

November 26, 2021

Dr. Janelle McCutchen, Chief  
Shortage Designation Branch  
Division of Policy and Shortage Designation  
Bureau of Health Workforce, HRSA  
Rockville, MD 20857

Dear Dr. McCutchen:

The National Rural Health Association (NRHA) is pleased to offer comments on the Health Resources and Services Administration (HRSA) proposed criteria for determining Maternity Care Health Professional Target Areas (MCTA) to address obstetric health professional shortages. We appreciate HRSA's continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health and health care access throughout rural America. MCTAs are to be designated and scored under a statutory mandate to identify "shortages of maternity care services within health professional shortage areas" by creating a maternity healthcare scoring mechanism for Health Professional Shortage Areas (HPSA).

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We provide leadership on rural health issues through advocacy, communications, education, and research.

### Rural Obstetric Background

Approximately 18 million reproductive-aged women live in rural America.<sup>1</sup> While about three out of four rural women give birth at local hospitals, many rural hospitals have discontinued obstetric (OB) services since 2005, resulting in detrimental outcomes for mothers and babies.<sup>2,3</sup> Studies show an increase in rates of out-of-hospital births, in hospital births without OB services and preterm births, as well as low prenatal care use in rural counties that have lost OB services.<sup>1</sup> There are also corresponding increases in costs, risks of complications, and longer lengths of stay when mothers have to travel further for obstetric care.<sup>4,5</sup> A recent study found that rural residents have a 9 percent greater probability of severe maternal morbidity and mortality when compared to their urban counterparts, when controlled for sociodemographic factors and clinical conditions.<sup>6</sup>

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<sup>1</sup> Kozhimannil KB, Hung P, Henning-Smith C, Casey MM, Prasad S. Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States. *JAMA*. 2018;319(12):1239–1247. doi:10.1001/jama.2018.1830.

<sup>2</sup> Kozhimannil KB, Casey MM, Hung P, Prasad S, & Moscovice IS. Location of childbirth for rural women: implications for maternal levels of care. *American Journal of Obstetrics and Gynecology*. 2016;214(5):661-e1.

<sup>3</sup> Hung P, Kozhimannil KB, Casey MM, Henning Smith C. State variability in access to hospital-based obstetric services in rural U.S. counties. *Policy Brief*. University of Minnesota Rural Health Research Center. 2017;1-6.

<sup>4</sup> Sontheimer D, Halverson LW, Bell L, Ellis M, Bunting PW. Impact of discontinued obstetrical services in rural Missouri: 1990-2002. *Journal of Rural Health*. 2008;24(1):96-98.

<sup>5</sup> American College of Obstetricians and Gynecologists. Health disparities in rural women. *Obstetrics and Gynecology*. 2014;586:1-5.

<sup>6</sup> Kozhimannil KB, Interrante JD, Admon, LK, Henning-Smith C. Rural-urban differences in severe maternal morbidity and mortality in the US, 2007-15. *Health Affairs*. 2019;38(12),2077-2085.

Hospitals that have discontinued OB services are more likely to:

- Have lower birth volumes (fewer than 100 births annually) and be smaller in bed size; specifically, critical access hospitals are more likely than other rural hospitals to close OB services<sup>7</sup>
- Be in states that have not expanded Medicaid<sup>3</sup>
- Experience financial distress<sup>7</sup>
- Be in communities with limited supply of obstetricians and family physicians<sup>2</sup>
- Face challenges with recruitment and retention of skilled maternal care providers<sup>8</sup>

Rural communities face numerous challenges in maintaining access to obstetric services. When hospitals face financial difficulties, obstetric units are often among the first to be closed.<sup>7</sup> Various financial constraints affect rural obstetric units, including low birth volume, higher malpractice costs, high costs of anesthesia coverage, and higher dependence on Medicaid.<sup>7</sup> When birth volumes are low, clinicians and nurses have difficulty maintaining skill level, which may increase liability concerns for the hospitals. Furthermore, low volumes influence revenue, and rural hospitals may find that they cannot cover the fixed capital and labor costs for obstetric units.<sup>9</sup>

A diversified mix of providers deliver maternal care, including obstetricians, family practice providers, and midwives (both advanced and non-advanced practice). Even with the mix of providers, however, workforce shortages remain in rural areas. In 2019, it is estimated that 58.7% of rural counties do not have an obstetrician, 81.7% have no advanced practice midwives, and 56.9% have no family physicians who deliver babies.<sup>10</sup> Based on utilization patterns, which includes the number of pregnant women who bypass a local rural hospital for urban OB services,<sup>11</sup> the demand for obstetricians is projected to exceed supply, resulting in a national shortage of approximately 5,000 FTEs by 2025.<sup>12</sup> Recruiting and retaining OB care clinicians is especially challenging in rural communities, with decreases in the percentage of family physicians attending deliveries, predicted shortages in the overall supply of obstetricians, and the workload and on-call requirements inherent in obstetric practice.<sup>8</sup>

#### NRHA Support for MCTA Designation

NRHA appreciates HRSA's efforts to expand HPSA scoring that would intentionally create better opportunities to recruit practicing maternity care providers in rural areas. Difficulties recruiting and retraining obstetric providers is one of the foremost challenges facing access to obstetric services. Given that rural areas often score lower on the HPSA scale because of limited volume and diversity, separate scoring to support the recruitment of maternity care providers is beneficial for rural residents.

#### NRHA Recommendation for MCTA

NRHA supports comments made by the National Organization of the State Offices of Rural Health's (NOSORH) proposed recommendations of the MCTA proposed criteria. Our comments can be organized into the following categories.

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<sup>7</sup> Peiyin H, Kozhimannil KB, Casey MM, Moscavice IS. Why are obstetric units in rural hospitals closing their doors? *Health Services Research*. 2016;51(4):1546-1560.

<sup>8</sup> Kozhimannil KB, Casey MM, Hung P, Han X, Prasad S, Moscavice IS. The rural obstetric workforce in US hospitals: challenges and opportunities. *Journal of Rural Health*. 2015;31(4):365-372. doi:10.1111/jrh.12112

<sup>9</sup> Zhao L. Why are fewer hospitals in the delivery business? Working Paper. NORC at the University of Chicago; 2007;1-39.

<sup>10</sup> Andrilla H, Garberson L, Patterson D. The supply and rural-urban distribution of the obstetrical care workforce in the U.S. Policy Brief. WWAMI Rural Health Research Center. 2020;168:1-11.

<sup>11</sup> Holmes M, Malone T. Patterns of Hospital Bypass and Inpatient Care-Seeking By Rural Residents. NC Rural Health Research Program. April 2020. Retrieved from: <https://www.ruralhealthresearch.org/alerts/305>

<sup>12</sup> National Center for Health Workforce Analysis. National and regional projections of supply and demand for women's health service providers: 2013-2025. 2016. <https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/womens-health-report.pdf>

*Weighting of considered factors:* NRHA recommends HRSA consider increasing the weighting scale from 25 points to 100, in order to allow points associated with individual factors to have a greater differentiation and a wider scale to prioritize critical issues. Further, NRHA supports NOSORH's approach to base MCTA scoring on three key factors:

- *Availability of maternity healthcare services:* NRHA recommends inclusion of FTE of health professionals who actively provide maternity care services, including pre and postnatal care. We believe this factor should be given the most scoring weight.
- *Travel distance/time to maternity health services:* NRHA recommends that HRSA change the limits in the scoring scale applied to travel distance/time. A maximum score should be assigned to any HPSA within 60 minutes or 60 miles or more travel to obstetric services to reflect the level of isolation of rural residents in terms of access to services.
- *High risk factors for maternity healthcare:* NRHA recommends that high risk factors for obstetric services should be set at a lower rate than the first two criteria. Poverty and access to maternity services are by far the greatest factors for rural residents, particularly given that the majority of rural births are financed by Medicaid and CHIP.

*Measurement of maternity provider supply:* NRHA disagrees with HRSA's exclusion of family practice physicians with obstetrics training. Family practice providers play a significant role in the provision of maternity services in rural areas.<sup>13</sup> Failure to include these health professionals in the calculation of MCTA supply may lead to a substantial undercount of service availability in rural HPSAs. Further, HRSA should work with the Primary Care Organizations (PCO) to include only the FTE of health professionals actively including obstetric services, rather than gynecology services.

*Indicators associated with high-risk maternity healthcare needs:* NRHA recommends HRSA revisit the maternal risk measures factored into the MCTA to include a broader mix of indicators. We believe this mix should include access measures, social determinant measures, maternal risk measures, and birth outcome measures.

Thank you for the chance to offer feedback on the proposed criteria and for your consideration of our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality and access to care. If you would like additional information, please contact Carrie Cochran-McClain at [ccochran@ruralhealth.us](mailto:ccochran@ruralhealth.us) or 202-639-0550.

Sincerely,



Alan Morgan  
Chief Executive Officer  
National Rural Health Association

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<sup>13</sup> <https://medicalxpress.com/news/2021-10-family-physicians-babies-majority-rural.html>