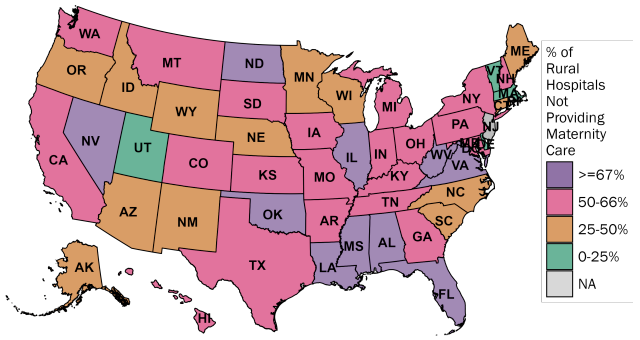
CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

ADDRESSING THE CRISIS IN RURAL MATERNITY CARE

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

More than half (57%) 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 five years, more than 100 rural hospitals across the country have stopped delivering babies.

Proportion of Rural Hospitals Without Labor and Delivery Services

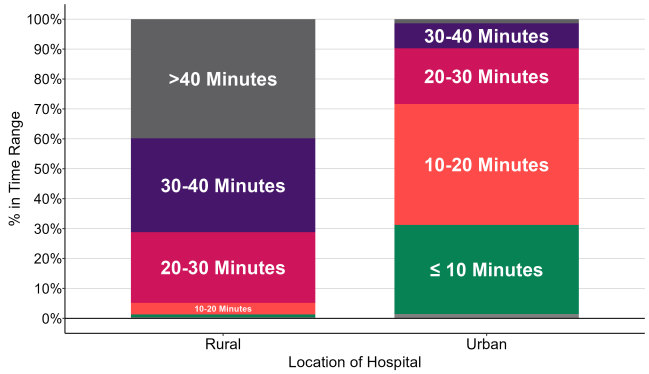


Maternity Care is Far Away for Mothers in Many Rural Communities

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.

Travel Time from Non-Maternity Care Hospitals to Closest Hospital with Maternity Services

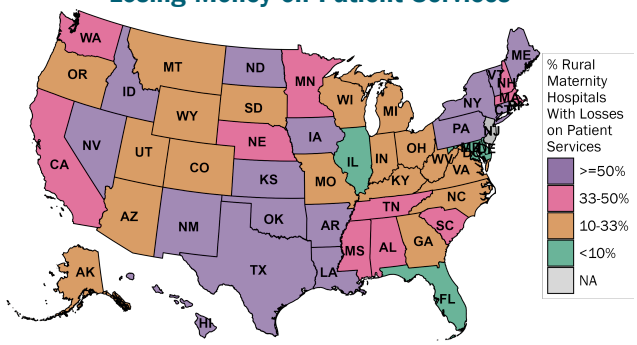


Many More Rural Communities Are at Risk of Losing Maternity Care

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 maternity care are increasing.

Many rural hospitals can't subsidize losses on maternity care because they are also losing money on other types of services. Almost 40% of the rural hospitals that still have labor & delivery services lost money on patient services overall in 2022-23, so their ability to continue delivering maternity care is at risk. In fourteen states, the majority of rural maternity care hospitals have been losing money.

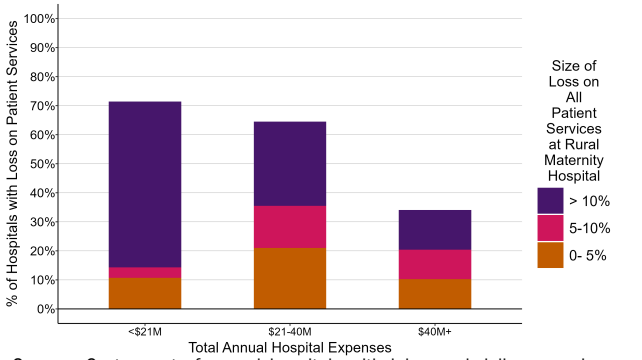
Proportion of Rural Maternity Care Hospitals Losing Money on Patient Services



Source: Hospital cost reports for 2022-23.

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. Two-thirds of small rural maternity care hospitals lost money on patient services overall in 2022-23.

Small Rural Maternity Care Hospitals Are Experiencing the Greatest Financial Problems



Source: Cost reports for rural hospitals with labor and delivery services.

RURAL MATERNITY CARE AT RISK

State	Total # of Rural Hospitals and REHs[1]	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[2]	Median Minutes to Alternative OB Hospital
Connecticut	3	33%	1	31	2	100%	33
Vermont	13	23%	3	34	10	80%	36
Kansas	100	59%	59	32	41	76%	38
North Dakota	39	79%	31	58	8	71%	77
Iowa	94	62%	58	31	36	69%	31
Maine	25	36%	9	48	16	69%	37
Hawaii	13	54%	7	38	6	67%	68
Oklahoma	81	69%	56	38	25	62%	41
Arkansas	50	64%	32	39	18	61%	42
New York	52	56%	29	38	23	61%	44
Louisiana	56	75%	42	36	14	57%	34
Texas	164	59%	97	36	67	57%	41
Idaho	30	47%	14	37	16	56%	38
New Mexico	28	32%	9	57	19	56%	54
Nevada	14	71%	10	56	4	50%	>90
Pennsylvania	43	63%	27	39	16	50%	39
Washington	45	53%	24	35	21	48%	43
California	58	59%	34	49	24	42%	43
Massachusetts	6	17%	1	24	5	40%	40
Alabama	52	69%	36	43	16	38%	40
New Hampshire	17	53%	9	34	8	38%	47
Tennessee	54	56%	30	36	24	38%	37
Minnesota	98	48%	47	32	51	35%	28
Nebraska	72	49%	35	32	37	35%	30
Mississippi	72	68%	49	35	23	35%	35
South Carolina	25	40%	10	38	15	33%	41
Missouri	58	55%	32	36	26	31%	43
Arizona	27	48%	13	46	14	30%	68
Utah	21	5%	1	35	20	30%	37
Oregon	33	27%	9	38	24	29%	43
Kentucky	72	56%	40	32	32	28%	35
Georgia	72	64%	46	35	26	27%	40
Montana	55	64%	35	56	20	26%	53
Alaska	17	35%	6	>90	11	25%	>90
South Dakota	49	63%	31	44	18	25%	50
West Virginia	31	74%	23	44	8	25%	37
Wisconsin	79	48%	38	32	41	24%	29
Indiana	54	52%	28	30	26	23%	34
Michigan	65	52%	34	35	31	23%	43
Wyoming	25	36%	9	46	16	19%	53
Ohio	71	54%	38	30	33	18%	30
Colorado	43	56%	24	44	19	16%	48
North Carolina	55	38%	21	32	34	12%	38
Virginia	30	70%	21	42	9	11%	47
Delaware	2	0%	0		2	0%	26
Florida	22	91%	20	50	2	0%	>90
Illinois	74	74%	55	33	19	0%	39
Maryland	4	50%	2	48	2	0%	59
New Jersey	0						
Rhode Island	0						
U.S. Total	2,263	57%	1,285	36	978	39%	39

[1] REH = Rural Emergency Hospital, which cannot deliver inpatient care

[2] 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 July 2024

Actions Needed to Preserve and Strengthen Rural Maternity Care

Rural hospitals can't provide labor and delivery services if they are unable to recruit an adequate number of qualified staff, but they can't afford to employ those staff unless health insurance plans pay the hospital adequately for its services. 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, physicians and/or midwives who can assist with vaginal deliveries, 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 who can perform C-sections are increasingly unable or unwilling to be on call for a large number of 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 or laborists. 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:

- **Recruiting and Training for *Rural* Maternity Care.** It is not enough to simply train physicians, midwives, and nurses in maternity care 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 care in rural areas.
- **Remote Specialty Support for Rural Maternity Care Teams.** Physicians, midwives, 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 from staff who have had experience addressing infrequently-occurring complications.
- **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 who can perform C-sections.

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 total cost of having physicians, nurses, midwives, 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.

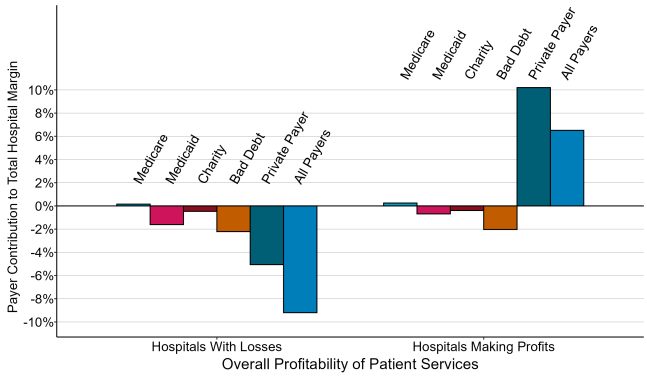
Employers should require their health insurance plans to demonstrate that their payments are adequate to cover the cost of rural maternity care services. Similarly, states should require Medicaid plans to pay adequate amounts for rural maternity care services. This includes payments for: (1) perinatal care services from physicians and midwives; (2) assistance during labor and delivery from appropriately-trained nurses; (3) anesthesia services (for pain relief and C-sections); 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 the hospital can afford the cost of on-call coverage.

Require Adequate Payments from Private and Public Payers for Other Rural Healthcare 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 the extent of 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 rural 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.

Payer-Specific Profits/Losses on Patient Services at Small Rural Maternity Care Hospitals



The bars show the median profit or loss on all services (both maternity and non-maternity) delivered to patients with each type of insurance.

Source: Hospital cost reports for 2022-23 at rural hospitals with less than $40 million in total expenses that deliver obstetric care.

Employers and residents of rural communities should only choose health plans that pay adequately for 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 their gynecologic and obstetric services are needed. Adequate payments will also help ensure that all types of women's health services are available in rural communities.
- In many small rural communities, C-sections and other obstetric care will 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.

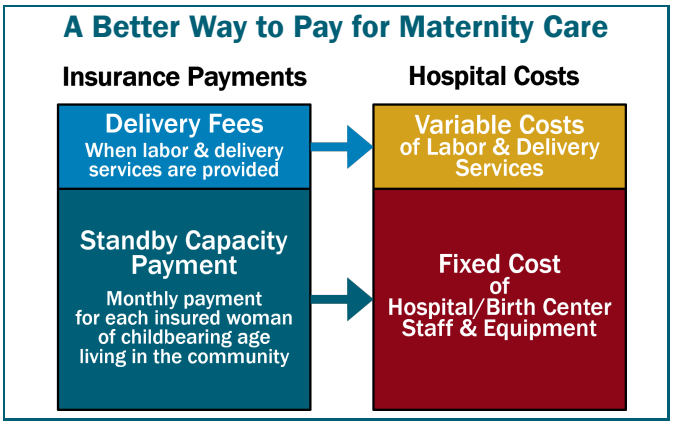
Create Standby Capacity Payments to Support the Fixed Costs of Maternity Care

Financial losses in delivering maternity care are caused not only by the inadequate *amounts* paid by insurance plans, but by the problematic *method* currently used to pay for services. A maternity care 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. Currently, however, the hospital is only paid when it actually delivers a baby. 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 that supports natural childbirth and reduces its C-section rate could lose money as a result.

A better approach is for private insurers and Medicaid programs to pay hospitals for maternity care services using a combination of two different types of payments instead of just fees for services:

1. **Standby Capacity Payments.** If a rural hospital maintains the round-the-clock staffing needed to deliver babies and perform C-sections at any time, each health insurance plan should pay the hospital a monthly or quarterly *Standby Capacity Payment* for each woman of childbearing age who lives in the hospital's service area and who is insured by that health plan. The amount of the Standby Capacity Payment should be equal to the total amount the hospital needs to spend in order to maintain adequate on-call staffing for labor and delivery services, divided by the total number of insured women ages 15-44 in the community. In aggregate, the Standby Capacity Payments from all health plans would provide the hospital with sufficient revenue to cover the fixed costs of labor and delivery services.
2. **Delivery Fees.** In addition to the Standby Capacity Payments, the hospital should receive a *Delivery Fee* when it provides labor and delivery services for an individual mother. If most or all of the hospital's fixed costs for labor & delivery are paid for through the Standby Capacity Payments, the Delivery Fee would only need to cover the extra (variable) costs associated with individual births. As a result, the Delivery Fee could be much smaller than current payments for labor and delivery. In addition, the Delivery Fee should be the same amount for a vaginal delivery and a C-section, so there is no financial penalty if the hospital, physicians, and midwives are able to safely increase the proportion of vaginal deliveries and reduce the number of C-sections.

Under this two-part payment system, both spending for the health plans and revenue for the hospital would be far more predictable than under the current system of paying per birth.



More details on this approach to payment 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 one of the highest rates of mortality for both infants and mothers among the world's advanced economies. Pregnant women are more likely to die in the U.S. than in Australia, Britain, Canada, France, Germany, and most other developed countries. Moreover, Black women in the U.S. are 2-3 times as likely to die for pregnancy-related causes as other racial and ethnic subgroups.

Over 80% of pregnancy-related deaths are preventable with appropriate prenatal, labor & delivery, and post-partum care. Although improvements in maternity care are needed in all parts of the country to reduce mortality rates, 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. Reversing this trend will require helping rural hospitals to recruit and retain a sufficient number of physicians, midwives, and nurses and ensuring that payments from insurance plans are adequate to cover the costs of delivering high-quality maternity care.

Rural maternity care is in a state of crisis, and a crisis demands immediate action. Women and babies in rural communities will die unnecessarily until the changes in workforce recruitment and payments described above are implemented.