American Hospital Association™
Advancing Health in America

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August 26, 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

Submitted Electronically

RE: Healthy Moms and Babies Act — Request for Information

Dear Senators Grassley and Hassan:

On behalf of the American Hospital Association's (AHA's) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 90 that offer health plans; our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, we thank you for the opportunity to respond to the request for information (RFI) on a low-volume payment adjustment for home health models for pregnant and postpartum women.

The AHA supports your interest in the health of pregnant women and babies, and the challenges they face in accessing care. Many of our members are trying unique approaches to ensure access to care and improve health outcomes for mothers and babies. As a part of our Better Health for Mothers and Babies initiative, the AHA has worked to safeguard mothers and babies in many ways, including participating in national partnerships, advocating for legislative and policy solutions, and raising awareness of best practices from within the hospital field to reduce maternal mortality and morbidity. The AHA promotes these best practices through case studies, webinars and podcasts, and maternal health will continue to be a high priority for the AHA.

Rural hospitals continue to face significant financial, workforce and other challenges. The cost of providing care in rural areas has skyrocketed, outpacing revenue growth and rate increases from Medicare, Medicaid and other payors. Patient volume has declined, and hospitals and health systems have navigated challenging staffing shortages. Hospitals and health systems explore strategies that allow them to remain viable within a community, while striving to provide high-quality care for their patients.

Amidst these pressures, many rural hospitals have closed obstetric units over the last decade. According to one study, twelve states saw at least 25% of rural hospitals close their obstetric units between 2010 and 2022.[1] A 2022 GAO study estimated that half of all rural counties lack obstetric units.[2] Hospitals, policymakers and other stakeholders have expressed concern that reduced access can create hardships for patients and their families, including potentially negative implications for maternal health outcomes.

The decision to reduce labor and delivery services is complex and one not taken lightly. Hospitals and health systems report that these decisions are largely driven by three factors: staffing challenges, declining patient volume and inadequate reimbursement.

Rural hospitals struggle to recruit and retain physicians, nurses and other appropriately trained caregivers to support labor and delivery services and, therefore, may determine they cannot safely provide these services for mothers and babies. Declining patient volume, financial pressures and lifestyle preferences contribute to these staffing challenges.

Rural hospitals also have lower patient volumes, which affects their ability to provide certain services. Lower volumes also make it difficult to attract and retain clinical staff and provide enough services for them to maintain skills and competence. In addition, the demographics of some rural areas may make it difficult to justify full-time maternity care. For example, only approximately one in five women of reproductive age live in rural areas.

Reimbursement for labor and delivery has not kept pace with the rising cost of providing these services. Payment rates from corporate commercial plans and Medicaid programs have not risen along with the cost of providing care. As a result, hospitals experienced negative margins (-18% on average across all payers) for labor and delivery services in 2023.[3]

Some states have piloted health home programs for pregnant women, and early evaluations indicate that such programs have promising potential to improve maternal health outcomes. While models vary, they generally connect participants with a multidisciplinary team of providers and advocates, screen for health and other risk factors and provide care accordingly. Some models have used telehealth to provide ongoing monitoring and care and support when needed. These features allow health homes to provide medical care and social support throughout a pregnancy and during the postpartum period. According to one study, women who participated in a pregnancy medical home experienced significantly fewer emergency department visits, and the

[1] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.01552
[2] U.S. Government Accountability Office, “Maternal Health: Availability of Hospital-Based Obstetric Care in Rural Areas.” https://www.gao.gov/products/gao-23-105515
[3] AHA analysis of data from Strata Decision Technology.

number of inpatient days was significantly reduced, compared to pregnant women who did not participate.[4] In a separate study, pregnancy medical home participants experienced statistically-significant higher rates of vaginal delivery and lower rates of cesarean delivery.[5] Pregnancy medical home pilots are often funded by a variety of sources, including public and private grant funding and health care service reimbursement.

A low-volume adjustment could provide additional support for rural hospitals and health systems. For example, the Medicare inpatient prospective payment system (PPS) includes a low-volume adjustment. It has existed since 2005, but Congress enacted an enhanced version beginning in 2011 in recognition of the critical challenges faced by small, rural hospitals.

The inpatient PPS low-volume adjustment recognizes that certain factors beyond providers' control, including patient volume, affect the costs of furnishing services. This is particularly relevant in small and isolated communities where providers frequently cannot achieve economies of scale like larger hospitals. The adjustment has resulted in a more level playing field for small, rural hospitals. This, in turn, has protected their financial viability and improved access to care in rural areas by ensuring that providers can continue to serve their patients and communities.

In addition to the ideas detailed above, the AHA encourages Congress to consider other legislative initiatives to assist hospitals in rural areas in their continued efforts to provide access to maternal health services. These include stand-by capacity payments to help support obstetrical and other support staff (i.e., sonographers) and maintain equipment, add-on payments for each birth, and assistance with medical malpractice insurance or tort protection similar to that provided to federally qualified health centers. We would welcome the opportunity to discuss these and other ideas.

With nearly four million babies born each year in the U.S., hospitals and health care systems play a key role in improving maternal and infant outcomes. AHA members have experienced both challenges and successes in reaching this goal. The AHA supports efforts to allow states to create maternity health homes and ensure that these are adequately funded.

Thank you for your consideration, and we look forward to working with you to improve maternal health outcomes. Please contact me if you have questions, or feel free to have a member of your team contact Megan Cundari, AHA's senior director of federal relations, at mcundari@aha.org.

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[4] https://www.ajog.org/article/S0002-9378(16)31919-6/fulltext
[5] https://medschool.cuanschutz.edu/docs/librariesprovider81/default-document-library/improving-maternal-health-birth-outcomes-an-evaluation-of-the-pregnancy-medical-home-developed-by-cusom-obgyn.pdf

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President
Advocacy and Political Affairs