July 20, 2026

Vermont Agency of Human Services
280 State Drive - Center Building
Waterbury, VT, 05676

Dear Governor Phil Scott, Secretary Jenney Samuelson, Commissioner DeShawn Groves, Director Jill Mazza Olson, and Director Julio Cespedes,

As another Vermont hospital considers closing its birthing center because of financial distress, **we urge the administration to increase funding for obstetric care statewide by aligning Medicaid reimbursement rates with what Vermont already pays for other primary care services**.

In Windham County, more than 45% of births are covered by Medicaid, higher than the state average.[1] Most families in the county choose to get obstetric care at Brattleboro Memorial Hospital, where leaders have reported nearly $4 million in annual losses on labor and delivery services. These deficits exist because reimbursement does not cover the true cost of obstetric care: the hospital collects less than 50 cents for every dollar billed.[2]

Policy Solutions

Increasing Medicaid rates for prenatal, labor and delivery, and postpartum services would make a meaningful difference to support obstetric care throughout Vermont and ensure that hospital-level care can be financially viable. While some obstetrical services are already classified as primary care under Medicaid's enhanced primary care professional fee schedule, labor and delivery services are not included in the enhanced primary care rates[3] (see billing codes below).

The Department of Vermont Health Access has the authority to increase reimbursement for these services immediately and the backing of state and federal lawmakers[4] to more sustainably reimburse providers for labor and delivery services.

[1] The Annie E. Casey Foundation, Kids Count Data Center
[2] BMH collection rate per dollar billed for OB/GYN care: 42.8 cents, Save Birth at BMH
[3] As of July 1, 2026, Medicaid reimbursement for primary care services is 122% of Medicare rates. Specialty care, including obstetric services, is paid at 85% of Medicare rates, on average.
[4] Windham County Delegation Statement on BMH Birthing Center; Becca Balint statement on possible closure of birthing center at Brattleboro Memorial Hospital

Federal lawmakers have proposed additional policy measures to address the financial challenges rural hospitals face in providing obstetrical care, including the Keep Obstetrics Local Act.[5] In addition to increasing Medicaid payment rates for targeted obstetric services, this legislation would:

- Provide "standby" payments to cover a portion of the fixed costs of staffing and maintaining an obstetric unit.
- Adjust payments for labor and delivery services at hospitals with low birth volumes.

Vermont does not need to wait for Congress to adopt similar policies.

Risks to Maternity Care Access

Without changes to the financing of obstetric care, researchers warn that labor and delivery units will continue to close, forcing pregnant patients to travel further for care.[6] Already, many families in southern Vermont live more than a 30-minute drive from hospital-based obstetrical care, and the closure of any birthing center in Vermont would significantly increase travel times. [7]

It's well documented that longer travel times and emergency department births are associated with increased risks of maternal morbidity and adverse infant outcomes[8]. Families in rural counties without birthing centers also have fewer options for outpatient maternal health services, including lactation support, doula care, and childbirth education.

While the Scott administration has said there are alternatives to birthing services for Windham County residents seeking maternity care[9], we want to stress the precarity of all rural obstetric services in the region[10]. We have heard reports that staffing shortages and revenue shortfalls are also a challenge for nearby hospitals, including Cheshire Medical Center in Keene, New Hampshire, and Baystate Franklin Medical Center in Greenfield, Massachusetts.[11]

We are also concerned about patients' access to affordable care at out-of-state hospitals. Because Vermont's Medicaid reimbursement rates for delivery services are substantially

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[5] See bill text and press release
[6] "Without targeted efforts that address health care financing for maternity care, obstetric unit closures will likely continue, and existing inequities may widen." *Health Affairs, Jan, 2026*
[7] The Perinatal Quality Collaborative Vermont drive time map
[8] https://pubmed.ncbi.nlm.nih.gov/36201778/
[9] Scott defends decision not to give Brattleboro Memorial Hospital more money, WCAX, July 10, 2026
[10] Map of obstetric unit closures in northern New England, Northern New England Perinatal Quality Improvement Network
[11] Baystate Franklin nurses speak out against hospital layoffs, Greenfield Recorder, June 18, 2026

lower than rates in Massachusetts and New Hampshire, [12] out-of-state hospitals have less financial incentive to accept Vermont Medicaid patients.[13]

Safe, Quality Care in Vermont

We believe Vermont should guarantee access to safe maternity care at the state's hospitals, rather than relying on obstetric services across state lines, where we have less transparency and regulatory control over costs, access and quality.

Even at Vermont's smallest hospitals, obstetrical care consistently exceeds national safety and quality benchmarks. This is not by chance. Clinicians at community hospitals receive support from specialists at tertiary care facilities through 24-hour consultation services and routinely participate in obstetric training sessions to support ongoing quality improvement.[14]

Finally, we want to emphasize that OB-GYNs and certified nurse-midwives provide comprehensive primary care beyond obstetrics, including cancer screenings, routine gynecological care, contraception, and menopause care. If hospital-based obstetric services close, other primary care clinicians may not be able to meet community needs for these essential services.

As the Agency of Human Services continues its statewide health care transformation efforts, clinicians stand ready to contribute with our expertise. We respectfully request that our organizations be included in regional planning. Thank you for your attention to these urgent issues and for your commitment to ensuring that safe, equitable maternity care remains accessible to all Vermonters.

Sincerely,

Naiim Ali, M.D. FRCPC, President, Vermont Medical Society

Lauren MacAfee, M.D., Chair, American College of Obstetricians and Gynecologists Vermont Section; President-Elect, Vermont Medical Society

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[12] See Table 2

[13] Baystate Franklin Medical Center's "billing department said it would only take Vermont Medicaid's patients in emergency situations," Vermont Public, July 15, 2026

[14] Understanding the Role of Local Maternity Care in Vermont, The Perinatal Quality Collaborative Vermont, September, 2025

Tracy Tyson, M.D., President, American Academy of Pediatrics Vermont Chapter

Michelle Dorwart, M.D., President, Vermont Academy of Family Physicians

Emily Zolten, DNP, APRN, CNM, PMHNP-BC, President, Vermont Affiliate of the American College of Nurse-Midwives

Michelle Wade, MSN/Ed, APRN, AGNP-C, ACNPC-AG, FAANP, President, Vermont Nurse Practitioners Association

Jon Hendrickson, MSN, RN, CNML, CEN, President, American Nurses Association Vermont

Nicole Clegg, President, Planned Parenthood of Northern New England

We are writing on behalf of the Vermont Medical Society, the Vermont Section of the American College of Obstetricians and Gynecologists, the Vermont Academy of Family Physicians, the Vermont Chapter of the American Academy of Pediatrics, the Vermont Affiliate of the American College of Nurse-Midwives, the Vermont Nurse Practitioners Association, American Nurses Association Vermont, and Planned Parenthood of Northern New England, representing over 15,000 physicians and other health care professionals in Vermont.

Appendix: Billing Codes

The most common prenatal and delivery care codes (effective through December 31, 2026) which should be included in DVHA Resource Based Relative Value Scale (RBRVS) Professional Fee Schedule enhanced primary care conversion factor:

59400 (Routine obstetric care, vaginal delivery)
59409 (Vaginal delivery only)
59410 (Vaginal delivery and postpartum care)
59510 (routine obstetric care, cesarean delivery)
59514 (Cesarean delivery only)
59515 (Cesarean delivery and postpartum care)
59610 (Routine obstetric care, vaginal delivery, after previous cesarean delivery)

59612 (Vaginal delivery only after previous cesarean delivery)
59614 (Vaginal delivery and postpartum care after previous cesarean delivery)
59618 (Routine obstetric care, cesarean delivery, after previous cesarean delivery)
59620 (Cesarean delivery only after previous cesarean delivery)
59622 (Cesarean delivery and postpartum care after previous cesarean delivery).
59425 & 59426 – antepartum visits only

Forthcoming billing codes (effective Jan 1, 2027):

59080 Initial day labor management; straightforward, per day
59091 Initial day labor management; complex, per day
59082 Subsequent day labor management; straightforward, per day
59083 Subsequent day labor management; complex, per day
59431 Vaginal delivery, with or without episiotomy
59432 Vaginal delivery, with or without episiotomy; after previous cesarean delivery
59502 Cesarean delivery: primary
59503 Cesarean delivery: repeat
59320 Cerclage of cervix, during pregnancy; vaginal
59325 Cerclage of cervix, during pregnancy; abdominal
59412 External cephalic version
59871 Removal of cerclage suture under anesthesia (other than local)
59030 Fetal scalp blood sampling
59051 Fetal monitoring during labor by consulting physician (ie, non-attending physician) or other qualified health care professional, with interpretation and report
59414 Delivery of placenta only (separate procedure)
59300 Repair of first or second-degree episiotomy or laceration, by other than attending physician or other qualified health care professional performing vaginal delivery care (separate procedure)
59433 Repair of third-degree episiotomy or laceration
59434 Repair of fourth-degree episiotomy or laceration
59504 Subtotal or total hysterectomy after cesarean delivery
59350 Hysterorrhaphy of ruptured uterus
59623 Uterine tamponade (eg. balloon catheter, vacuum, packing material)
59160 Curettage, postpartum

We also ask that all billing codes with a TH modifier be paid at the enhanced rate if they are not otherwise included in the enhanced fee schedule.