National Rural Health Association Position Paper

Maternity Care in Rural America

Policy Solutions

Improving maternal health outcomes across the United States is critical, especially in rural areas. The closure of rural maternal health programs is a multi-faceted problem that requires various approaches and potential solutions, including:

- Provide adequate Medicaid coverage and provider payment
  - Incentivize the expansion of Medicaid eligibility to cover pregnant women with income below 138 percent of the federal poverty level, as well as full-year post-partum coverage
  - Establish alternative payment models for obstetrics and delivery, such as pay for performance and value-based payment models
  - Finance infrastructure to increase rural obstetric facilities, equipment, and maternal health providers
  - Expand telehealth access and reimbursement to help connect specialty OB providers with rural practitioners
- Support regionalization and integration of maternal care
  - Incentivize the integration of rural EMS programs, community health workers, other non-traditional providers specializing in maternal care, and hospitals to support maternity care in maternal health professional shortage areas
  - Incentivize local perinatal regionalization through referral networks, with focus on the level 0 hospitals that do not typically provide OB services
- Support rural maternal health workforce
  - Provide malpractice insurance supplements to rural providers, inclusive of family practice physicians
  - Develop and support rural-specific obstetrics-focused residency programs, including advanced and surgical OB training within Family Medicine and General Surgery residencies and access to OB fellowship training
  - Expand scope of practice and reimbursement for advanced practice providers and non-traditional providers subject to state regulations for professional practice
  - Support rural training programs, including interprofessional team building and simulation training
  - Advocate for midwifery and doula training programs in rural areas to provide services, such as breastfeeding/lactation counseling and mental health services
  - Provide training to combat structural racism and implicit bias

Recommended Action

- Support H.R. 769/ S.1491 Rural MOMS Act to expand initiatives to address maternal health in rural areas by establishing rural obstetric networks, awarding demonstration grants to medical schools to support education and training on MH in rural areas, and incorporating services in telehealth grant programs.
- Support H.R. 1218/ 2. 198 Data Mapping to Save Moms' Lives Act to directs the FCC to include data on certain maternal health outcomes in broadband health mapping tool.
- Support H.R. 959/ S. 346 Black Maternal Health Momnibus Act of 2021 by directing multi-agency efforts to improve maternal health among racial and ethnic minority groups, particularly related to COVID-19.
- Support H.R. 5376 Build Back Better Act to permanently extend and require Medicaid coverage continuously for 12 months postpartum.
- Support H.R. 4387 Maternal Health Quality Improvement Act of 2021 to improve MH and obstetric care in rural areas.

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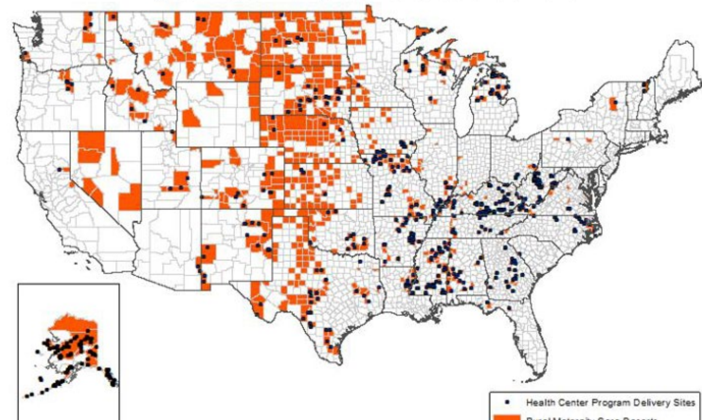
Overview

High rates of maternal morbidity and mortality continue to threaten the lives of rural residents. Maternal mortality is defined as deaths that occur during pregnancy and deaths related to pregnancy which occur up to a full year postpartum.[i] These rates are the most concerning in rural communities, where access to obstetric services is on the decline.[ii] In 2018, 23.8 maternal deaths per 100,000 live births occurred in rural counties, whereas 14.6 maternal deaths occurred per 100,000 live births in metropolitan counties.[iii] Though rural individuals who give birth face greater disparities, the issue of maternal mortality and morbidity persists throughout the country. Infants in rural, micropolitan counties had a 26 percent higher risk of death and infants in noncore counties had a 32 percent higher risk of mortality compared to infants in urban counties.[iv] This data highlights the disparities that persist throughout various parts of the country.

There are many reasons that can explain why maternal care suffers in rural areas. One reason for this disparity is structural urbanism: the lack of infrastructure in rural areas compared to urban areas, including the closure of rural hospitals or obstetric units within rural hospitals.[iv] This can be attributed to 1) maternity care clinical workforce, 2) malpractice and indemnity insurance, 3) Medicaid reimbursement rates, coverage and eligibility, 4) low volume of services, and 5) external administrative challenges. Pregnant women in rural areas often receive delayed or inconsistent prenatal care due to prohibitive factors, such as burdensome travel distances and transportation barriers.[v] The prohibitive aspects of obtaining health care in rural areas creates challenges in receiving treatment for a myriad of ailments.

Figure 1. Map of Priority Health Centers and Rural MCDs



HRSA. "Exploring Health Center Data in Rural Maternity Care Deserts. "https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/research/brief-1.pdf. Accessed December 2021

In addition to the gap in outcomes created by structural urbanism, the effects of structural racism also contribute to poor health outcomes for rural families. Not all rural mothers face the same mortality risks, as Black and Indigenous mothers have the highest rates of premature death compared to white mothers in rural counties and Black or Indigenous mothers in urban counties.[vii] Severe morbidity and mortality among Indigenous women was greater in both rural and urban areas compared to the rates of maternal morbidity and mortality among non-Hispanic white women.[vi] Among indigenous women, incidence of severe morbidity and mortality was greatest in rural areas, with 2.3 percent for rural Indigenous women and 1.8 percent for urban indigenous women.[viii] Among rural white women, the incidence of severe morbidity and mortality was 1.3 percent for rural compared to 1.2 percent for urban.[viii] The gap in health outcomes between mothers of different races underscores deep-rooted beliefs and biases, or interpersonal racism, that persists in the medical field.

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[i] World Health Organization. Indicator Metadata Registry List. Maternal Deaths. Accessed January 2022. https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4622

[ii] Kozhimannil KB, Interrante JD, Tuttle MKS, Henning-Smith C. Changes in Hospital-Based Obstetric Services in Rural US Counties, 2014-2018. *JAMA.* 2020;324(2):197–199. doi:10.1001/jama.2020.5662

[iii] U.S. Government Accountability Office. "The Additional Risks and Challenges for Pregnant Women in Rural and Underserved Communities." May 2021. https://www.gao.gov/blog/additional-risks-and-challenges-pregnant-women-rural-and-underserved-communities

[iv] Kozhimannil, K.B. Keeping Rural Infants Alive: Combatting Structural Inequities. *Pediatrics*. 2020; 146(5)

[v] deValpine MG, Jones M, Bundy-Carpenter D, Falk J (2016) First Trimester Prenatal Care and Local Obstetrical Delivery Options for Women in Poverty in Rural Virginia. J Comm Pub Health Nurs 2:137. doi:10.4172/2471-9846.1000137

[vi] Kozhimannil, K.B. et al. Severe Maternal Morbidity and Mortality Among Indigenous Women in the United States. *Obstetrics and gynecology*. 2020; 135(2), 294-300