National Rural Health Association

August 25, 2025

The Honorable Charles E. Grassley
United States Senate
135 Hart Senate Office Building
Washington, DC 20510

The Honorable Maggie Hassan
United States Senate
324 Hart Senate Office Building
Washington, DC 20510

Re: Request for Information – Healthy Moms and Babies Act

Dear Senators Grassley and Hassan,

The National Rural Health Association (NRHA) appreciates the opportunity to provide feedback on the discussion of incorporating a low-volume adjustment for a rural health home model for pregnant and postpartum women within the Healthy Moms and Babies Act. We appreciate the Senators' commitments to improving access to maternal health in rural communities. This legislation will combat the unique challenges rural communities face in maintaining access to obstetrics care: it will help support rural obstetrics delivery units, improve efforts for high-quality coordinated care, and take steps to reduce maternal mortality rates.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Obstetrics care access is in decline throughout the United States, this is especially apparent in rural areas. Rural communities often face unique challenges in terms of maternal healthcare access, including difficulty in recruiting and retaining maternal healthcare workers and in maintaining and sustaining maternal healthcare infrastructure to keep obstetric services open. From 2010 to 2022, about 238 rural hospitals closed their obstetrics units, dropping the share of rural hospitals offering obstetrics care from 57% to 48%.[1]

Low-volume payment adjustment for OB services
NRHA supports special payment designations to fund rural hospitals through Medicare. There is evidence that expanding this model to be applicable for low-volume hospitals would help maintain OB units in rural areas.

[1] Hulver S, Levinson Z, Godwin J, Neuman T. 10 Things to Know About Rural Hospitals. KFF. Published April 16, 2025. Accessed December 22, 2025. https://www.kff.org/health-costs/10-things-to-know-about-rural-hospitals/

RuralHealth.US
50 F. St., N.W., Suite 520
Washington, DC 20001 | 202-639-0550

There is a known correlation of risk in severe maternal morbidity being elevated for obstetric patients who give birth in lower-volume rural hospitals.[2] Rural hospitals with lower birth volume (< 240 births per year) are more likely to have family physicians and general surgeons attending deliveries, while those with a higher birth volume more frequently have obstetricians and midwives attending deliveries.[3] Studies show that rural hospitals need to perform at least 200 births a year to maintain patient safety and financial viability. A study in 2021 demonstrated that about 42% of rural hospitals with obstetric care did not have enough deliveries for their units to be profitable.[4] As a result, many of these OB units in rural hospitals are forced to close.

Rural areas often heavily rely on Medicaid to cover obstetric services and thus, Medicaid reimbursement rates often are essential for helping rural obstetrics units stay open.[5] Within the United States, 23.3% of women of childbearing age in rural areas are covered by Medicaid with the program covering almost half (27%) of births in rural areas.[6] The GAO suggests that increasing Medicaid reimbursement would help to keep obstetric services open. Many rural hospitals deal with low-volume birth rates and as a result, cannot keep up with fixed costs to keep OB units open. To combat this, it is suggested that a low-volume hospital payment adjustment for rural hospitals can maintain access to labor and delivery services.

A model currently being used for low-volume hospitals in rural areas provides hospitals with a payment adjustment on a sliding scale based on volumes so that they can stay afloat even with low discharge numbers. Many low-volume hospitals receive up to 25% higher payments through the Inpatient Prospective Payment System (IPPS).[7] Currently, the IPPS for FY 2026 and onward classifies a low-volume hospital as a hospital more than 25 road miles from another subsection and having less than 200 discharges (that is, less than 200 discharges total, including both

---

[2] Kozhimannil KB, Leonard SA, Handley SC, Passarella M, Main EK, Lorch SA, Phibbs CS. Obstetric volume and severe maternal morbidity among low-risk and higher-risk patients giving birth at rural and urban US hospitals. *JAMA Health Forum.* 2023;4(6):e232110. doi:10.1001/jamahealthforum.2023.2110

[3] Kozhimannil KB, Casey MM, Hung P, Han X, Prasad S, Moscovice IS. The rural obstetric workforce in US hospitals: Challenges and opportunities. *J Rural Health.* 2015;31(4):365-372. doi:10.1111/jrh.12112

[4] Adams EK, Markowitz S. Reducing maternal morbidity and mortality: addressing disparities and building resilience. JAMA Health Forum. 2022;3(3):e220698. doi:10.1001/jamahealthforum.2022.0698.

[5] U.S. Government Accountability Office. Maternal Health: Availability of Hospital-Based Obstetric Care in Rural Areas. GAO-23-105515. Published October 19, 2022. Accessed December 22, 2025. https://www.gao.gov/products/gao-23-105515

[6] Alker J, Osorio A. Medicaid Plays a Key Role for Maternal and Infant Health in Rural Communities. Georgetown University Center for Children and Families; 2025. Published May 15, 2025. Accessed December 22, 2025. https://ccf.georgetown.edu/2025/05/15/medicaid-plays-a-key-role-for-maternal-and-infant-health-in-rural-communities/

[7] Hulver S, Levinson Z, Godwin J, Neuman T. 10 Things to Know About Rural Hospitals. KFF; 2025. Published April 16, 2025. Accessed December 22, 2025. https://www.kff.org/health-costs/10-things-to-know-about-rural-hospitals/

Medicare and non-Medicare discharges) during the fiscal year. These low-volume hospitals with less than 200 total discharges receive a payment adjustment of an additional 25 percent.[8]

To translate this low-volume hospital payment adjustment to be applicable to obstetrics care, there would need to be a classification of low-volume birthing hospitals. This could include criteria such as hospitals that are more than 25 road miles from another like-hospital and have less than 240 births during the fiscal year. Additionally, to mirror the IPPS low-volume adjustment rule, low-volume birthing hospitals with less than 240 births would also receive a payment adjustment of an additional 25 percent. This would allow OB units in rural areas that have low birth volumes to still be compensated through enhanced payments and continue operations.

Health Home Model for pregnant and postpartum women

Many states have piloted health home programs to support pregnant and postpartum women. A maternal health home model strives to provide financial incentives for providers to better coordinate and improve quality of care through the perinatal period.[9] Although there are many variations of these models, all are a collaborative network of coordinated care to address pregnant and postpartum women's needs as a whole person. These models strive to advocate to improve the quality of care a patient receives and health outcomes for both mother and infant.[10] This includes providing mothers with primary and inpatient care, behavioral health care, social support services, care management and planning for health coverage changes, and even early newborn intervention care.[11] There have been studies that have shown success in these models[12]

---

[8] Centers for Medicare & Medicaid Services; Office of the National Coordinator for Health Information Technology. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Changes to the FY 2025 IPPS Rates Due to Court Decision; Requirements for Quality Programs; and Other Policy Changes. *Federal Register.* 2025;90(150):36536-36950. Published August 4, 2025. https://www.federalregister.gov/documents/2025/08/04/2025-14681/

[9] Ranji U, Salganicoff A, Gomez I. Maternal Health in the Build Back Better Act. KFF; 2021. Published December 16, 2021. Accessed December 22, 2025. https://www.kff.org/womens-health-policy/maternal-health-in-the-build-back-better-act/

[10] Schilling LM, Fraumeni BR, Nacht AS, et al. Improving maternal health care quality and outcomes: evaluation of a pregnancy medical home. Am J Med Qual. 2024;39(3):123 130. doi:10.1097/01.JMQ.0000000000000000

[11] Clark M, Burak EW. *Maternal Health Home Option in Build Back Better Plan Lays Groundwork for Two-Generation Success.* Georgetown University Center for Children and Families; 2021. Published November 12, 2021. Accessed December 22, 2025. https://ccf.georgetown.edu/2021/11/12/maternal-health-home-option-in-build-back-better-plan-lays-groundwork-for-two-generation-success/

[12] Zephyrin LC, Seervai S, Lewis C, Katon JG. Community-based models to improve maternal health outcomes and promote health equity. *Commonwealth Fund.* Published March 4, 2021. Accessed December 22, 2025. https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity

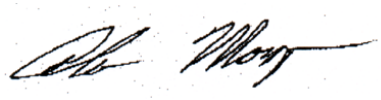
National Rural Health Association

and that they effectively reduced healthcare utilization and cost for participating pregnant members.[13]

NRHA supports programs that encourage "whole-person" centered care for rural obstetrics during pregnancy and postpartum including grants that pilot programs for health care models to coordinated care and encourage rural hospitals and community providers to utilize integrated care to treat the whole birthing person and infant.

NRHA strongly endorses the introduction of the Healthy Moms and Babies Act. NRHA thanks Senators Grassley and Hassan for their efforts on this important legislation and for the opportunity to submit public comments. For any additional information, please contact NRHA's Chief Policy Officer, Carrie Cochran-McClain (ccochran@ruralhealth.us). We look forward to working with the Senators on this legislation and seeing rural maternal health reform move forward, ensuring all rural residents have access to necessary care.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

[13] You WB, Wolf M, Bailey SC, et al. Factors associated with patient understanding of preeclampsia. *Am J Obstet Gynecol.* 2016;214(4):535.e1-535.e7. doi:10.1016/j.ajog.2015.12.050.

RuralHealth.US
50 F. St., N.W., Suite 520
Washington, DC 20001 | 202-639-0550