Maternity Care Health Professional Target Area Criteria Request for Information – NOSORH Comments

Overview

The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS) released a ***Maternity Care Health Professional Target Area (MCHPTA) Criteria*** Request for Information (RFI). This RFI seeks input from the public on considerations that would inform HRSA decisions regarding the criteria for, and identification of, MCHPTAs.

The RFI is issued in compliance with provisions of P.L. 115-320, the Improving Access to Maternity Care Act, directing DHHS to identify areas within existing Health Professional Shortage Areas (HPSAs) that should be the target of enhanced National Health Service Corps (NHSC) support through the placement of maternity care providers. Maternity care is defined as "*full scope maternity care*", and includes all health services provided during labor care, birthing, prenatal care and postpartum care. P.L. 115-320 limits MCHPTA designation to existing geographic Primary Medical Care HPSAs – excluding areas with maternity care needs outside HPSA boundaries. The Act also limits the definition of *maternity care providers* to those licensed or certified health professionals who are currently eligible to receive NHSC awards

The National Organization of State Offices of Rural Health (NOSORH) submits these comments to HRSA related to this RFI. NOSORH was established in 1995 to assist State Offices of Rural Health (SORH)s in their efforts to improve access to, and the quality of, health care for over 60 million rural Americans. All 50 states have a SORH, and each SORH helps their state's rural communities build effective health care delivery systems.

In preparing these comments NOSORH drew upon its recently completed planning initiative which developed a ***Model Maternal and Infant Health Service System for Rural Areas***. A copy of this model is attached to these comments. More importantly, NOSORH conducted a survey of its member State Offices of Rural Health (SORHs), exploring their perspectives on the questions raised in the RFI. It also held an online listening session with SORHs for discussion of these issues. NOSORH believes that SORH perspectives provide important real world understanding of the findings of national studies.

NOSORH is encouraged by the wide-ranging questions raised in the RFI. Improvement in maternity care is a difficult challenge, particularly in rural areas. It will likely require an integrated Federal and State response with appropriate policy and program changes affecting primary care workforce, specialist workforce, inpatient facility services and payment programs. Coordination of multiple providers across the spectrum of maternity care services will be needed.

NOSORH's comments are organized into the following sections:

- **Background: Model for Maternity Care in Rural America,**
- **Access Issues: Rural Maternity Care Services,**
- **Health Outcome Issues: Impact of Limited Access on Rural Residents,**
- **Workforce Issues: Shortages of Rural Maternity Care Workforce,**
- **Targets for the Maternity Care Expansion in Shortage Areas, and**
- **Recommendations for MCHPTA Designation and Prioritization.**

NOSORH trusts that its comments will contribute meaningfully to this discussion. NOSORH stands ready to share the results of its analysis and to assist HRSA in further exploration of this topic.

Background – Model for Maternity Care in Rural America

NOSORH believes that a ***comprehensive system of maternal and infant health services*** should be made available for all rural communities. A comprehensive system of maternal and infant health services is comprised of multiple components, including the following:

- **Prenatal Care**: including clinical and non-clinical services for pregnant women. These services can be delivered at a mix of health service facilities and home settings.
- **Delivery-Related Services**: including all birthing and delivery-related clinical services and newborn services. These services are largely delivered at health service facilities but may be delivered in home settings.
- **Perinatal and Post-Partum Care**: Clinical and non-clinical services for mother and infant. These services can be delivered at a delivered at a mix of health service facilities and home settings.
- **Care Coordination and Adjunct Care**: Services for pregnant women and newborns assuring care continuity and addressing the determinants of health. These services can be delivered at a delivered at a mix of health service facilities and home settings.

A more detailed description of this model is included as an attachment to these comments.

Not all services will be available within every rural community. NOSORH believes, however, that ***all services should be reasonably accessible to all rural residents***. Further, NOSORH believes that all services should be coordinated in a manner which assures continuity of care throughout the prenatal, birthing/delivery and post-partum periods of service delivery. This is particularly important for rural communities where different services will be offered by a myriad of providers in locations dispersed throughout a wide region. ***The challenge for health workforce policy is to provide equitable priority for placement of maternity care providers in areas with and without birthing/delivery services.***

Access Issues - Rural Maternity Care Services

Rural counties have a significantly lower availability of maternal and infant health services than do urban counties. While this is true for most of the services in the NOSORH Model, the lack of availability of ***obstetrics/delivery services*** in rural communities poses the most serious challenge for national maternal and infant health policy.

A study published in *Health Affairs* in 2017 found that ***more than half of all rural counties in the United States***, with 2.4 million women of reproductive age, ***had no hospital obstetric services***. These communities may have no hospital or may have a hospital without obstetric services. This means that residents of half of the nation's rural counties must travel to find obstetric services – often for prohibitive distances.

The *Health Affairs* study noted that 9% of ***rural counties lost obstetric services*** in the period 2004-2014. This decrease in rural service availability is part of a long-term trend. The trend was confirmed in a separate study by Chartis which showed that between 2011 and 2018, 134 rural hospitals – 12% of all rural hospitals with OB services – ceased to provide OB services. Added to this number was an additional 18 facilities that ceased operations altogether. The combined impact meant that 152 rural communities lost access to OB services in this time period.

This Chartis analysis also showed that ***only 46% of America's rural hospitals*** (1,011) ***currently provide labor & delivery services***. A related Commonwealth Fund analysis indicates that the lack of these services is also associated with poorer access to prenatal care services for rural mothers. The Chartis analysis describes this shortage of basic care as a **maternity care desert** in a majority of the nation's rural communities.

The Chartis study indicated that the closure of obstetric services at rural hospitals during this period was due largely to declining volumes and poor financial performance of the services. Financial challenges, such as the low Medicaid reimbursement and the high cost of malpractice insurance, are significant barriers to keeping financially stressed obstetrics units open in rural hospitals. The closures impacted nearly ***450,000 women of reproductive age***, who are now without maternity care in their home counties.

The NOSORH survey of individual SORHS confirms the obstetric and prenatal care availability problem highlighted in these studies. SORHs uniformly identified the lack of local obstetric services as a major obstacle to good maternal and infant health care. Most ***SORHs indicated that pregnant women in rural counties must travel at least 30 to 60 minutes to secure maternity care*** – either from OB/GYNs or from OB-trained family practitioners. ***Several states indicated that multiple communities were faced with 1-2 hour travel times for these services.***

It should be noted that pregnancy service payment arrangements can compound the access problem for residents of rural counties without local hospital birthing/delivery services. Payments for pregnancy services, including obstetrics, are often bundled. A single payment is made to a health provider covering both prenatal care and typical birthing/delivery. This creates an additional barrier to access – rural residents must travel

to distant communities for both their prenatal care and birthing/delivery services. While it is possible for a health provider to split their fees with prenatal care providers in a patient's home community, it is highly unlikely that this will occur. ***NOSORH notes that this issue makes it difficult to address the lack of maternity care with health workforce solutions alone.***

SORHs responding to the NOSORH survey confirmed the existence of this problem. ***SORHs linked the bundled payment problem to a lack of local access to prenatal care for pregnant mothers in rural communities without local hospital OB services.*** Multiple SORHs indicated that local family practices in these communities could be enlisted to provide accessible prenatal care, but that collaborative arrangements with out of area birthing/delivery services would need special payment arrangements.

SORHs also pinpointed two additional access issues of importance. Several SORHs noted that ***patient cost-sharing*** for prenatal care and birthing/delivery services – administered as co-pays or up-front costs – were associated with delays in starting and reduced overall use of prenatal care. This results in poorer birth outcomes. In addition, several SORHs noted that the limited Medicaid coverage of post-partum care for mothers – typically limited to 60 days – is a problem for maternal health. SORHs recommended that a full year of coverage is preferable.

Health Outcome Issues: Impact of Limited Access on Rural Residents

There are multiple negative impacts for rural women and newborns resulting from the lack of access to maternal and infant health services. These are documented in multiple reports and studies linked at the end of these comments. Some studies identify **higher rates of premature birth** for rural mothers who must travel longer distances to obstetric services. Other studies report ***higher rates of elective deliveries*** – including induced deliveries and caesarian sections – for rural mothers needing to travel longer distances for obstetric services. Additional studies have highlighted ***higher maternal morbidity and complications*** for rural mothers needing to travel longer distances to access obstetric services.

SORHs responding to the NOSORH survey confirm these findings. In addition, individual states report, for their rural counties:

- Lower use of prenatal care and preventive services,
- Later entry into prenatal care, and
- Higher rates of neonatal intensive care unit use.

The Alaska SORH reported a highly sobering statistic. Sixteen (16) maternal deaths were reported in 2017-2018 – of these, 12 were women who resided in rural communities.

This is consistent with other studies which show that maternal mortality risk is not evenly shared – and that Native American, Alaskan Native and African American women are three to four times more likely to die from pregnancy-related issues than both Hispanic and white non-Hispanic women combined.

Workforce Issues: Shortages of Rural Maternity Care Workforce

Workforce shortages complicate the question of maternal and infant health service supply. For example, in locations with some prenatal care and birthing/delivery capacity, provider shortages will lead to a supply of services that is below the demand for these services. As a result, some pregnant mothers may need to wait to get the care they need. or may receive fewer than the optimal number of provider visits.

At a national level, there are significant maternal and infant health service provider shortages. The Association of American Medical Colleges has estimated that, in 2020, ***the nation has 8,000 fewer obstetrician/gynecologists than are needed***. Similar shortages exist for other provider types, both clinical and non-clinical. The distribution of the available workforce is also a major problem – one which further exacerbates the supply shortage. Rural areas have the greatest shortages of crucial maternal and infant service providers. A Commonwealth Fund report indicates that ***fewer than half of all rural counties have even one practicing obstetrician*** or gynecologist.

Clinical maternal and infant health care services are provided by obstetricians, family practice physicians, certified nurse midwives, advanced practice nurses, general surgeons and pediatricians. Anesthesiologists and certified nurse anesthetists may also be needed for deliveries requiring surgery. Most of these providers are not dedicated full-time to maternal and infant health care, and are called on to serve a broad range of patients. ***Many rural counties are designated health professional shortage areas***, facing substantial shortages of providers. Maternal and infant health service providers working in health professional shortage areas will find a greater demand on their practice time for other types of services. This can further reduce the effective number of providers supplying maternal and infant health care.

Birthing/delivery services can be provided by obstetricians, trained family/general practitioners, certified nurse midwives and licensed midwives. For non-vaginal deliveries general surgeons may be required. Studies have shown that rural counties have fewer of these providers per 10,000 population than do urban counties. This is a significant disparity in rural America. High-risk pregnancies may require additional clinical services from endocrinologists, pediatric specialists and other medical specialists. Rural counties have far fewer of these specialists available, making it more difficult to manage high-risk maternal conditions.

Care coordination and adjunct services, including prevention education services, are provided by a range of providers, including community health workers, health educators, social workers, doulas and nurses. There is also a shortage of these providers in many rural communities. This increases the difficulty in accessing the full range of maternal and infant health services in rural America.

SORHs responding the NOSORH survey have emphasized the problems created by health service provider shortages in their rural counties. ***SORHs identified the difficulty in attracting highly trained providers and the even greater difficulty in retaining them.***

Maternal and infant health practice in rural areas can be challenging. In general, call schedules are more rigorous than in urban areas. Work and educational opportunities for a provider's family are more limited than what is available in urban areas. Clinical support for high-risk pregnancies may be inadequate or non-existent. SORHs prioritized this issue as one needing special attention. These are barriers to the placement of maternity care providers in rural areas.

In addition, even when a rural provider such as a family practitioner is trained as a maternity care clinician ***s/he may choose not to provide these services*** because of call schedules or other rigors associated with this aspect of rural practice. ***This information about provider practice cannot be determined without an actual survey***. Simple provider headcounts will not reveal provider practice choices.

The decision not to offer these services may also be affected by *malpractice policies*. In many states, the cost of malpractice for a family practitioner providing prenatal care *only* is not very different from a family practitioner who also does deliveries. ***This is a disincentive against providing prenatal care services in rural areas without delivery facilities.*** Attempts to have local providers in these communities provide prenatal care and refer to regional birthing/delivery facilities can be stymied by the higher cost of malpractice coverage.

In summary, the practice environment for maternity care services is very complex. Payment, malpractice insurance, facility and provider choice factors can influence whether maternity care services are made available. ***Workforce policy and programs must consider these other factors to be most effective***. NOSORH believes that MCHPTA priorities and NHSC placements need to take these factors into account.

Targets for the Maternity Care Expansion in Shortage Areas

NOSORH believes that HRSA programs can be an important component in an overall strategy designed to improve maternity care services in shortage areas. Maternity care workforce development and deployment is an essential component of efforts to make these improvements. NOSORH believes that, to effectively target rural shortage areas, MCHPTA designation and prioritization and NHSC placements must:

- Target placement of maternity care providers to shortage areas with the ***highest percentage of shortage,***
- Recognize the challenges faced by pregnant women at ***greatest distance from maternity care***,
- Give consideration to the special needs of shortage areas with ***maternal/infant health disparities***,
- Permit placement of maternity care providers in ***shortage areas without birthing/delivery capacity*** so that appropriate prenatal/post-partum care services can be delivered in coordination with out of area birthing/delivery facilities, and
- Give consideration to the special circumstances of ***small population and frontier shortage areas***.

As mentioned previously, NOSORH believes that NHSC maternity care improvement efforts must be coordinated with those of other Federal programs. MCHTPA designation and prioritization should be consistent with the investment priorities of these other programs.

NOSORH provides specific recommendations for MCHPTA designation and prioritization in the next section of these comments.

Recommendations for MCHPTA Designation and Prioritization

NOSORH believes that the development of MCHPTA designations will help in the targeting of NHSC resources to areas with significant maternity care needs. NOSORH believes that a MCHPTA designation and prioritization methodology can be crafted that accurately reflects the severity of these needs in rural and frontier areas. Outlined below are specific recommendations that NOSORH believes will achieve this outcome.

- **Recommendation – Measures Used for Designation of MCHPTAs**

  NOSORH recommends that appropriate maternity care *availability* measures be used as the basis for identifying MCHPTAs. These measures should include an assessment of ***maternity care supply*** in a HPSA, compared with the ***estimated demand*** for these services.

  NOSORH believes that the assessment of maternity care supply ***not*** be based on simple head counts of potential providers. NOSORH recommends that maternity care supply be assessed by appropriate survey by HRSA state partners. This assessment should include the ***annual number of pregnancies that can be managed by each provider*** within the provider's practice.

  NOSORH understands that statutory provisions may limit the assessment of maternity care supply to an examination of primary care physician-supplied services only. MCHPTAs are a subset of Primary Medical Care HPSAs, and these HPSAs are defined as shortages of physicians exclusively. NOSORH recognizes the importance of non-physician clinicians for the delivery of maternity care services. Nevertheless, NOSORH realizes that HRSA may need to limit its consideration to physicians only, as the original HPSA definition is based solely on physician numbers.

  NOSORH suggests that physician assessment target family/general practitioners and obstetrician/gynecologists. While other primary care providers could potentially provide pre-natal care or other maternity care services, this would be very unlikely. Limiting the primary care specialties considered should make survey assessment of providers more feasible.

  NOSORH believes that the best measure of target population ***demand*** for maternity care services is the ***annual number of births*** within the MCHPTA. A multi-year average of this indicator will accurately reflect ongoing demand, particularly for smaller population HPSAs. NOSORH believes that the difference

between the *annual number of pregnancies that can be managed by maternity care providers* in a HPSA and the *annual number of births* will provide an accurate measure of an area's ***maternity care shortage***. The ***shortage percentage of all HPSA births*** can be calculated. HRSA can establish a minimum maternity care shortage percentage threshold above which a HPSA could be considered a MCHPTA.

- **Recommendation – MCHPTA Prioritization Factors**

  NOSORH recommends that HRSA establish criteria to differentiate MCHPTAs with the highest relative need.

  NOSORH believes that HRSA should create a mechanism for ranking the relative need of MCHPTAs. This could be done in a manner similar to the HPSA scoring methodology. HRSA can create a composite score for MCHPTAs based on multiple HPSA factors including:

  - Maternity Care Shortage,
  - Maternity Care Accessibility,
  - Maternity Care Affordability, and
  - Population Maternity Care Risk.

  Suggested measures for these factors are described below.

  Maternity Care Shortage Factor: The ***maternity care shortage percentage,*** described previously, is a continuous variable showing what percent of a HPSA's needed maternity care can be supplied by its maternity care providers. HRSA can establish a scoring scale similar to those used in HPSA scoring to create a partial score for this factor.

  Maternity Care Accessibility Factor: NOSORH strongly believes that ***adequate access to prenatal care and post-partum care*** should be no more than ***30-minutes travel time*** for a HPSA's residents. In urban and rural communities, the distance equivalent for this travel time may vary. NOSORH understands that, given the large number of maternity care deserts, 30-minute ***access to birthing/delivery services*** may not be feasible for many rural HPSAs. NOSORH feels that ***60-minutes travel time*** to these services may serve as an acceptable maximum, particularly if transportation and temporary housing services are available to pregnant women.

  HRSA can establish a scoring scale that awards MCHPTAs a needs score based on travel times to prenatal or post-partum care in excess of the 30-minutes maximum. HRSA can establish a separate scoring scale that awards MCHPTAs a needs score based on travel times to birthing/delivery services in excess of the 60-minutes maximum.

  Maternity Care Affordability Factor: Maternity care affordability can be measured, in part, by the ***uninsured population percentage*** of a HPSA. These data are available for the population below age from the U.S. Census Small Area

Health Insurance Estimates (SAHIE) program. SAHIE provides uninsured population estimates for every county in the nation. It can be further filtered by age group and gender. This could generate, for example, uninsured population percentage for women age 18-64. This would be a close approximation of health coverage for women of childbearing age, although it would exclude information on younger teens. HRSA can establish a scoring scale that awards MCHPTAs a needs score based on this uninsured population percentage.

Uninsured population data alone will not identify all financial barriers to maternity care. ***High co-pay and deductible amounts assessed for maternity care*** could provide an additional barrier for to service for pregnant women. Maternity care co-pays and deductibles can be assessed in two ways. In many states, the Medicaid program provides health coverage for a large percentage of pregnancies. State PCO and SORH partners can easily identify whether these barriers exist within their state Medicaid programs. They can also explore private insurance coverage on the state health exchanges – sampling policies available in the state to identify whether significant barriers exist. HRSA can identify what constitutes excessive cost-sharing for maternity care and give an additional score to MCHPTAs with significant deductible and co-pay barriers.

Population Maternity Care Risk Factor: There are multiple maternity-related population health risk indicators that can be used to measure the relative health risk in MCHPTAs. Data is available to measure:

- Infant mortality,
- Low birth weight,
- Pre-term births, and
- Low levels of prenatal care

HRSA can establish scoring scales for each of these measures. Each scale would award MCHPTAs a needs score based upon relatively high measures of health risk.

- **Recommendation – Weighting of MCHPTA Prioritization Factors**

  NOSORH recommends that HRSA convene a planning group to establish an appropriate weighted scoring formula for MCHPTA high-needs prioritization.

  The planning group can consider appropriate weights for the different prioritization factor partial scores to be used in creating the composite score. NOSORH believes that significant weight should be given to the Maternity Care Shortage factor and the Maternity Care Accessibility factor. NOSORH feels that these two factors are most directly related to the need for health care personnel.

- **Recommendation – Separate Consideration of Small Population and Frontier MCHPTA Needs**

  NOSORH recommends that HRSA make special provisions for designation and prioritization of MCHPTAs in small population and frontier HPSAs.

Many of these areas will likely have generalist provider services delivering prenatal and post-partum care. They will need to coordinate with providers outside the HPSA for specialist consultation and birthing/delivery services. These areas will also need a minimum of 2 maternity care providers to be sustainable.

NOSORH believes that potential NHSC placement sites in small population and frontier HPSAs should be evaluated with the understanding of these considerations. A separate NHSC carve-out dedicated to these areas might be considered. This would require special identification as part of the MCHPTA designation process.

- **Recommendation – Coordination of Maternity Care Service Development Efforts**

  NOSORH believes that improved rural maternal and infant health can only be achieved through the coordinated efforts of multiple agencies. Workforce development is only one piece of what must be a multi-pronged approach. Development of regional maternity services systems will also be needed as will payment policy modifications. Efforts must extend beyond HPSAs to non-HPSA areas with maternity care shortages.

  NOSORH recommends that HRSA coordinate the work of its component programs around this program focus - including the Bureau of Health Workforce (BHW), the Maternal and Child Health Bureau (MCHB), the Bureau of Primary Health Care (BPHC) and the Federal Office of Rural Health Policy (FORHP). Joint efforts should target the creation of integrated, comprehensive, regional maternity care service systems for all shortage areas.

  NOSORH also recommends that HRSA work with CMS to improve payment policies for these maternity care service systems. Emphasis should be placed on improved reimbursement of system operation and care coordination activities, both for Medicaid programs and ACA-related coverage. This will assure sustainability of expanded services.

Model Maternal and Infant Health Service System for Rural Areas

NOSORH believes that a comprehensive system of maternal and infant services should be made available for all rural communities. A comprehensive system of maternal and infant health services is comprised of multiple components, including the following:

- **Prenatal Care**: Clinical and non-clinical services for pregnant women, including:
    - **Clinical Services**
        - Routine care for low risk pregnancies.
        - Specialty care for high-risk pregnancies, including the complications of gestational diabetes and pre-eclampsia.
        - Medical screening.
        - Laboratory services.
        - Radiologic and ultrasound services.
        - Immunization.
    - **Non-Clinical Services**
        - Pregnancy and childbirth education.
        - Social/Physical Risk Factor Screening – including assessment of home environment, social determinants of health, adverse childhood experiences (ACEs) and other factors.
        - Counseling.
- **Care Coordination and Adjunct Care**: Care coordination and social support for pregnant women addressing the determinants of health:
    - **Patient care management** for all needed medical services.
    - **Social support management** to assure that mothers and infants receive all necessary adjunct services, including
        - Nutrition –WIC, SNAP and other services.
        - Income Support.
        - Health Coverage.
        - Transportation.
        - Housing
        - Child care.
- **Delivery-Related Services**: Clinical services and newborn inpatient services, including:
    - **Low-risk vaginal delivery services**.
    - **High-risk delivery services** - which can also include surgical, anesthesiology and pediatric services needed for non-vaginal deliveries.
    - **Newborn inpatient/nursery services**.

- **High-risk neonatal services** - including specialized inpatient neonatal services such as those of a neonatal ICU.
- **Newborn screening services** for metabolic, hormone, hemoglobin, genetic and other problems.

- **Post-Partum and Perinatal Care**: Clinical and non-clinical services for mother and infant. These services can be delivered at a health service facility, through home visiting or telehealth. Services can include:

  - **Perinatal (neo-natal and post-neonatal) services**, including:
    - Well-child and developmental screenings.
    - Immunizations.
    - Nutritional support.
    - Other EPSDT services.
    - Parenting and infant care education.
    - Psychological counseling.
    - Family Planning/Contraceptives
  - **Post-partum maternal services** – including screening for and treatment of depression.