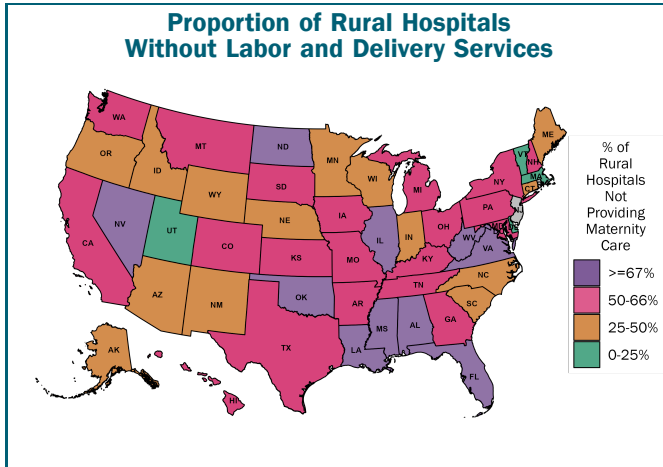


ADDRESSING THE CRISIS IN RURAL MATERNITY CARE

Most Rural Hospitals in the U.S. No Longer Deliver Babies

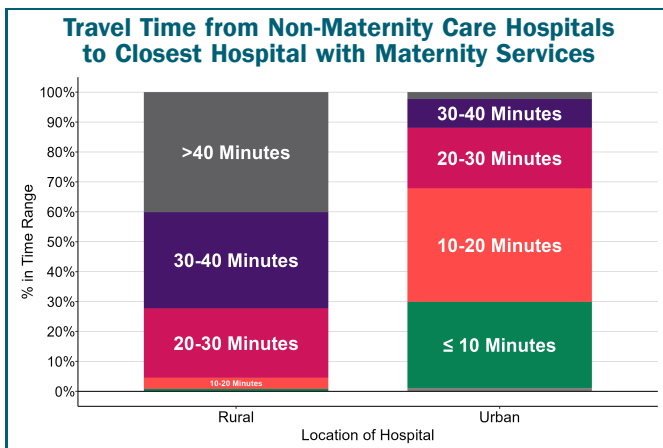
More than half (55%) of the rural hospitals in the U.S. do not offer labor and delivery services, and in 10 states, more than two-thirds do not. Over the past decade, more than 200 rural hospitals across the country have stopped delivering babies.



Maternity Care is Far Away for Mothers in Many Rural Communities

If the closest hospital does not offer labor and delivery services, a pregnant woman may have to travel to a different community to deliver her baby. In most urban areas, the travel time to a hospital with labor and delivery services is under 20 minutes, but in rural areas, the travel time is likely to be at least 30 minutes, and it is often 40 minutes or more.

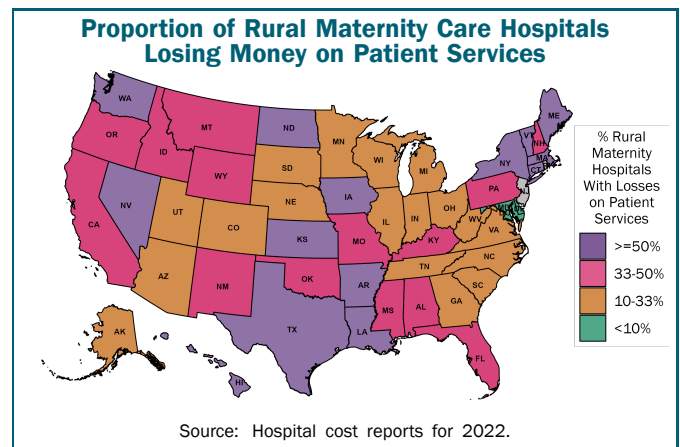
There is a higher risk of complications and death for both mothers and babies in communities that do not have local maternity care services. Women are less likely to obtain adequate prenatal and postpartum care when it is not available locally.



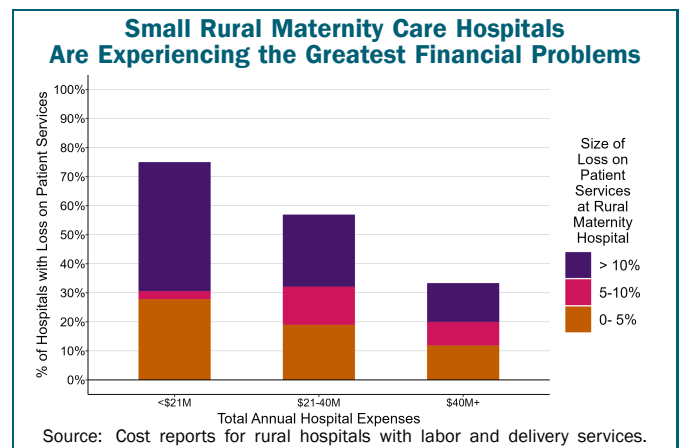
Many More Rural Communities Are at Risk of Losing Maternity Care

Hundreds more communities are at risk of losing maternity care because of the serious financial and workforce challenges rural hospitals are facing. Safe, high-quality maternity care requires having physicians and nurses available on a 24/7 basis, and rural hospitals are experiencing dramatically higher costs to maintain adequate staffing. Payments from many private insurance and Medicaid plans are not adequate to cover these costs, so hospital losses on these services are increasing.

Many rural hospitals can't subsidize losses on maternity care because they are also losing money on other types of patient services. More than 1/3 of the rural hospitals that still have labor & delivery services have been losing money on patient services overall, so their ability to continue delivering maternity care is at risk. In a dozen states, the majority of rural maternity care hospitals have been losing money.



Smaller rural communities are at greater risk, both because their losses on maternity care are higher and because they are more likely to experience large losses on other patient services. More than half of small rural maternity care hospitals lost money on patient services overall in 2022.



RURAL MATERNITY CARE AT RISK							
State	Total Number of Rural Hospitals	Rural Hospitals Without Obstetric (Labor & Delivery) Services			Rural Hospitals Still Providing Obstetric Services		
		% Rural Hospitals without OB Services	Number without OB Services	Median Minutes Driving Time to Hospital with OB Services	Number of Hospitals with OB Services	% with Losses on Patient Services ¹	Median Minutes to Alternative OB Hospital
Connecticut	3	33%	1	31	2	100%	33
Vermont	13	23%	3	34	10	80%	43
New York	51	55%	28	38	23	78%	44
Nevada	13	69%	9	58	4	75%	>90
Kansas	102	58%	59	32	43	70%	37
Hawaii	12	50%	6	47	6	67%	68
Maine	25	36%	9	48	16	62%	37
Texas	158	56%	88	37	70	59%	40
Iowa	93	61%	57	31	36	58%	30
Arkansas	48	60%	29	39	19	58%	42
North Dakota	39	79%	31	58	8	57%	77
Louisiana	52	75%	39	37	13	54%	35
Massachusetts	5	20%	1	24	4	50%	76
Washington	40	50%	20	40	20	50%	47
Oklahoma	78	68%	53	39	25	48%	41
California	56	57%	32	50	24	46%	43
Idaho	30	47%	14	37	16	44%	38
Alabama	52	67%	35	39	17	41%	40
Kentucky	72	56%	40	32	32	41%	35
Mississippi	73	68%	50	35	23	39%	35
Missouri	57	54%	31	37	26	38%	43
New Hampshire	17	53%	9	34	8	38%	47
New Mexico	28	32%	9	61	19	38%	54
Oregon	32	25%	8	39	24	38%	43
Wyoming	24	33%	8	58	16	38%	53
Pennsylvania	41	59%	24	39	17	35%	41
Florida	21	86%	18	50	3	33%	50
Montana	55	60%	33	51	22	33%	55
Minnesota	95	45%	43	31	52	33%	29
South Carolina	23	43%	10	38	13	31%	42
Utah	21	5%	1	35	20	30%	37
Nebraska	72	46%	33	32	39	26%	29
Alaska	17	35%	6	>90	11	25%	>90
South Dakota	48	62%	30	44	18	25%	50
Tennessee	55	56%	31	35	24	25%	37
West Virginia	28	71%	20	44	8	25%	37
Indiana	52	42%	22	31	30	23%	32
Ohio	70	53%	37	30	33	21%	30
Georgia	68	63%	43	36	25	20%	40
Michigan	63	51%	32	36	31	19%	43
Wisconsin	75	44%	33	29	42	19%	29
North Carolina	52	35%	18	32	34	18%	38
Virginia	29	69%	20	41	9	11%	47
Illinois	70	73%	51	33	19	11%	39
Arizona	27	48%	13	46	14	10%	68
Colorado	42	52%	22	46	20	10%	47
Delaware	2	0%	0		2	0%	26
Maryland	4	50%	2	48	2	0%	59
New Jersey	0						
Rhode Island	0						

¹ Percentage of hospitals with OB services that had a negative margin (loss) on all patient services in the most recent year available.

Data current as of January 2024

Actions Needed to Preserve and Strengthen Rural Maternity Care

Rural hospitals can't provide labor and delivery services if they are unable to find an adequate number of qualified staff, but they can't afford to employ adequate staff unless they receive adequate health insurance payments for delivering babies. Maintaining access to high-quality maternity care in rural areas requires addressing both the workforce recruitment and payment challenges facing rural hospitals.

Help Rural Communities Attract and Retain a Maternity Care Workforce

Safe, high-quality maternity care requires having physicians who can perform cesarean sections, nurses trained in obstetric care, and nurse anesthetists or anesthesiologists, all of whom are available on a 24/7 basis to manage deliveries and to perform cesarean sections when necessary. Obstetricians and family physicians with obstetric skills are increasingly unable or unwilling to be on call for many nights and weekends every month. As a result, hospitals have to either employ more physicians, contract with additional physicians to cover on-call shifts, or change to entirely different models of staffing, such as hiring or contracting for ob-gyn hospitalists. In addition, all hospitals have been experiencing challenges recruiting and retaining registered nurses, but the challenges are greater for maternity care hospitals because they need nurses who have training and experience in obstetrics.

A national workforce shortage requires a national solution. Otherwise, filling a position at one small rural hospital may simply create or extend a vacancy at another hospital, and hospitals with greater financial resources may be filling their positions at the expense of hospitals in lower-income communities. A rural maternity workforce strategy must include:

- **Training Designed for Rural Maternity Care.** It is not enough to simply train more physicians and nurses and hope that they will be willing to work in rural areas. Medical and nursing students need to be recruited and trained specifically to deliver team-based care in rural areas.
- **Remote Specialty Support for Rural Maternity Care Teams.** Physicians and nurses will be better able and hopefully more willing to deliver obstetric care in rural areas if they have access to remote support from maternal-fetal medicine specialists and more experienced OB nurses.
- **New Staffing Models for On-Call Coverage.** Since the traditional model of long hours of on-call coverage is becoming less viable, new models of staffing and compensation must be developed that hospitals can use to successfully recruit and retain physicians.

Pay Adequately for Maternity Care Services

Higher costs for maternity care staffing means that higher payments are needed from insurance plans to cover those costs. Moreover, payments per birth that are adequate at a large hospital will be too low to support maternity care at a small rural hospital. The reason is that the cost of having physicians, nurses, and anesthetists available 24/7 can be the same at a small hospital as a larger hospital, but since there are fewer births at the small hospital, the same payment per birth generates insufficient revenue to cover that cost.

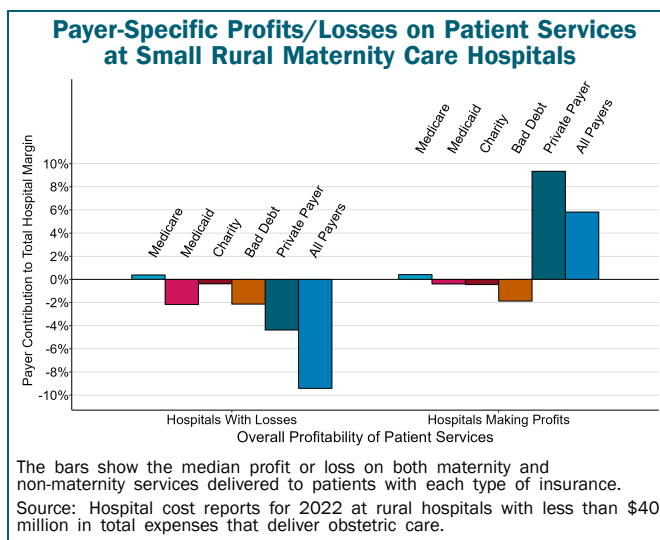
It is often assumed that low Medicaid payments and uninsured patients are the reasons hospitals lose money on maternity services, but over 40% of births in rural communities are paid for by private health plans, so inadequate payments from private payers also threaten the viability of rural maternity care.

Employers should require their health insurance plans to demonstrate that they are paying amounts that are adequate to cover the cost of maternity care services. Similarly, states should require Medicaid plans to pay adequate amounts for maternity care services. This includes: (1) perinatal care services from physicians and midwives; (2) assistance during labor and delivery from appropriately-trained nurses; (3) anesthesia services (such as when C-Sections are needed); and (4) telemedicine assistance from specialists for complex cases. Payment amounts must be higher in communities that have difficulty attracting staff, and payments must also be higher in communities with smaller numbers of births to ensure that revenues cover the cost of on-call coverage.

Require Adequate Payments from Private and Public Payers for Other Rural Health Care Services

It does little good to pay adequately for maternity care if losses on other services force a hospital to close completely. The majority of small rural maternity care hospitals are losing money on other services such as emergency care and primary care. Many small rural hospitals are at risk of shutting down because of the overall financial losses they have been experiencing. *Rural Hospitals at Risk of Closing* provides more information on this problem and how to address it.

The primary cause of these overall losses is not low Medicaid or Medicare payments or losses on uninsured patients. As shown in the chart below, the biggest problem is private insurance companies (including Medicare Advantage plans as well as commercial health insurance) paying the hospitals less than what it costs to deliver services to patients. Conversely, the small rural maternity hospitals that avoid overall losses do so by receiving payments from private health plans that not only cover the costs of services (of all types) to the patients with private insurance but also offset the hospitals' losses on services to uninsured and Medicaid patients.



Employers and residents of rural communities should only choose health plans that pay adequately for all services delivered at the rural hospital. It is particularly important to ensure that payments from insurance plans support the costs of primary care and gynecologic care as well as obstetric care:

- OB-Gyn physicians deliver care for gynecologic conditions as well as obstetric services, so adequate payments for both gynecologic and obstetric services will ensure that both types of services are available for women in rural communities.
- In small rural communities, obstetric care will often be delivered by family physicians rather than obstetricians. The hospital's ability to employ these physicians requires that health plans pay adequately for the primary care services the physicians deliver as well as for maternity care.
- Rural Health Clinics (RHC) can serve as an important way of supporting maternity care as well as primary care services in rural areas. However, Medicare staffing and productivity standards need to be revised so that RHCs are not penalized for hiring physicians who spend time delivering maternity care. Private insurers should also be required to pay amounts for primary care visits based on the clinic's costs, just as Medicare does for its patients.

Create Standby Capacity Payments to Support the Fixed Costs of Maternity Care

Financial losses in delivering maternity care are caused not only by the inadequate amounts paid by insurance plans, but by the problematic method used to pay for services. Currently, a rural hospital is only paid when it actually provides a service. However, a small hospital must be staffed and ready to deliver a baby at all times, even though there will be no deliveries at all on many days. As a result, when there are fewer pregnancies than expected, the hospital will lose money, even if payments would have been adequate for a larger number of births. Moreover, since payments are typically higher for c-sections, a hospital with a low c-section rate will lose even more.

A better approach is for private insurers and Medicaid to pay an annual **Standby Capacity Payment** to the hospital for each insured woman of childbearing age living in the community. These payments would provide the hospital with more predictable revenue to cover the fixed costs of maternity care than a purely fee-based system can. The hospital should still receive Service-Based Fees for individual births and other services, but the amounts should be based on the variable costs of the services. More details on this approach are available in [A Better Way to Pay Rural Hospitals](#).

Immediate Action is Needed to Address the Crisis in Rural Maternity Care

The U.S. has the highest rates of mortality for both infants and mothers among the world's advanced economies. Pregnant women in the U.S. are three times as likely to die in the U.S. as in Australia, Britain, Canada, France, Germany, and other developed countries. Moreover, the problem is getting worse, not better; maternal mortality rates in the U.S. nearly doubled between 2018 and 2021.

Although improvements in maternity care are needed in all parts of the country to address this problem, one of the greatest challenges is in rural areas, because most rural hospitals are no longer providing maternity care at all. The problem will get even worse if more rural communities lose maternity care services because they didn't receive adequate help in recruiting physicians and nurses or they didn't receive payments from insurance plans that were adequate to cover the costs required to continue delivering maternity care services.

It is not an exaggeration to say that rural maternity care is in a state of crisis, and a crisis demands immediate action. Every day that steps are not taken to implement the changes in workforce recruitment and payments described above increases the likelihood that more women and babies will die unnecessarily.

