licensed midwife at birth. They may also be RNs but are not always nurses. AABC Standards and CABC Indicators state that there must be 2 people at every birth who are trained in adult CPR and NRP, but they do not require the second person to be a licensed person. Most birth center guidelines do not require that two midwives attend each birth or that a second midwife be in the building during each labor and birth. This would be burdensome and difficult to manage with staffing patterns at birth centers.

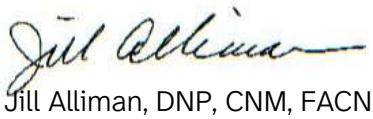
6.2.6 Collaboration, Transfer, and Services Policies

States that " These policies and procedures must be provided to the relevant service providers and the Department, along with "**any agreements** with these entities . . . "

Comment: Signed agreements with transfer hospitals, physicians, or emergency services are not required by CABC accreditation. This statement implies that there may be signed agreements. Please clarify in this Rule that this statement in no way requires that the birth center enter into signed agreements with consultative and transfer physicians or hospitals.

Thank you for allowing us to comment on the proposed Birth Center Licensing Rule. If you have any questions or need clarification on these comments, please contact us.

Respectfully Submitted,



Jill Alliman, DNP, CNM, FACNM
Chair, AABC Government Affairs Committee



Kate E. Bauer
Executive Director

From: Devon Green
To: AHS - VDH Rules
Cc: McCarthy, Meg (she/her); Schifano, Jessica
Subject: Birth Center Proposed Rule Comments
Date: Thursday, September 10, 2026 1:40:22 PM
Attachments: image001.jpg

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Good afternoon,

Thank you for the opportunity to comment on the Proposed Birth Center Licensing Rule.

We really appreciate the Vermont Department of Health considering provider input.

VAHHS suggests that the transfer plan to a hospital with 24/7 labor and delivery access be shared with the EMS services serving the Birthing Center so they are aware who their local/regional partners are – as EMS may have different rules where patients need to be sent based on distance and level of medical emergency (changes in bold)

> **5.2.3.7.** A written plan for consultation with physicians and other health care providers, and for emergency transfer of an infant or a patient to an appropriate health care facility that includes a health care facility with 24/7 obstetric services and includes evidence of work to develop a collaborative relationship through meetings and drills. The written plan shall be shared with the health care facilities and **EMS Services serving the Birthing Center.**

Thank you. Please feel free to contact me at devon@vahhs.org with any questions or concerns.

Devon Green, JD, MHCDS (she/her) *why pronouns?*
Senior Vice President of Policy and Strategy
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From: Bernstein, Ira
To: AHS - VDH Rules
Cc: Meyer, Marjorie C.; Peipert, Jeffrey
Subject: Birth Center Rules
Date: Tuesday, August 4, 2026 9:37:50 AM

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I would outline an expectation/requirement that birth centers report the outcomes and complications associated with both child birth and the immediate postpartum window, on a regular basis (annually), and that these data be available to state approved investigators for examination, analysis and public dissemination.

Ira

Ira Bernstein MD

From: Kathy Mahoney
To: AHS - VDH Rules
Subject: Birth center rules
Date: Monday, August 31, 2026 6:47:32 AM

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Hello - I have some questions regarding this process.

First, why is this document being created now? Does Vt already have birth centers, and where are they? Is there a push for more, and if so why? Is this work related to a recommendation to expand birth centers from a consultant the green mountain care board hired a couple of years ago?

Is there any physician oversight of these places? Periodic review of records?

Have Ob gyn and Pediatric physicians been involved in the creation of this document?

Exclusion criteria should include any previous cesarean section.

Is there a certain distance these must be from a hospital?

Does EMS sit at the table for these conversations? In the event of an emergency, can EMS respond adequately for either the mom or newborn?

If this effort is an attempt to reduce the cost of OB care, please share the modeling used to predict these savings.

I am an ob gyn physician who has worked collaboratively with nurse midwives and nurse practitioners and created such a model in my former practice. I highly support this concept, but I do not support the idea of a free standing birth centers since even very low risk patients can quickly become critically ill or compromised.

Thank you

Kathy

Kathy Mahoney, MD, MBA, FACOG

From: Stephanie Koch
To: AHS - VDH Rules
Subject: Birthing Center rules comment
Date: Tuesday, August 4, 2026 1:22:18 PM

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Hello,

I am a registered nurse and clinical educator on the Family Birth Center at Northwestern Medical Center in St Albans VT. Also, I am in instructor for Neonatal Resuscitation and AWHONN Intermediate Fetal Heart Monitoring.

Question: will this language preclude hospital based perinatal units from using the term "birth center"? (as in, do we need to find a new name for our unit) Can this be clarified somehow in the language?

Comment: I am unclear as to why continuous fetal monitoring is expressly prohibited. It seems that this tool could be helpful in determining if a patient needs to be transferred to a different level of care. Continuous electronic fetal heart monitoring is a screening tool-- it can provide information to add to the clinical picture and decision making. While it would likely rarely be used or even indicated in low risk labors, it seems prudent to have the tool available to providers rather than expressly prohibited.

Comment: I am very pleased to have the Birthing Center option available in VT. Thank you to all in working diligently to make this a viable & safe option.

Sincerely,
Stephanie Koch BS RNC-MNN C-EFM

Birth Center Licensing Rule

1. Authority

1.1. This rule is adopted pursuant to 18 V.S.A. § 2359.

2. Purpose

2.1. This rule sets forth the standards that apply to the licensing of Birth Centers in Vermont as defined in 18 V.S.A. Chapter 53.

3. Definitions

3.1. "Birth center" means a facility the primary purposes of which are to provide midwifery care, low-risk deliveries, and newborn care immediately after delivery, for a stay of generally less than 24 hours. The term does not include:

3.1.1. A facility that is a hospital, is part of a hospital, or is owned by a hospital, although a birth center may be located on the grounds of a hospital;

3.1.2. A facility that is an ambulatory surgical center; or

3.1.3. The residence of the individual giving birth.

3.2. "Certified nurse midwife" means an advanced practice registered nurse licensed in accordance with 26 V.S.A. chapter 28, subchapter 2 who has specialized training in childbirth, newborn care, and reproductive health care services.

3.3. "Corrective action plan" means a plan that a licensee is required to submit to address any identified deficiency to bring the birth center into compliance with these rules and applicable law.

3.4. "Deficiency" means a policy, procedure, practice, or any other action by a birth center that results in the birth center not being in compliance with this rule or applicable laws.

3.5. "Department" means the Department of Health.

3.6. "Licensed maternity care provider" means a licensed provider whose professional scope of practice, as established under Vermont law, includes preconception, prenatal, labor, birth, and postpartum care and early care of a newborn and who may be the primary attendant during the perinatal period.

3.7. "Licensed midwife" means a professional licensed in accordance with 26 V.S.A. chapter 85.

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3.8. "Licensed provider" means an individual licensed or certified in Vermont to provide specific health care-related services within a scope of practice defined by licensing statutes and rules, and may include advanced practice registered nurses, including certified nurse midwives; licensed midwives; physician assistants; naturopathic physicians with a childbirth endorsement in accordance with 26 V.S.A. §§ 4122(b) and 4125(b); and physicians.

3.9. "Patient complaint" means any expression of dissatisfaction related to the care and treatment provided by a Birth Center, from a patient or the patient's representative.

3.10. "Risk factors" or "risk criteria" means factors present in the patient's medical, social or obstetrical history, or developing during pregnancy, labor and birth, postpartum or in the neonate, that may increase the risk of complications or adverse outcomes and preclude out-of-hospital birth or continuing care in the birth center.

4. Incorporation by Reference

4.1. This rule incorporates by reference American Association of Birth Centers (AABC) Standards for Birth Centers as published on October 17, 2017, including any further revisions or amendments thereof, only to the extent that the provisions therein are not inconsistent with this rule.

4.2. This rule incorporates by reference Commission for the Accreditation of Birth Centers (CABC) Indicators for Compliance with Standards for Birth Centers Reference Edition 2.3, including any further revisions or amendments thereof, only to the extent that the provisions therein are not inconsistent with this rule.

5. Birth Center Licensing

5.1. General Provisions

5.1.1. No person shall establish, maintain, or operate a birth center in Vermont without first obtaining a license from the Department for the birth center.

5.1.2. No person shall represent itself as a "birth center" or use the term "birth center" in its title or in its advertising, publications, or other form of communication unless the person has been licensed as a birth center in accordance with 18 V.S.A. Chapter 53 and this rule.

5.1.3. Every Vermont birth center license shall expire one year from the date of issuance unless otherwise revoked.

5.2. License Application and Initial Inspection

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5.2.1. An application for a birth center license or license renewal must be submitted using forms provided by the Department.

5.2.2. The application must contain all information required by the Department and be accompanied by a license fee in the amount required by 18 V.S.A. § 2353.

5.2.3. Applications for an initial license shall include:

5.2.3.1. Identifying information and facility location.

5.2.3.2. Proof of registration with the Vermont Secretary of State.

5.2.3.3. A chart or description of the birth center's ownership or organizational hierarchy, including the names of the owners.

5.2.3.4. All materials submitted by the birth center to the CABC as part of the accreditation process, including the accreditation application and self-evaluation report.

5.2.3.5. Documentation of a completed application for accreditation with the CABC.

5.2.3.6. A written plan for access to and use of emergency medical transport services that includes evidence of work to develop a collaborative relationship through meetings and drills. The written plan shall be shared with the emergency medical transport services serving the birth center.

5.2.3.7. A written plan for consultation with physicians and other health care providers, and for emergency transfer of an infant or a patient to an appropriate health care facility that includes a health care facility with 24/7 obstetric services and includes evidence of work to develop a collaborative relationship through meetings and drills. The written plan shall be shared with the health care facilities and emergency medical transport services serving the birth center.

5.2.3.8. The procedures and policies required under Section 6.2.2 - 6.2.9.

5.2.3.9. Any other information as required by the Department.

5.2.4. Upon receipt of a complete application for a license and the licensing fee, the Department or its designee will schedule an inspection of the applicant's buildings, grounds and records.

5.2.5. If the birth center is determined to be substantially in compliance with the standards in these rules and applicable statutes, the Department may issue a license.

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5.3. Inspections and Corrective Actions

5.3.1. The Department or its designee may conduct inspections of licensed birth centers as necessary, including but not limited to inspections in response to complaints or grievances, as necessary.

5.3.2. A birth center, its building and grounds, and its records are subject to inspection by the Department or its designee at all times.

5.3.3. If the Department or its designee finds a birth center is out of compliance with any requirement in these rules or applicable statutes, the Department or its designee shall notify the birth center of the deficiency.

5.3.4. When notified of a deficiency, a birth center shall, within 30 days, or such shorter period as may be specified in the notice for good cause, develop and submit a corrective action plan for addressing any identified deficiencies and for achieving compliance with this rule and applicable statutes.

5.3.5. A corrective action plan shall identify the root cause of the deficiencies, outline procedures for correcting the deficiencies, and establish procedures for monitoring to ensure quality improvement and future compliance.

5.3.6. The Department shall determine whether a corrective action plan submitted pursuant to Section 5.3.4 of this rule is sufficient to effectively address each identified deficiency and bring the birth center into compliance with the requirements of this rule and applicable statutes.

5.3.7. Within thirty (30) days after receipt of a corrective action plan, the Department shall notify the birth center whether the Department

5.3.7.1. Accepts the proposed corrective action plan; or

5.3.7.2. Requests a revision to the corrective action plan, specifying the reason for the request.

5.3.8. A birth center required to submit a revised corrective action plan shall develop and submit the revision within thirty (30) days during which time the Department or its designee shall make available a representative to review with the birth center any proposed revisions.

5.3.9. Notwithstanding the issuance of a corrective action plan, the Department may exercise any and all powers granted to it under Vermont law, including the authority to condition, suspend, deny, or revoke a birth center's license.

5.3.10. Deficiencies and violations of this rule and of corrective action plans shall be posted on the Department's website.

5.4. License Renewal

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5.4.1. Licenses are valid for one year from the date of issuance. A license becomes inactive if not renewed by midnight on the date of expiration.

5.4.2. Renewal applications must be submitted using forms provided by the Department on or before the deadline set by the Department.

5.4.3. Renewal forms must contain all information required by the Department and be accompanied by a license renewal fee in the amount required by 18 V.S.A. 2353.

5.4.4. A birth center shall be accredited by the CABC to be eligible to renew a license.

5.4.5. Upon receipt of a complete application for a license renewal and the licensing fee, the Department or its designee may, at the Department's discretion, schedule an inspection of the applicant's buildings, grounds and records to determine compliance with Section 6 of this rule.

5.5. Change of Ownership

5.5.1. Licenses are not transferable or assignable, and are only applicable to the premises and persons named in the application.

5.5.2. A licensed birth center changing ownership, closing or eliminating or significantly reducing services shall provide at least 90 days' advance notice to the Department and to its patients.

5.5.3. New owners shall apply to the Department for a new license as required in Section 5.2. New owners shall not operate a birth center until they obtain a license from the Department.

5.6. License Posting

5.6.1. The birth center license must be posted in a conspicuous place on the licensed facility's premises.

5.7. License Denial, Suspension, Revocation

5.7.1. The Department may condition, deny, suspend, or revoke a birth center license if it finds that there has been a substantial failure to comply with the requirements established in this rule or applicable statutes.

5.7.1.1. If the Department finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its notice, summary suspension of a birth center's license may be ordered pending proceedings for conditioning, denying, suspending, or revoking a birth center's license.

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5.7.1.2. A hearing on an order of summary suspension proceedings shall be instituted and held in compliance with Section 5.7.3 within five (5) business days of the initial summary suspension and an order shall be issued within two (2) business days of the conclusion of the hearing.

5.7.2. When the Department or its designee finds that a birth center has substantially failed to comply with the requirements established in this rule or applicable statutes, the Department shall serve a written notice to the birth center by registered mail or by personal service. The notice shall set forth the reasons for the proposed action, and shall set a date not less than 60 days from the date of the mailing or service on which the applicant or licensee shall be given opportunity for a hearing.

5.7.3. The hearing shall be before the Commissioner or designee.

5.7.3.1. At a hearing, a birth center shall have the opportunity to respond to the Department's findings and reasons included in the notice sent pursuant to Section 5.7.2 and to present evidence and argument regarding the same.

5.7.3.2. The Department shall have an opportunity to present evidence and argument to support its findings and reasons included in the notice sent pursuant to Section 5.7.2 and to respond to a birth center's response made in accordance with Section 5.7.3.1.

5.7.4. After the hearing, or upon default of the applicant or licensee, the Commissioner shall file its findings of fact and conclusions of law and send a copy of the findings and decision by registered mail or serve the copy personally upon the applicant or licensee.

5.7.5. Any applicant or licensee aggrieved by the decision of the Commissioner after a hearing may appeal the decision in accordance with 18 V.S.A. § 128.

6. Standards for Birth Center Licensure

6.1. Accreditation

6.1.1. To obtain an initial license in Vermont, each birth center shall have submitted a complete application for CABC accreditation before applying for a license.

6.1.2. To renew and retain licensure, each birth center shall have current accreditation from the CABC.

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6.1.3. If the birth center fails to obtain accreditation, loses its accreditation, or has its accreditation restricted, the birth center must immediately notify the Department and its patients.

6.1.4. Upon request, the birth center shall provide the Department or designee with any material submitted by the birth center to the CABC and from the CABC to the birth center as part of the accreditation process, including the accreditation application, self-evaluation report, accreditation decision letter from the CABC, any progress reports or interim status reports submitted by the birth center to the CABC, and any reports from the CABC following a site visit.

6.1.5. Notwithstanding the CABC's determination that a birth center is in substantial compliance with all CABC indicators, the Department or its designee may:

6.1.5.1. Inspect, independently review, or investigate a birth center at any time to determine whether a birth center is in compliance with these rules and applicable statutes; and

6.1.5.2. Require a corrective action plan in accordance with these rules; and

6.1.5.3. Condition, suspend, deny or revoke a birth center's license if the Department finds the birth center is not in substantial compliance with these rules and applicable statutes.

6.2. Standards: To be licensed and retain licensure in Vermont, each birth center must meet and demonstrate substantial compliance with all of the following requirements.

6.2.1. Standards and Indicators: A birth center shall demonstrate and remain in compliance with AABC's Standards for Birth Centers and the CABC's Indicators for Compliance with Standards for Birth Centers, including all critical and required indicators of compliance.

6.2.2. Accreditation: A birth center shall remain accredited after initial accreditation. Loss or restriction of accreditation may result in a corrective action plan in accordance with Section 5.3 or suspension, conditioning, denial, or revocation of a license.

6.2.3. Scope of Services: A birth center shall perform a limited scope of services as follows:

6.2.3.1. A birth center shall provide only prenatal care, low-risk deliveries, newborn care, and postpartum care.

6.2.3.2. The use of general or regional anesthesia, including epidurals, is prohibited.

6.2.3.3. Local anesthesia, systemic analgesia, nitrous oxide, and other forms of pain relief may be administered at the birth center if it is performed within the provider's scope of practice, and as determined by the birth center's policies and procedures.

6.2.3.4. Labor shall not be induced, stimulated, or augmented with pharmacologic agents during the first or second stages of labor or before labor.

6.2.3.5. Surgical services must be limited to those normally performed during an uncomplicated birth, including repairing tears or performing and repairing episiotomies as necessary per scope of practice. No operative obstetrics or cesarean sections shall be performed.

6.2.3.6. The use of vacuum extractors, vaginal forceps, or continuous electronic fetal monitoring is prohibited.

6.2.3.7. Nothing in this rule shall be construed to expand or limit the scope of the services that a licensed midwife, certified nurse midwife, or other provider may offer at a birth center or perform in a space that is shared with or adjacent to a birth center.

6.2.3.8. All licensed providers must provide health care-related services only within their scope of practice and in compliance with the relevant licensing statutes and rules.

6.2.3.9. A birth center may serve as a location for additional services offered in shared or adjacent spaces, including outpatient gynecologic care, primary care, and education and support services, provided that any licensed provider providing services in those spaces shall only provide those services that are within the licensed provider's authorized scope of practice.

6.2.3.9.1. Services offered and performed by the birth center are subject to these rules and statutes governing birth centers, regardless of whether the services are provided in a shared or adjacent space.

6.2.3.10. Licensed providers may prescribe or administer medications only as allowed by their respective authorized scope of practice.

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6.2.4. Risk Factors, Risk Criteria: A birth center shall not provide labor and delivery services to patients who have risk factors or risk criteria which, when present, would preclude the patient from being considered a low-risk patient, and make the patient ineligible for a birth center birth. Birth centers shall ensure ongoing risk assessments are conducted.

6.2.4.1. Risk factors or risk criteria that preclude a patient from receiving labor and delivery services at a birth center include, but are not limited to:

6.2.4.1.1. More than one cesarean birth;

6.2.4.1.2. Classical uterine scar;

6.2.4.1.3. BMI greater than defined limits;

6.2.4.1.4. Preexisting diabetes;

6.2.4.1.5. Medication-dependent gestational diabetes (with exception of metformin);

6.2.4.1.6. Chronic hypertension with or without medication;

6.2.4.1.7. Known breech or non-vertex presentation at the onset of labor or delivery;

6.2.4.1.8. Multiple gestation, including twins;

6.2.4.1.9. Gestation less than 36 weeks and 0 days, or greater than 42 weeks and 0 days; and

6.2.4.1.10. Other risk factors or risk criteria established by the birth center, the CABC, or the Department.

6.2.4.2. A birth center shall ensure the ongoing assessment of patients seeking perinatal care to determine whether the patient continues to not have any risk factors or criteria.

6.2.5. Staffing: A birth center must have adequate and competent staffing consistent with the scope of services in order to provide safe maintenance and operation of the birth center.

6.2.5.1. The birth center shall develop a staffing pattern consistent with the caseload and size of the birth center.

6.2.5.2. A birth center shall ensure all staff have documentation of the training required to provide the services offered by the birth center and their job duties, including professional licenses and required certifications.

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6.2.5.3. All licensed providers on staff shall have certification of current training in neonatal and adult resuscitation.

6.2.5.4. The birth center shall ensure 24-hour staffing coverage by licensed maternity care providers and appropriate support staff, meaning 24-hour telephone consultation and provider availability to the patients of the birth center.

6.2.5.5. The birth center shall ensure at least one licensed maternity care provider is present at each labor and birth. Another staff person who has certification of current training in neonatal and adult resuscitation shall be present at each labor and birth.

6.2.6. Collaboration, Transfer and Services Policies: In addition to plans for emergency transport and emergency transfer of clients and newborns, a birth center shall have policies and procedures in place for collaboration with hospitals, agencies, other facilities, and individuals to provide services to patients. These policies and procedures must be provided to the relevant service providers and the Department, along with any agreements with these entities a birth center may have pursuant to these policies and procedures, if applicable, and must include:

6.2.6.1. Obstetric and pediatric consultation, referral, transfer of care;

6.2.6.2. Emergency transfer and transport of a newborn to a newborn nursery or neonatal intensive care nursery;

6.2.6.3. Emergency transfer or transport of a patient to an appropriate hospital when additional care is necessary, including at least one hospital with 24/7 obstetric services;

6.2.6.4. Laboratory and diagnostic services; and

6.2.6.5. Community education and home health services.

6.2.7. Pharmaceuticals: A birth center shall comply with state and federal laws regarding obtaining, storing, possessing, prescribing, administering, and dispensing drugs, as that term is defined in 26 V.S.A. § 2022(6).

6.2.7.1. A birth center shall ensure that all drugs, including controlled substances, are possessed, obtained, stored, prescribed, administered, and dispensed by a licensed provider in accordance with their professional scope of practice, and in accordance with all applicable federal and state laws.

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6.2.7.2. Drugs shall be handled and stored in a safe and effective manner, as determined by the birth center's policies and procedures, and the drug manufacturer's instructions, and applicable state and federal laws.

6.2.7.3. If controlled substances are kept at the birth center, they shall be stored pursuant to federal and state law.

6.2.8. Facility, Equipment and Supplies: A birth center shall ensure that the facility, equipment, and supplies in a birth center are maintained to ensure safety, sanitation, and health of patients and staff. A birth center shall:

6.2.8.1. Comply with applicable federal, state and local codes, regulations and ordinances for construction, fire prevention, public safety and accessibility;

6.2.8.2. Ensure the regular inspection, maintenance and cleaning of facility, equipment and supplies; and

6.2.8.3. Have an adequate amount of supplies for routine and emergency care of patients.

6.2.9. Record Retention and Confidentiality: A birth center shall maintain patient records and ensure confidentiality of those records according to applicable law. A birth center shall:

6.2.9.1. Maintain a health record for every patient for the purposes of making decisions about the patient's care and for continuity and evaluation of care, in accordance with professional standards;

6.2.9.2. Document any organized care and services provided to the patient in a way to easily facilitate the accessibility of information;

6.2.9.3. Update records accurately, appropriately and in a timely manner;

6.2.9.4. Provide a complete record in the event of a transfer of care;

6.2.9.5. Retain and disclose records in accordance with federal and state privacy and other applicable laws;

6.2.9.6. Ensure records are confidential, and prevented from loss, destruction, unauthorized use or disclosure; and

6.2.9.7. Allow patients to access their own records in accordance with state and federal law.

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6.2.10. Complaint Process and Tracking: A birth center shall have and comply with processes for filing and receiving complaints, communicating the complaint process to patients, responding to complaints, and tracking complaints, including:

6.2.10.1. A process for providing all patients entering care with written information regarding:

6.2.10.1.1. How and where a patient can make a complaint with the birth center and appeal a decision regarding a complaint made by the birth center;

6.2.10.1.2. How the complainant can contact the Department, the Vermont Office of the Healthcare Advocate, the Board of Medical Practice, and the Office of Professional Regulation;

6.2.10.1.3. A time frame for processing and resolving complaints and appeals within the birth center; and

6.2.10.1.4. A description of internal procedures for receiving, processing, responding to and resolving complaints from or filed on behalf of patients.

6.2.10.2. Procedures for responding to patient complaints, including a time frame for processing, resolving, and appealing complaints.

6.2.10.3. Procedures for maintaining complaint records.

6.2.10.4. Procedures for tracking complaints and reporting to the Department annually in accordance with Section 6.2.11.

6.2.11. Annual Report of Complaints: A birth center shall report the following to the Department annually:

6.2.11.1. The number of patients served during the licensing period;

6.2.11.2. The total number of complaints received;

6.2.11.3. The total number of complaints in each of the categories the birth center uses to track complaints; and

6.2.11.4. A brief narrative report describing examples of actions taken to resolve complaints during the licensing period.

6.2.12. Quality Assurance and Improvement: A birth center shall ensure there is a process in place for evaluating the quality of care provided to patients and the environment in which the services are provided. The process must include:

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6.2.12.1. Ongoing monitoring and evaluation of the birth center's program of care;

6.2.12.2. A mechanism to review and respond to patient feedback and complaints;

6.2.12.3. Documentation and review of adverse events;

6.2.12.4. Documentation and review of emergent transfers, including appropriateness and quality of transfer;

6.2.12.5. Regular review of health records for accuracy, completeness, and compliance with applicable state and federal laws;

6.2.12.6. In-service drills with all clinical staff; and

6.2.12.7. Annual reviews of protocols, policies and procedures.

6.2.13. Written Policies, Guidelines and Protocols: A birth center shall have written practice policies, guidelines or protocols on topics in Sections 6.2.3 - 6.2.12, in addition to any required by the CABC Indicators for Compliance with Standards for Birth Centers. The birth center shall continuously comply with these processes and policies and make these available to the Department or its designee for review and inspection.

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Public Comment on Proposed Birth Center Licensing Rule

Rule 26P029

Submitted by	Nancy Lynch
Location	Montpelier, Vermont
Date	September 18, 2026
Submitted to	Meg McCarthy, Policy Advisor, Vermont Department of Health

Dear Ms. McCarthy:

My name is Nancy Lynch, and I live in Montpelier. I have more than 25 years of experience in maternal and child health policy and have supported women through pregnancy, labor, birth, and the postpartum period in hospitals and homes. My background also includes childbirth education, the anthropology of birth, doula work, assisting a home-birth midwife, public policy, and nonprofit leadership.

I support the licensing of independent birth centers. Vermont needs birth centers, and families deserve clear safety standards. I respectfully recommend several revisions to ensure that the proposed rule is evidence-based, transparent, and workable.

1. Define and support the BMI exclusion

Section 6.2.4.1.3 excludes a person whose "BMI is greater than defined limits," but the proposed rule does not state those limits, identify who defines them, or provide the evidence supporting them.

A standard affecting eligibility for birth-center care should not be left undefined or controlled by material outside the rule. BMI alone is also an incomplete measure of an individual's health or clinical risk.

I recommend that the Department:

- State the precise threshold in the rule.
- Identify the evidence supporting that threshold.
- Explain how the threshold relates to specific maternal or neonatal outcomes.
- Allow an individualized clinical assessment when appropriate, rather than making BMI alone an automatic exclusion.

2. Require public accountability for additional patient exclusions

Section 6.2.4.1 states that disqualifying conditions "include, but are not limited to" those listed. Section 6.2.4.1.10 also permits "other risk factors or risk criteria established by the birth center or the Department."

This language allows eligibility for birth-center care to be restricted through criteria that are not stated in the rule and have not undergone public review. It creates uncertainty for families, providers, and birth centers and makes consistent enforcement difficult.

Clinical judgment must remain available when circumstances change. That is different, however, from allowing additional categorical exclusions to be created without defined standards or public accountability.

I recommend that the Department specify the circumstances in which additional risk criteria may be applied, require those criteria to be evidence-based and documented, and subject any new categorical exclusion established by the Department to the appropriate public rulemaking process.

3. Require state review of future private accreditation standards

Sections 4.1 and 4.2 identify the specific private standards incorporated into the rule: the American Association of Birth Centers' Standards for Birth Centers published on October 17, 2017, and the Commission for the Accreditation of Birth Centers' Indicators for Compliance, Reference Edition 2.3. Both sections then extend that incorporation to "any further revisions or amendments thereof."

Private accreditation can support quality and accountability, but future changes made by a private organization should not automatically alter the practical requirements for Vermont licensure without state review and an appropriate public process.

This concern is particularly important because Sections 5.4.4, 6.1.2, and 6.2.2 require continuing CABC accreditation to renew and retain a Vermont license. A birth center that does not comply with a future private accreditation requirement could lose or have its accreditation restricted, potentially placing its state license at risk.

I recommend that the rule incorporate only the identified editions. Future revisions should become applicable in Vermont only after the Department has evaluated them and completed any notice, public-comment, and rulemaking requirements that apply.

4. Evaluate the effect on independent birth-center viability

The administrative filing states that "only minimal economic impacts" are anticipated and that "[t]here is no anticipated impact to small businesses." It consequently concludes that no small-business compliance evaluation is necessary. Those conclusions warrant further examination.

The rule requires 24-hour staffing coverage by licensed maternity-care providers and appropriate support staff under Section 6.2.5.4. Section 6.2.5.5 requires a licensed maternity-care provider to be present at every labor and birth and a second licensed provider to be immediately available in the building. Accreditation expenses, staffing, administrative compliance, emergency planning, and other operational requirements can impose substantial costs on a small independent birth center.

If the cumulative requirements make operation financially or practically impossible, Vermont could establish a birth-center licensing framework without preserving a viable path for birth centers to exist.

I recommend that the Department publish a more complete analysis of these costs and determine whether each requirement is necessary, evidence-based, and reasonably tailored to the actual risks involved.

Safety does not require treating every maternity-care setting as though it were a hospital. It requires appropriate screening, qualified providers, informed consent, continuing risk assessment, timely consultation, and reliable plans for escalation and transfer. Hospitals are essential for high-risk pregnancy, operative delivery, and intensive care. Properly integrated community birth settings can appropriately serve screened, low-risk pregnancies.

The goal should be a coordinated maternity-care system in which each setting is held to clear standards appropriate to its role.

I respectfully ask the Department to revise the proposed rule to:

- Establish clear, evidence-based eligibility and exclusion criteria.
- Require individualized clinical assessment where appropriate.
- Remove or narrowly define open-ended exclusion authority.
- Preserve state and public oversight of future changes to private standards.
- Fully assess the operational and economic consequences for independent birth centers.

These revisions would strengthen both safety and public accountability while helping ensure that birth-center care remains a genuine option for Vermont families.

Right for Vermont Foundation
September 9, 2026

RE: Proposed Rule 26P029 — Licensure of Freestanding Birth Centers Submitted to: Vermont Department of Health.

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

From: Kacey Burakowski
To: AHS - VDH Rules
Subject: Regarding Vermont Birth Center Licensing Rule
Date: Friday, September 11, 2026 8:49:31 PM

You don't often get email from attunedbeginnings@gmail.com. Learn why this is important

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

Hello,

I would like to comment regarding the need for Vermont Birth Centers to have a contract with a transportation entity.

1) A CONTRACT WITH A TRANSPORTATION ENTITY SEEMS UNNECESSARY.

2) If the VT Department of Health determines that a contract with a transportation entity is necessary for a Vermont Birth Center to be licensed then transport entities, across the state of Vermont, need to also be required, by VT Law, to have and hold contracts with Vermont Birth Centers in reciprocity.

Please consider my comments.
Sincerely,
Kacey

Kacey Burakowski, M.A., CCC-SLP
www.attunedbeginnings@gmail.com
www.attunedbeginnings.com
802-730-4188

Written Comments on the Proposed Birth Center Licensing Rule
Submitted by Green Mountain Birth Center
Vermont Department of Health
admin@greenmountainbc.org

9/18/26

Dear Vermont Department of Health,

Green Mountain Birth Center appreciates the opportunity to comment on the proposed Birth Center Licensing Rule. We strongly support the Department of Health's work to establish a clear regulatory framework for freestanding birth centers in Vermont. We believe these rules are an important step toward ensuring safe, high-quality, midwife-led birth center care for Vermont families.

We offer the following comments to strengthen the proposed rule and ensure that Vermont's framework remains aligned with established national birth center standards.

Section 3. We think it is important for the definition of Midwifery to be included in the rules for Birth Centers. Midwifery care is at the center of Birth Center care and it is important that the rules for Birth Centers acknowledge what Midwifery is when defining how Birth Centers will function.

Add proposed definition: “Midwifery” means the provision of care, support and education to healthy people during the childbearing cycle, including normal pregnancy, labor, childbirth and the postpartum period. Such care occurs in collaboration and consultation with other health care providers, and can appropriately occur at home, in birth centers, or in medical facilities. Midwifery care includes the care of the newborn, support of the family unit, and gynecologic health and wellness care, in accordance with the professional scope and standards of practice of the profession’s certifying or licensing body.

5.1.2. With many hospitals using the term “birth center” and “birthing center” for their labor and delivery units within the hospital, we want to ensure that there is clear public awareness about what services are offered in freestanding birth centers vs. hospital labor and delivery units, referred to as “birth or birthing centers”. Please consider adding the term “birthing center” to this section of names that cannot be used unless licensed by 18 V.S.A. Chapter 53 and this rule in order to reduce public confusion.

5.3.1. Consider removing routine inspections by the Department, as CABC will be conducting regular inspections as part of the accreditation process.

6.2.3.9.1. We recommend removing this section because the shared and adjacent clinic space is not only to be used for low-risk planned birth center patients, it is also inclusive of patients who are receiving midwifery care at the birth center clinic, but who are not planning a birth center birth and may have risk factors appropriate for co-managed care. This section could be

interpreted as limiting the ability for care provided by midwives in the clinic space. Risk criteria guidelines should only be applied to the birth center birthing space.

6.2.4. Change this section to state “A birth center shall not provide *birth* services to patients who have risk factors or risk criteria which, when present, would preclude the patient from being considered a low-risk patient, and make the patient ineligible for a birth center birth. Birth Centers shall ensure ongoing risk assessment is conducted.” This is important because some patients may be seen in collaboration with high-risk providers, such as OBGYNs and MFM doctors, who plan to deliver at the hospital but will be receiving prenatal and postpartum care at the birth center. This change in wording will ensure those patients can receive co-managed care from the midwives at the birth center.

6.2.4.1. We recommend that in this section we rely on the current CABC Indicators and AABC standards as the framework for birth center eligibility and risk assessment. The list of risk criteria listed in this section may cause confusion, as it is not comprehensive, and referring to the established and frequently updated risk criteria from CABC and AABC will provide more relevant and comprehensive guidelines. The risk criteria should not be determined by the Department of Health, as they are not experts in up to date birth center care and perinatal research and guidelines.

Thank you for allowing us to comment on the proposed Birth Center Licensing Rule. We appreciate you taking the time to read our comments. Please feel free to contact us with any questions regarding these comments.

Sincerely,

Green Mountain Birth Center Board of Directors
admin@greenmountainbc.org

Vermont Department of Health
280 State Drive
Waterbury, VT 05671-8300

Re: Proposed Birth Center Licensing Rule

Dear Vermont Department of Health:

Americans for Prosperity appreciates this opportunity to comment on Vermont's recently proposed Birth Center Licensing Rule.[1] Our organization supported Act 19 because it was an important move towards giving Vermont mothers greater access to safe and affordable maternity care in their communities. By exempting freestanding birth centers from certificate-of-need (CON) review and instead replacing that process with a streamlined licensing framework, the Vermont General Assembly recognized that qualified providers should be able to serve mothers without first proving to bureaucratic institutions why their services are economically "necessary."[2]

Act 19 opened a door so new providers could enter Vermont's maternity-care system, expressly allowing birth centers to be independently owned and operated while maintaining oversight to protect health and safety. The proposed rule by this agency should seek to preserve this opportunity to help Vermont families and avoid imposing novel costs that otherwise make opening these centers impractical, leaving mothers without options for care.[3]

Vermont families are struggling without choices in maternity care. Vermont is the only state in New England without a freestanding birth center, and communities are continuing to lose existing hospital maternity services. Following the closure of Copley Hospital's birthing unit, several former midwives from the facility joined together to organize the opening of the Green Mountain Birth Center, which would be the first freestanding birth center in Vermont. For low-risk pregnancies, centers like these provide women with an option other than home birth or traditional hospital birth that balances professionalism with proximity, giving safe alternatives to mothers in rural communities across the state.[4]

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[1] See VT. DEP'T OF HEALTH, BIRTH CENTER LICENSING RULE (proposed rule 2026), https://www.healthvermont.gov/sites/default/files/document/pol-birth-center-licensing-updated-draft-rule.pdf.
[2] See *Americans for Prosperity Applauds Passage of S.18*, AMS. FOR PROSPERITY (Apr. 18, 2025), https://americansforprosperity.org/press-release/americans-for-prosperity-applauds-passage-of-s-18/; No. 19, *An Act Relating to Licensure of Freestanding Birth Centers*, 2025 Vt. Acts & Resolves (S.18), https://legislature.vermont.gov/Documents/2026/Docs/ACTS/ACT019/ACT019%20As%20Enacted.pdf.
[3] See Act 19, supra note 2, § 2352(b).
[4] See Lola Duffort, *Efforts are underway to open Vermont's first freestanding birth center*, VERMONT PUBLIC (Dec. 2, 2025), https://www.vermontpublic.org/local-news/2025-12-02/efforts-open-vermonts-first-freestanding-birth-center.

In passing Act 19, the General Assembly recognized that expanding choice did not have to come at the expense of patient safety. Birth centers are still subject to state licensure and inspection, and said centers have procedures for transferring patients to higher-level facilities should it be required. The law specifically directs the Department to base its regulations on national birth-center standards. Therefore, the Department should move away from asking whether these centers are sufficiently regulated and instead ask whether these additional requirements are necessary to protect mothers and infants. Otherwise, rather than protecting these families, regulation instead puts them at greater risk.[5]

Unfortunately, portions of this proposed rule instead elevate this risk by placing substantial barriers before the very providers Act 19 was intended to encourage, and the very Vermonters it was intended to help. Requiring both state licensure and Commission for the Accreditation of Birth Centers (CABC) accreditation while also implementing extensive staffing and compliance measures will make it considerably more expensive for a small, independent birth center to open and remain in operation. The proposed 24-hour staffing requirement is also particularly concerning for many of Vermont's small communities because it imposes round-the-clock coverage regardless of whether patients are present. This adds significant labor costs even though the rule otherwise requires staffing patterns to be consistent with a center's size and patient load. By imposing these requirements, this agency would effectively nullify Act 19, creating a statutory pathway to establish a birth center while making their creation impractical in Vermont's many small towns with the greatest unmet need.[6]

This same argument was made by the Obama administration, during which the Federal Trade Commission and the Department of Justice warned that CON laws create barriers to entry that limit consumer choice and stifle innovation. The agencies also warned that incumbent providers could use CON laws to delay or prevent new competitors from entering the market. The agencies further concluded that the evidence did not demonstrate that CON laws succeed in controlling costs or improving the quality of care and may instead undermine those goals. This same sentiment has been conveyed by every presidential administration since 1987.[7] Vermont's General Assembly acted in concordance with this guidance when it exempted birth centers from CON review. The Department should not undercut the democratic process and recreate through licensure the same barriers that the people's representatives intentionally removed.[8]

Since the people most affected by these regulations are mothers in rural and medically underserved communities, it is especially important to resist the urge to impose burdensome regulations. For a woman with a low-risk pregnancy, this availability of care can mean the

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[5] See Act 19, supra note 2, §§ 2357, 2359.
[6] See Birth Center Licensing Rule, supra note 1, §§ 5.1.1, 5.4.4, 6.1, 6.2.5.4-.5.
[7] See *What Do the Last Eight Presidential Administrations Have in Common? They All Agree Certificate-of-Need (CON) Laws Are Bad for Health Care*, AMS. FOR PROSPERITY FOUND. (2025), https://americansforprosperityfoundation.org/wp-content/uploads/2025/08/AFPF-CON-AdminQuotes-081325-v2.pdf
[8] See *Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice to the Virginia Certificate of Public Need Work Group*, FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE (Oct. 26, 2015), https://www.ftc.gov/legal-library/browse/advocacy-filings/joint-statement-federal-trade-commission-antitrust-division-us-department-justice-virginia.

difference between having a safe option close to home or traveling nearly an hour to the nearest hospital offering maternity services. In Morrisville and surrounding communities, for example, this is already the reality since Copley Hospital's birthing center closed, leaving the next closest option roughly 45 to 50 minutes away. For those without reliable transportation, facing financial troubles, or traveling in Vermont's winter conditions, these distances can easily translate into a total lack of care.[9]

Americans for Prosperity therefore urges the Department to reconsider those portions of the proposed rule that unnecessarily increase the cost of opening and operating a freestanding birth center, including mandatory CABC accreditation, 24-hour staffing requirements, and the requirement that a second licensed provider remain immediately available during labor and birth.[10] Vermont's Legislature already decided that these facilities should be allowed to operate outside the burdensome CON structure. The final rule should honor the democratic process by creating a framework that protects mothers and infants without making the care that Act 19 sought to encourage practically infeasible.

The Department has a great opportunity to carry out Act 19 by giving Vermont mothers more than a theoretical option to use a birth center. A more workable structure can help to bring new providers into the Green Mountain State and give Vermont women greater control over their bodies and where they can receive maternity care. We respectfully urge the Department to adopt a final rule that better advances these goals.

Thank you for your consideration,

Respectfully submitted,

Rachel Burgin
Northeast Deputy Regional Director
Americans for Prosperity

[9] See Lexi Krupp, *State backs rural birthing center closure and warns of more 'difficult decisions'*, VERMONT PUBLIC (July 9, 2025), https://www.vermontpublic.org/local-news/2025-07-09/state-backs-rural-birthing-center-closure-warns-more-difficult-decisions; see also Lexi Krupp, *Vt. hospitals plan to break even or lose money to keep prices in check*, VERMONT PUBLIC (Aug. 19, 2025), https://www.vermontpublic.org/local-news/2025-08-19/vermont-hospitals-plan-break-even-lose-money-keep-prices-check.

[10] See Birth Center Licensing Rule, supra note 1, §§ 5.4.4, 6.1, 6.2.5.4-.5.

PACIFIC LEGAL FOUNDATION

To: Vermont Department of Health
From: Jaimie Cavanaugh, Senior State Policy Counsel, Pacific Legal Foundation
Date: September 18, 2026
Re: Public Comment on Birth Center Licensing Rule

Thank you for the opportunity to comment on Vermont's proposed Birth Center Licensing Rule. Establishing a clear, viable licensure path for freestanding birth centers is a vital step toward expanding equitable, community-based maternity care across Vermont.

Pacific Legal Foundation (PLF) works around the country to ensure that women have access to safe, high-quality maternal healthcare and that women have freedom and choice in where to receive maternal healthcare and give birth.

PLF supports Vermont's effort to regulate birth centers and urges this Department to ensure that all regulations are evidence-based, flexible, and operationally feasible. Overly restrictive regulations risk creating insurmountable hurdles that will prevent freestanding birth centers from opening. For that reason, PLF has the following concerns.

First, the proposed rule requires birth centers to be accredited by the Commission for the Accreditation of Birth Centers (CABC). Few states require this as a prerequisite to a separate state licensure process. One reason may be because accreditation is so expensive. As of September 1, 2026 CABC raised its fees to $6,000 for initial registration and $4,000 for annual review. This is in addition to a monthly fee of $350 for a primary location.

PLF suggests allowing birth centers to seek CABC accreditation in lieu of any state inspections or other licensure requirement. This would prioritize safety, while streamlining the licensure process.

Second, the proposed rule requires 24-hour staffing coverage. The industry standard is to require 24-hour on-call staff, but not to mandate that staff are present at the birth center 24 hours per day. Mandating 24-hour staffing coverage could negatively impact a birth center's ability to open without further patient safety.

Third, in the Collaboration, Transfer and Services Policies section, the rule implies that a birth center needs formal agreements with facilities and providers related to collaboration and transfer. This seems contrary to the clear intent of the language.

The best practice is to require birth centers to maintain transfer protocols and plans and to notify third-party providers about these protocols and plans. Requiring consent from a third-party (such as a hospital or EMS service provider) gives birth center competitors too much authority to potentially prevent an otherwise safe birth center from opening. may prevent birth centers from opening.

Thank you for considering these comments. PLF looks forward to continuing the process to ensure that birth centers are able to open quickly, safely, and economically.

Respectfully,



Jaimie Cavanaugh
Senior State Policy Counsel
jcavanaugh@pacificlegal.org
248-895-1555

Vermont Medical Society

To: Vermont Department of Health, Meg McCarthy, Public Health Policy Advisor
Sent via email to: ahs.vdhrules@vermont.gov
From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org
Date: September 15, 2026
RE: Comments - Birth Center Licensing Rule

Thank you for the opportunity to review and submit comments regarding the Vermont Department of Health's Proposed Birth Center Licensing Rule (Proposed Rule). We have solicited feedback from our clinician members, including OBGYNs, who are committed to safe labor and delivery for all patients in Vermont, understanding patients may choose different settings for care.

In general, VMS is in support of the Proposed Rule as drafted. In particular, we thank VDH for your incorporation of many of VMS' comments submitted in the pre-filing drafting phase and support the current additions of: (1) written communication being shared with potential receiving transport and health care providers; (2) transfer plans including at least one facility with 24/7 obstetric care; and (3) the inclusion of additional high risk conditions consistent with Commission for the Accreditation of Birth Centers (CABC) criteria.

In more detail:

1. **VMS supports Sections 5.2.3.6, 5.2.3.7 and 6.2.6 as drafted, requiring that birth centers provide a written plan regarding transfer to a potential transport provider or receiving health care provider ahead of time,** so that the provider knows that they are a potential receiving provider. This written communication in advance of a transfer between the birthing center and other providers advances the fundamental goal of ensuring that the providers are aware of their roles and expectations and can facilitate timely communication and support when transfer is needed.

2. **VMS strongly supports the requirement contained in Sections 5.2.3.7 and 6.2.6.3 that transfer plans include a plan to transfer to a hospital that offers 24/7 obstetric services.** While depending on the circumstances, OB services may not be needed, the rule should require that transfer plans need to include at least one hospital with 24/7 obstetric services. Emergency department care alone is often not sufficient for a complex obstetric transfer.

3. **VMS supports section 6.2.4 as drafted, outlining the risk factors and risk criteria** that preclude a patient from receiving care from a birth center. As currently drafted, the rule is consistent with risk factors listed by CABC at Sec. 5.1.f.

In receiving additional comments during the rulemaking process, VMS' only additional suggestion is to support the comment by the Vermont Association of Hospitals and Health Systems that the plan for transfer to a hospital with 24/7 obstetric services also be shared with the EMS services serving the birthing center so they are aware who the birth center's preferred/pre-arranged health care partners are, as this may not always be consistent with where EMS would typically transport patients based on geography and medical need.

VMS Recommends:

5.2.3.7. A written plan for consultation with physicians and other health care providers, and for emergency transfer of an infant or a patient to an appropriate health care facility that includes a health care facility with 24/7 obstetric services and includes evidence of work to develop a collaborative relationship through meetings and drills. The written plan shall be shared with the health care facilities and EMS Services serving the Birthing Center.

Thank you for your work on Birth Center Licensure and for considering the feedback from the Vermont Medical Society. Please reach out with any questions or for additional information.

Commission for the Accreditation of Birth Centers
Supporting Standards & Inspiring Excellence through Learning

240 Independence Drive, Hamburg, PA 19526 · PH: 877-241-0262
www.birthcenteraccreditation.org

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Richard Thigpen, MD, FACOG

June 24, 2026

Meg McCarthy
Public Health Policy Advisor
Vermont Department of Health
280 State Drive
Waterbury, VT 05671

Dear Meg McCarthy,

The Commission for the Accreditation of Birth Centers (CABC) appreciates the opportunity to comment on the updated draft of Vermont's birth center rulemaking, as well as to participate in the ongoing meeting discussions.

We respectfully offer the following additional comments:

3.1. definition: "Birth center" means a facility the primary purposes of which are to provide midwifery care, low-risk deliveries, and newborn care immediately after delivery, for a stay of generally less than 24 hours. The term does not include:

3.1.1. A facility that is a hospital, is part of a hospital, or is owned by a hospital, although a birth center may be located on the grounds of a hospital.

CABC would like to note that birth centers may be owned by a hospital while remaining operationally distinct from acute care obstetrical services. Freestanding birth centers are defined by their model of care rather than ownership structure and may be located either on or off hospital grounds. Therefore, excluding facilities solely on the basis of hospital ownership may not accurately reflect current practice or the established definition of freestanding birth centers.

3.6. "Licensed maternity care provider" means a licensed provider whose professional scope of practice, as established under Vermont law, includes preconception, prenatal, labor, birth, and postpartum care and early care of a newborn and who may be the primary attendant during the perinatal period.

We appreciate the revisions made to this definition, particularly the clarification of scope of services. However, the current language remains somewhat unclear. To improve clarity, we recommend deleting the phrase beginning with "and who may be the primary attendant during the perinatal period." Removing this portion would help

ensure the definition more clearly includes nurses and other licensed providers whose scope of practice encompasses perinatal and newborn care.
Additionally, the definition of "licensed provider" in Section 3.8 appears to be limited to professionals whose scope of practice includes serving as the primary birth attendant, which may create inconsistency between the two definitions.

5.2.3. Applications for an initial license shall include:

5.2.3.4. All materials submitted by the birth center to the CABC as part of the accreditation process, including the accreditation application and self-evaluation report.

5.2.3.5. Documentation of a completed application for accreditation with the CABC.

This revision is an improvement; however, it does not fully address the situation in which a birth center obtains licensure but does not subsequently achieve CABC accreditation.

Section 5.4 indicates that CABC accreditation is required for license renewal. Because the license term is one year, this suggests that a birth center may be initially licensed without accreditation and may operate for up to one year prior to demonstrating accreditation. Under this structure, a birth center could continue operating during that period even if its accreditation application is ultimately denied.

If this is the intended approach, the regulations are sufficiently clear. If a different outcome is intended, additional clarification may be warranted regarding accreditation requirements during the initial licensure period.

5.2.3.6. A written plan for access to and use of emergency medical transport services that includes evidence of work to develop a collaborative relationship through meetings and drills. The written plan shall be shared with the emergency medical transport services.

CABC appreciates this revision. Replacing the requirement for a written EMS agreement with a written plan is a positive and practical improvement. We also strongly support the addition of language emphasizing collaboration through meetings and drills, as this better reflects how relationships with emergency medical transport services are developed and maintained in practice.

6.1. Accreditation

6.1.1. To obtain an initial license in Vermont, each birth center shall have submitted a complete application for CABC accreditation before applying for a license.

6.1.2. To renew and retain licensure, each birth center shall have current accreditation from the CABC.

As noted in our earlier comments, if the intent is to allow a birth center to operate under an initial license for up to one year without achieving CABC accreditation, this section is acceptable as written.
However, we recommend clarifying expectations in the event that accreditation is denied. CABC policy requires that a birth center wait one year before reapplying

following a denial of accreditation. As a result, a birth center that is denied accreditation would be unable to reapply within the initial licensure period, which may have implications for continued operation and licensure renewal.
Providing additional clarity on how such situations should be handled would strengthen this section.

6.2.3.9.1. Services offered and performed by the birth center are subject to these rules and statutes governing birth centers, regardless of whether the services are provided in a shared or adjacent space.

The intent of "services offered and performed by the birth center" is unclear. Additional clarification would be helpful regarding how this applies in shared or adjacent spaces.
For example, if an independent provider (such as a chiropractor) rents space within the birth center but operates a separate practice, it is our understanding that those services would not be subject to birth center regulations. We request confirmation that the rule applies only to services provided under the birth center's scope of operation, and not to independent providers who are not affiliated with or operating as part of the birth center.

6.2.4.1. Risk factors or risk criteria that preclude a patient from receiving services at a birth center include, but are not limited to:

6.2.4.1.1. More than one cesarean birth;
6.2.4.1.2. Classical uterine scar;

We recommend revising this language to state "any uterine scar other than a low transverse incision." While a classical uterine scar is appropriately included, there are other types of uterine incisions that also contraindicate a trial of labor after cesarean (TOLAC). This revision would provide a more comprehensive and clinically accurate standard.

6.2.4.1.3. BMI greater than defined limits;

The reference to "BMI greater than defined limits" is unclear, as BMI limits are not specified within this document. Clarification is needed regarding where these limits are established.

While CABC Indicators reference "defined limits," this term refers to limits set within the birth center's own policies and procedures, not standards established by CABC. CABC does not prescribe specific BMI thresholds. As written, this provision may create confusion without identifying the source of the defined limits.

6.2.4.1.10. Other risk factors or risk criteria contrary to those established by the birth center or the Department.

We recommend adding a reference to CABC in this provision. As written, the language refers only to criteria established by the birth center or the Department.

Including CABC would better align this section with nationally recognized accreditation standards and ensure consistency with established clinical and operational guidelines.

6.2.5.5. The birth center shall ensure at least one licensed maternity care provider is present at each labor and birth. A second person who is a licensed provider must be immediately available in the building at each labor and birth.

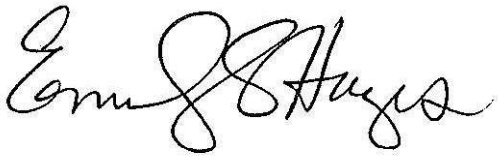
We continue to have significant concerns with this provision. Allowing the second provider to be "immediately available in the building" rather than physically present in the room is not consistent with CABC Indicators and does not reflect safe practice.

"Immediately available" does not provide the same level of readiness as having two qualified individuals present in the room during labor and birth. A provider located elsewhere in the building must still be notified and physically arrive, creating an inherent delay in response. In contrast, a second provider who is already present in the room is able to continuously assess the clinical situation, anticipate needs, and respond without delay.

For these reasons, we strongly recommend revising this requirement to reflect that two qualified individuals should be present for the birth to ensure client safety and alignment with established standards.

Thank you for your thoughtful consideration of our recommendations. We welcome any questions or further discussion.

Sincerely,



Emily Hayes, MHA, BSN, RNC-OB/EFM
Chair

The Commission for the Accreditation of Birth Centers

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Richard Thigpen, MD, FACOG

August 27, 2026

Meg McCarthy
Public Health Policy Advisor
Vermont Department of Health
280 State Drive
Waterbury, VT 05671

Dear Ms. McCarthy,
The Commission for the Accreditation of Birth Centers (CABC) appreciates the opportunity to comment on the current draft of Vermont's Birth Center Licensing Rule. We also appreciate the Department's willingness to engage stakeholders throughout the rulemaking process and its consideration of comments previously submitted by CABC. Several revisions made during the rulemaking process reflect meaningful improvements and greater alignment with nationally recognized birth center standards.

In particular, CABC appreciates the revisions replacing the requirement for formal emergency medical services agreements with a written plan for access to emergency transport services that includes evidence of collaboration through meetings and drills. We also appreciate the revisions made to the surgical services section clarifying that repair of tears and episiotomies may be performed as necessary within the provider's scope of practice. Additionally, the revised accreditation process appropriately recognizes that a birth center cannot achieve accreditation prior to opening and allows an accreditation application to serve as part of the initial licensure process.

While these changes represent important improvements, we respectfully offer the following recommendations for further consideration.

Definition of Birth Center (Section 3.1)

The rule continues to exclude facilities that are owned by a hospital from the definition of a birth center. CABC notes that freestanding birth centers are defined by their model of care, governance, and operational distinction from hospital obstetric units rather than by ownership alone. Nationally, some freestanding birth centers operate under hospital ownership while maintaining full compliance with AABC Standards and CABC accreditation requirements. We recommend reconsidering this exclusion or clarifying that ownership alone does not determine whether a facility qualifies as a birth center.

Licensed Maternity Care Provider Definition (Section 3.6)

We continue to believe the phrase "and who may be the primary attendant during the perinatal period" creates ambiguity regarding which licensed professionals may be included within this definition. Removing this language would improve clarity and better distinguish the definition of a licensed maternity care provider from the separate definition of licensed provider.

Accreditation and Licensure (Sections 5.4 and 6.1)

The current rule requires accreditation for license renewal but does not clearly address circumstances in which a birth center's accreditation application is denied during its initial year of operation. CABC policy requires a 1-year waiting period before a denied applicant may reapply to provide the birth center with ample time to correct all deficiencies and assure that CABC has enough data available to conduct an adequate site visit and evaluation. Additional clarification regarding licensure status following an accreditation denial would strengthen implementation of these provisions and avoid uncertainty for both regulators and birth centers.

Shared and Adjacent Services (Section 6.2.3.9.1)

The meaning of the phrase "services offered and performed by the birth center" remains unclear. We recommend clarifying that the rule applies to services provided under the birth center's operation and authority, and not to independent providers who may lease space within or adjacent to the facility while operating separate healthcare practices. Such clarification would help avoid confusion regarding regulatory oversight and scope of application.

Risk Criteria (Section 6.2.4)

We respectfully recommend several revisions to the risk criteria provisions.

First, Section 6.2.4.1.2 references only a classical uterine scar. We recommend revising this language to refer to "any uterine scar other than a prior low-transverse uterine incision" or similar language that more accurately reflects current clinical considerations regarding the appropriateness of a trial of labor after cesarean birth.

Second, Section 6.2.4.1.3 references a "BMI greater than defined limits," but the source of those limits is not identified. CABC does not establish a universal BMI threshold for accredited birth centers. Instead, birth centers establish eligibility criteria through their policies and procedures based on current evidence and community resources. Clarification regarding the origin of the limits referenced in the rule would improve consistency and enforceability.

Third, Section 6.2.4.1.10 permits additional risk criteria established by the birth center or the Department. Because the rule already incorporates CABC Indicators and requires compliance with CABC accreditation standards, we recommend adding a reference to CABC as an additional source of recognized risk criteria.

Staffing During Labor and Birth (Section 6.2.5.5)

This remains CABC's most significant concern.

The current draft requires that "one licensed maternity care provider is present at each labor and birth. A second person who is a licensed provider must be immediately available in the building at each labor and birth." We do not believe this standard provides the same degree of readiness and patient safety as requiring two qualified personnel to be physically present during the birth. A second individual who is elsewhere in the building must first be notified, travel to the birth room, and receive a report on the presenting complication and needed treatment before being able to provide assistance. All of this must occur as the person who attended the birth manages one or simultaneous emergencies alone, such as a newborn who is not breathing and/or a postpartum hemorrhage. In contrast, a second qualified individual already present at the bedside can continuously and directly participate in assessing maternal and newborn status, anticipate needed actions, and respond immediately in emergency situations.

We strongly recommend revising this section to require that two qualified individuals be physically present during every birth. Such a revision would align with nationally recognized birth center standards and the CABC Indicator requiring that two staff fully trained in NRP are present for every birth.

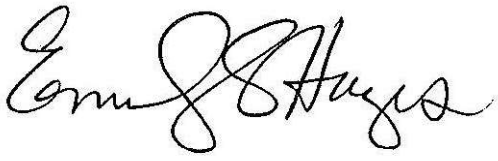
Emergency Medications and Neonatal Resuscitation

The pharmaceutical provisions appropriately require compliance with state and federal law but do not address the minimum emergency medications necessary for the provision of safe birth center care. We encourage the Department to consider clarifying expectations regarding emergency medications required for maternal and neonatal stabilization, including medications necessary to support neonatal resuscitation when indicated before arrival of emergency transport personnel.

Please note that the formulary for licensed midwives, as shown in Vermont's Administrative Rules for Midwives (table on page 25), does not address the requirement that birth center staff be able to manage neonatal resuscitation according to the current *American Heart Association and American Academy of Pediatrics Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care (https://www.aap.org/en/pedialink/neonatal-resuscitation-program/neonatal-resuscitation-guidelines/).* The Vermont Administrative Rules for Midwives allows epinephrine 1:1,000 for allergic reactions, the adult concentration. The formulary does not include the neonatal concentration of 1:10,000 used for neonatal resuscitation.

We also recommend consideration of language explicitly requiring that two staff who are fully trained in neonatal resuscitation are present at every birth. While the rule requires licensed providers to maintain neonatal resuscitation certification, greater specificity regarding staffing and response capabilities during births would strengthen alignment with nationally recognized standards.

Thank you for your thoughtful consideration of these recommendations and for your continued collaboration throughout this rulemaking process. We appreciate the significant progress reflected in the current draft and remain available to answer questions or provide additional information regarding national birth center standards and accreditation requirements.
Sincerely,



Emily Hayes, MHA, BSN, RNC-OB/EFM
Chair

Title 3 : Executive

Chapter 025 : Administrative Procedure

Subchapter 001 : GENERAL PROVISIONS

(Cite as: 3 V.S.A. § 801)

- **§ 801. Short title and definitions**

(a) This chapter may be cited as the "Vermont Administrative Procedure Act."

(b) As used in this chapter:

(1) "Agency" means a State board, commission, department, agency, or other entity or officer of State government, other than the Legislature, the courts, the Commander in Chief, and the Military Department, authorized by law to make rules or to determine contested cases.

(2) "Contested case" means a proceeding, including but not restricted to rate-making and licensing, in which the legal rights, duties, or privileges of a party are required by law to be determined by an agency after an opportunity for hearing.

(3) "License" includes the whole or part of any agency permit, certificate, approval, registration, charter, or similar form of permission required by law.

(4) "Licensing" includes the agency process respecting the grant, denial, renewal, revocation, suspension, annulment, withdrawal, or amendment of a license.

(5) "Party" means each person or agency named or admitted as a party, or properly seeking and entitled as of right to be admitted as a party.

(6) "Person" means any individual, partnership, corporation, association, governmental subdivision, or public or private organization of any character other than an agency.

(7) "Practice" means a substantive or procedural requirement of an agency, affecting one or more persons who are not employees of the agency, that is used by the agency in the discharge of its powers and duties. The term includes all such requirements, regardless of whether they are stated in writing.

(8) "Procedure" means a practice that has been adopted in writing, either at the election of the agency or as the result of a request under subsection 831(b) of this title. The term includes any practice of any agency that has been adopted in writing, whether or not labeled as a procedure, except for each of the following:

(A) a rule adopted under sections 836-844 of this title;

(B) a written document issued in a contested case that imposes substantive or procedural requirements on the parties to the case;

(C) a statement that concerns only:

(i) the internal management of an agency and does not affect private rights or procedures available to the public;

(ii) the internal management of facilities that are secured for the safety of the public and the individuals residing within them; or

(iii) guidance regarding the safety or security of the staff of an agency or its designated service providers or of individuals being provided services by the agency or such a provider;

(D) an intergovernmental or interagency memorandum, directive, or communication that does not affect private rights or procedures available to the public;

(E) an opinion of the Attorney General; or

(F) a statement that establishes criteria or guidelines to be used by the staff of an agency in performing audits, investigations, or inspections, in settling commercial disputes or negotiating commercial arrangements, or in the defense, prosecution, or settlement of cases, if disclosure of the criteria or guidelines would compromise an investigation or the health and safety of an employee or member of the public, enable law violators to avoid detection, facilitate disregard of requirements imposed by law, or give a clearly improper advantage to persons that are in an adverse position to the State.

(9) “Rule” means each agency statement of general applicability that implements, interprets, or prescribes law or policy and that has been adopted in the manner provided by sections 836-844 of this title.

(10) “Incorporation by reference” means the use of language in the text of a regulation that expressly refers to a document other than the regulation itself.

(11) “Adopting authority” means, for agencies that are attached to the Agencies of Administration, of Commerce and Community Development, of Natural Resources, of Human Services, and of Transportation, or any of their components, the secretaries of those agencies; for agencies attached to other departments or any of their components, the commissioners of those departments; and for other agencies, the chief officer of the agency. However, for the procedural rules of boards with quasi-judicial powers, for the Transportation Board, for the Vermont Veterans’ Memorial Cemetery Advisory Board, and for the Fish and Wildlife Board, the chair or executive secretary of the board shall be the

adopting authority. The Secretary of State shall be the adopting authority for the Office of Professional Regulation.

Title 18 : Health

Chapter 053 : Birth Center Licensing [Effective January 1, 2027 or on effective date of rules]

(Cite as: 18 V.S.A. § 2359)

- **§ 2359. Rules [Effective January 1, 2027 or on effective date of rules]**

The Department of Health shall adopt rules in accordance with 3 V.S.A. chapter 25 as needed to carry out the purposes of this chapter. The rules shall be based on the national birth center standards published by the American Association of Birth Centers and shall, at a minimum, include provisions regarding:

(1) requirements for operating a birth center, including requirements for safety, sanitation, and health;

(2) obtaining, storing, and dispensing pharmaceuticals consistent with State and federal laws;

(3) requirements for notice to the Department of Health when there is a change in ownership of a birth center and any additional licensing requirements related to a change in ownership;

(4) the scope of services that may be provided at a birth center, including risk factors that preclude a patient from receiving labor and delivery services at a birth center;

(5) appropriate staffing for a birth center, including the types of licensed providers who may practice at a birth center;

(6) birth center complaint processes;

(7) birth center facility, equipment, and supply requirements, including requirements for the maintenance of safety, sanitation, and health;

(8) record retention and confidentiality;

(9) quality assurance and improvement;

(10) processes for the development, submission, approval, and implementation of corrective action plans;

(11) a requirement for written practice guidelines and policies that include procedures for transferring a patient to a hospital if circumstances warrant; and

(12)(A) requirements for written policies and procedures for collaboration with hospitals, other agencies and facilities, and individuals to provide services to patients as appropriate, including:

(i) laboratory and diagnostic services;

(ii) childbirth education and parenting education support services;

(iii) obstetric consultation services;

(iv) pediatric consultation services;

(v) transport services;

(vi) obstetric and newborn acute care in licensed hospitals; and

(vii) home health care services;

(B) a requirement that the policies and procedures established pursuant to subdivision (A) of this subdivision (12) are provided to the relevant service providers upon request; and

(C) a requirement that the birth center provide the health record of the patient or the newborn, or both, to the receiving service provider upon referral or transfer, in accordance with applicable privacy laws. (Added 2025, No. 19, § 1.)

OFFICE OF THE SECRETARY OF STATE

VERMONT STATE ARCHIVES & RECORDS ADMINISTRATION (VSARA)

(802) 828-2863

TO:	Seven Days Legals (legals@sevendaysvt.com)	Tel: (802) 865-1020 x110.
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	Times Argus / Rutland Herald Classified Ads (classified.ads@rutlandherald.com)	Tel: 802-747-6121 ext 2238 FAX: 802-776-5600
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	News & Citizen (mike@stowereporter.com)	Tel: 888-2212 FAX: 888-2173
	St. Albans Messenger Legals (legals@samessenger.com; cfoley@orourkemediagroup.com)	Tel: 524-9771 ext. 117 FAX: 527-1948 Attn: Legals
	The Islander (islander@vermontislander.com)	Tel: 802-372-5600 FAX: 802-372-3025
	Vermont Lawyer (hunter.press.vermont@gmail.com)	Attn: Will Hunter
	VT Digger (legals@vtdigger.org)	Attn: Legals

FROM: APA Coordinator, VSARA **Date of Fax:** August 3, 2026

RE: The "Proposed State Rules " ad copy to run on **August 13, 2026**

PAGES INCLUDING THIS COVER MEMO: **3**

NOTE **8-pt font in body. 12-pt font max. for headings - single space body. Please include dashed lines where they appear in ad copy. Otherwise minimize the use of white space. Exceptions require written approval.**

If you have questions, or if the printing schedule of your paper is disrupted by holiday etc. please contact VSARA at 802-828-3700, or E-Mail sos.statutoryfilings@vermont.gov, Thanks.

PROPOSED STATE RULES

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By law, public notice of proposed rules must be given by publication in newspapers of record. The purpose of these notices is to give the public a chance to respond to the proposals. The public notices for administrative rules are now also available online at https://secure.vermont.gov/SOS/rules/ . The law requires an agency to hold a public hearing on a proposed rule, if requested to do so in writing by 25 persons or an association having at least 25 members.

To make special arrangements for individuals with disabilities or special needs please call or write the contact person listed below as soon as possible.

To obtain further information concerning any scheduled hearing(s), obtain copies of proposed rule(s) or submit comments regarding proposed rule(s), please call or write the contact person listed below. You may also submit comments in writing to the Legislative Committee on Administrative Rules, State House, Montpelier, Vermont 05602 (802-828-2231).

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14 050 022 Inspection of Motor Vehicles.

Vermont Proposed Rule: 26-E02

AGENCY: Agency of Transportation, Department of Motor Vehicles

CONCISE SUMMARY: The Department is updating the requirements for annual motor vehicle inspections to remove failure reasons that are not directly related to motor vehicle safety. Items being removed include: all references to on-road testing; tire cuts, snags, or weather cracks; broken power steering belts; loss of shock absorber function; rust on brakes; headlamp aiming; ABS or airbag failure lights; horn, speedometer, and odometer malfunction; cracks or star breaks on windshield; power window malfunction; damaged windshield wiper blades; and modification to exhaust system causing an unreasonable sound level.

FOR FURTHER INFORMATION, CONTACT: Ben Shelp, Chief Inspector, Agency of Transportation, Department of Motor Vehicles, 120 State St Montpelier, VT 05602 Tel: 802-828-4647 Fax: 802-828-5418 E-Mail: Benjamin.Shelp@Vermont.gov URL: https://dmv.vermont.gov/about-vermont-dmv/administrative-rules.

FOR COPIES: Isaac Luce, Agency of Transportation, Department of Motor Vehicles, 120 State St Montpelier, VT 05602 Tel: 802-522-8924 Fax: 802-828-5418 E-Mail: Isaac.Luce@Vermont.gov.

Prohibited Data and Design Practices.

Vermont Proposed Rule: 26P027

AGENCY: Attorney General's Office

CONCISE SUMMARY: This Rule implements 9 V.S.A. § 2449f of Act 63 of 2025, Vermont's Age-Appropriate Design Code Act. It establishes standards for data processing and design practices that apply to covered businesses serving covered minors. The Rule explains which practices are prohibited, defines key terms, provides examples, and helps covered businesses understand how to comply with the law. It is intended to protect covered minors while giving covered businesses clear, flexible guidance for meeting their obligations under Vermont law.

FOR FURTHER INFORMATION, CONTACT: Sarah Aceves, Office of the Attorney General, 109 State Street, Montpelier VT 05609 Tel: 802-828-3170 Fax: 802-828-2154 E-Mail: sarah.aceves@vermont.gov URL: https://ago.vermont.gov/vermont-age-appropriate-design-code-rulemaking.

FOR COPIES: Todd Daloz, Office of the Attorney General, 109 State Street, Montpelier VT 05609 Tel: 802-585-5964 Fax: 802-828-2154 E-Mail: todd.daloz@vermont.gov.

Age Assurance Privacy.

Vermont Proposed Rule: 26P028

AGENCY: Attorney General's Office

CONCISE SUMMARY: This Rule implements 9 V.S.A. § 2449g of the Vermont Age-Appropriate Design Code Act. It establishes standards for how covered businesses determine whether a user is a covered minor while protecting privacy and minimizing unnecessary collection and use of personal data. The Rule provides requirements for selecting and using age assurance methods, protecting age assurance data, ensuring accuracy, providing fallback options and appeals, and documenting compliance. The Rule uses a flexible, technology-neutral approach that requires covered businesses to use the least intrusive age assurance method reasonably available that achieves the level of confidence necessary under the circumstances.

FOR FURTHER INFORMATION, CONTACT: Sarah Aceves, Office of the Attorney General, 109 State Street, Montpelier VT 05609 Tel: 802-828-3170 Fax: 802-828-2154 E-Mail: sarah.aceves@vermont.gov URL: https://ago.vermont.gov/vermont-age-appropriate-design-code-rulemaking.

FOR COPIES: Todd Daloz, Office of the Attorney General, 109 State Street, Montpelier VT 05609 Tel: 802-585-5964 Fax: 802-828-2154 E-Mail: todd.daloz@vermont.gov.

Birth Center Licensing Rule.

Vermont Proposed Rule: 26P029

AGENCY: Agency of Human Services, Department of Health

CONCISE SUMMARY: This rule sets forth the standards that apply to the licensing of birth centers in Vermont. This rulemaking establishes the process by which a birth center can apply for a license in Vermont.

FOR FURTHER INFORMATION, CONTACT: Meg McCarthy, Policy Advisor, Agency of Human Services - Vermont Dept. of Health, 280 State Drive Waterbury, VT 05671 Tel: 802-904-9319 E-mail: ahs.vdhrules@vermont.gov

URL: http://www.healthvermont.gov/laws-regulations/laws/rules-public-comment. FOR COPIES: Jessica Schifano, Policy Director, Agency of Human Services - Vermont Department of Health 280 State Drive, Waterbury, VT 05671 Tel: 802-798-6756 E-mail: ahs.vdhrules@vermont.gov.

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(802) 828-2863

MEMORANDUM OFFICE OF THE SECRETARY OF STATE

Primary Contact: Meg McCarthy, Policy Advisor, Agency of Human Services - Vermont Dept. of Health, 280 State Drive Waterbury, VT 05671 Tel: 802-904-9319 E-mail: ahs.vdhrules@vermont.gov

Secondary Contact: Jessica Schifano, Policy Director, Agency of Human Services - Vermont Department of Health 280 State Drive, Waterbury, VT 05671 Tel: 802-798-6756 E-mail: ahs.vdhrules@vermont.gov.

URL: www.healthvermont.gov/laws-regulations/laws/rules-public-comment

From: APA Coordinator, VSARA

RE: Birth Center Licensing Rule.

Date 07/31/2026

We received Proposed Rule on 07/31/2026
Final Proposed Rule on
Adopted Rule on
We have assigned the following rule number(s):
Proposed Rule Number: 26P029
Adopted Rule Number:
(Final Proposals are not assigned a new number; they retain the Proposed Rule Number.)

The following problems were taken care of by phone/should be taken care of immediately: Proposed Filing: SOS staff amended the statutory authority on the forms to include 3 V.S.A. § 801(b)(11) which designates the Secretary (aka chief officer of the agency) as the adopting authority for the Agency of Human Services.

We cannot accept this filing until the following problems are taken care of:

The notice for this proposed rule appeared/will appear online on: 8/5/2026 and in the newspapers of record on 8/13/2026.

This rule takes effect on
Adoption Deadline: 03/31/2027

Please note:

If you have any questions, please call me at 828-2863. OR
E-Mail me at: sos.statutoryfilings@vermont.gov

cc: Megan Cannella