United States Senate
WASHINGTON, DC 20510

April 21, 2026

The Honorable Shelley Moore Capito
Chair
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Committee on Appropriations
United States Senate
Washington, D.C. 20510

The Honorable Tammy Baldwin
Ranking Member
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Committee on Appropriations
United States Senate
Washington, D.C. 20510

Dear Chair Capito and Ranking Member Baldwin:

We thank you for investing in maternal health in Fiscal Year (FY) 2026 by enacting provisions of the *Maternal Health Quality Improvement Act* and the *Rural Maternal and Obstetric Modernization of Services (Rural MOMS) Act*, authorized in FY 2022 (P.L. 117-103). As the Subcommittee considers the FY 2027 Labor, Health and Human Services, Education, and Related Agencies appropriations bill, **we respectfully request that you fully fund these authorized programs to ensure these initiatives can fulfill their goal of improving maternal health outcomes, especially for Black, Latina, and Indigenous individuals, and those living in rural areas.**

Addressing maternal mortality and morbidity must continue to be a priority. According to the Centers for Disease Control and Prevention (CDC), approximately 700 women die each year from pregnancy-related complications, and the rate of maternal deaths remains high. From 2018 to 2021, the number of pregnancy-related deaths nearly doubled. Three years after that alarming increase, the 2024 rate of 17.9 deaths per 100,000 live births remains higher than the pre-COVID 2018 rate of 17.4 per 100,000 live births. While any reduction in maternal deaths is encouraging, it is important to note that that progress has stalled: the decrease from 2023 to 2024 is not statistically significant. Additionally, maternal mortality review committees (MMRCs) found that 87 percent of pregnancy-related deaths in the United States are preventable.[1] The maternal mortality rate among Black people is more than three times higher than that of white people, and the maternal mortality rate among American Indian and Alaska Native (Indigenous) people is more than two times that of white people.[2,3]

[1] *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees*, Centers for Disease Control and Prevention (Aug. 2025), https://www.cdc.gov/maternal-mortality/php/data-research/mmrc/index.html.
[2] *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths,* Centers for Disease Control and Prevention (Sept. 2019), https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html.
[3] Marian MacDorman, Marie Thoma, Eugene Declcerq, and Elizabeth Howell, *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records,* American Journal of Public Health (Sep. 2021), https://ajph.aphapublications.org/doi/10.2105/AJPH.2021.306375.

Further, more than 2.3 million women of childbearing age live in "maternity care deserts," defined as counties with no hospitals offering obstetric care, no birth centers and no other obstetric providers.[4] Black, Latina, and Indigenous individuals and women living in rural areas are more likely to die due to pregnancy-related causes than their white and urban-dwelling peers. To help address disparities in maternal health outcomes and improve maternal health across the country, investing in programs authorized by the *Maternal Health Quality Improvement Act* and the *Rural MOMS Act* in FY 2027 is critical.

Alliance for Innovation on Maternal Health (AIM) Program. The implementation of patient safety bundles and evidence-informed best practices has been shown to reduce preventable maternal deaths, improve maternal outcomes, and close the gap in inequitable care. The AIM program has bundles on a range of important maternal safety topics, including obstetric hemorrhage, severe hypertension in pregnancy, safe reduction of primary cesarean birth, cardiac conditions in obstetrical care, maternal mental health, sepsis in obstetrical care, and care for pregnant and postpartum people with substance use disorder, as well as an obstetric emergency readiness resource kit. These bundles were designed to reduce maternal mortality and severe maternal morbidity by engaging multidisciplinary health care clinicians, public health professionals, and cross-sector stakeholders committed to improving maternal outcomes in the United States.

Ongoing work of AIM includes incorporating concepts and practices of respectful, equitable, and supportive patient care in all bundles, to support the reduction of peripartum racial and ethnic disparities.[5] The AIM program also continues to provide technical assistance and support capacity building for any state, jurisdiction, and entity implementing the AIM program, including community health centers and Indian Health Service, and tribal health care facilities. We urge the Subcommittee to support the funding level of $17.3 million for the AIM program to further support the goals of the AIM program, address maternity care deserts, improve patient outcomes, and reduce maternal mortality and severe maternal morbidity.

Training for Health Care Providers. Black women bear a disproportionate burden of maternal mortality and morbidity rates in the U.S., a burden that spans income and education levels. Research shows implicit racial bias plays a role in these stark disparities.[6] Training health care professionals to recognize and remedy biases improves care and reduces inequities in maternal health outcomes. For FY 2027, we urge the

[4] *Nowhere to Go: Maternity Care Deserts Across the US*. (Report No 4), March of Dimes (2024), https://www.marchofdimes.org/maternity-care-deserts-report.
[5] *Patient Safety Bundles*, Alliance for Innovation on Maternal Health, https://saferbirth.org/patient-safety-bundles/.
[6] Keisha Montalmant and Anna Ettinger, *The Racial Disparities in Maternal Mortality and Impact of Structural Racism and Implicit Racial Bias on Pregnant Black Women: A Review of the Literature*, Journal of Racial and Ethnic Health Disparities (2023), https://doi.org/10.1007/s40615-023-01816-x.

Subcommittee to allocate $5 million to support grants for the training of health care professionals to improve the provision of racial and ethnic minority populations.

Integrated Services for Pregnant and Postpartum Women. Social determinants of health are key factors in caring for obstetric patients. Individuals with unmet social needs, such as housing, food access, and transportation, are more likely to have negative health outcomes.[7] Patient-centered, integrated health services models can connect obstetric patients to needed social services and supports as well as ensure coordination among clinical care service providers, including providers of mental health and substance use disorder services. We encourage you to provide $10 million in FY 2027, consistent with the enacted FY 2026, to foster the development, demonstration, and evaluation of models of care to improve maternal health outcomes in the United States by increasing access to quality, equitable, comprehensive care for pregnant and postpartum people who experience health disparities and have limited access to basic social and health care services.

Rural Obstetric Network Grants. Pregnant individuals residing in rural areas experience maternal mortality rates of up to almost twice the rate of individuals in urban areas.[8] The inequity is especially concerning given the decline of obstetric care facilities in these rural areas, which are expected to experience even more declines in access to care in the coming decade. To address the unique needs of pregnant and postpartum people living in rural areas, the Subcommittee should fund the rural obstetric network grant program (also known as Rural Maternity and Obstetrics Management Strategies or RMOMS) at the enacted FY 2026 level of $15 million. These grants will help identify and implement innovative strategies to improve maternity care, access to care, and collaboration between health care settings in rural areas, frontier areas, maternity care health professional target areas, or tribal entities.

Rural Maternal and Obstetric Care Training Demonstration Program. To address the growing shortage of obstetric health care professionals serving rural areas, we urge the Subcommittee to support the allocation of $5 million in FY 2027, consistent with the FY 2022 authorized funding level, to facilitate a new demonstration program aimed at increasing the number of rural-based clinicians able to provide prenatal, labor and delivery, and postpartum care, with a special emphasis on health conditions and social determinants of health affecting the rural population. Investing in the Rural Maternal and

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[7] *Importance of social determinants of health and cultural awareness in the delivery of reproductive health care,* ACOG Committee Opinion No. 729, American College of Obstetricians and Gynecologists (Jan. 2018), https://pubmed.ncbi.nlm.nih.gov/29266079/.

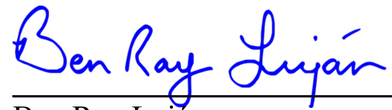
[8] Katharine Harrington, Natalie Cameron, Kasen Culler, William Grobman, Sadiya Khan, *Rural–Urban Disparities in Adverse Maternal Outcomes in the United States*, American Journal of Public Health (Feb. 2013), https://pubmed.ncbi.nlm.nih.gov/36652639/.

Obstetric Care Training Demonstration Program will strengthen the effort to address this urgent need.

The programs outlined above are foundational to improving maternity care for populations disproportionately impacted by maternal mortality and morbidity. We urge you to continue to invest in these critical programs and include the programs authorized within the *Maternal Health Quality Improvement Act* and the *Rural MOMS Act* in the FY 2027 appropriations bill. Thank you for considering this request and for your work to address the nation's maternal health crisis.

Sincerely,

Raphael Warnock
United States Senator



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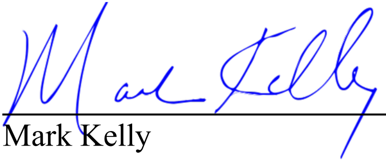

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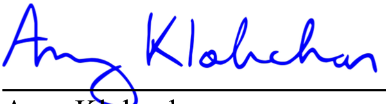

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