

March 5th, 2026

Dr. Candice Chen
Associate Administrator
Bureau of Health Workforce
Health Resources and Services Administration
Rockville, MD 20857

Dear Dr. Chen:

The National Rural Health Association (NRHA) is pleased to offer comments on the Health Resources and Services Administration (HRSA) proposal to remove the Social Vulnerability Index (SVI) criteria from 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.

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.

MCTAs are to be designated and scored under a statutory [mandate](#) directing HRSA 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), in which there are six scoring criteria. The proposed rule would eliminate the two-point SVI criteria and reallocate one point to the travel time criteria and one point to the population/professional ratio criteria. HRSA identified 200 MCTAs that would decrease in score with this change, largely including areas that are designated for Medicaid eligible populations, low-income migrant worker seasonal populations, and low-income migrant farmworker populations.

NRHA appreciates that this reallocation would highlight the health care shortages and maternity care deserts in rural communities and therefore increase MCTA scores for rural areas.

Rural Obstetric Background

Approximately 18 million reproductive-aged women live in rural America.¹ 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.^{2,3} Studies show an increase in rates of out-of-hospital births, in hospital births without OB services and preterm births, and low prenatal care use in rural counties that have lost OB services.¹ There are also corresponding increases in costs, risks of complications, and longer lengths of stay when mothers have to travel

¹ 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.

² 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.

³ 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.

further for obstetric care.^{4,5} Rural residents have a 9% greater probability of severe maternal morbidity and mortality when compared to their urban counterparts, when controlled for sociodemographic factors and clinical conditions.⁶

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.⁷ More than 330 rural hospitals stopped offering obstetric services between 2011 and 2024- representing over 25% of the rural obstetric units nationwide.⁷ Based on utilization patterns, which includes the number of pregnant women who bypass a local rural hospital for urban OB services,⁸ the demand for obstetricians is projected to exceed supply, resulting in a national shortage of 6,410 full time employees by 2032.⁹ 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.⁸

Rural intersection with the Social Vulnerability Index (SVI)

The SVI is a designation tool used by the Centers for Disease Control and Prevention to identify communities at an increased risk for health stressors caused by disasters. There are four main variables: (1) socioeconomic status, including unemployment rates, uninsured rates, and education, (2) household characteristics, including individuals aged 65 and older and single-parent households, (3) racial and ethnic minority status, and (4) housing type and transportation, including mobile homes and group quarters.

Many of the variables considered in the SVI are disproportionately worse in rural areas. For example, factors in the socioeconomic status variable are core inputs to the SVI and drive many rural counties into the top quartile of vulnerability such as rural residents are less likely to have health insurance compared to individuals living in urban areas and¹⁰ are more likely to not obtain a high-school diploma.¹¹ Within the household composition and disability variables, 20% of the rural population in the United States are aged 65 years or older,¹² contributing to this area as one of the strongest rural SVI scores. Finally, rural areas tend to score as highly vulnerable in the housing type and transportation sector given limited public transportation, longer distance to travel, and higher occupancy in mobile homes.¹³

HRSA predicts an overall increase in MCTA scores by 6.6%, with 200 MCTAs likely to receive a decreased score. Decreases were stated to largely include the Medicaid eligible population and low-income migrant working population. However, scores for rural health clinics will likely increase by an

⁴ 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.

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

⁶ 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.

⁷ 2026 State of the State | Chartis. (2026, February 10). Healthcare Advisory Services and Analytics | Chartis. <https://www.chartis.com/insights/2026-rural-health-state-state>

⁸ 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>

⁹ *Workforce Projections*. (2025). Hrsa.gov. <https://data.hrsa.gov/topics/health-workforce/nchwa/workforce-projections>

¹⁰ Bureau, U. S. C. (2019, April 9). Rates of Uninsured Fall in Rural Counties, Remain Higher Than Urban Counties. *Census.gov*. <https://www.census.gov/library/stories/2019/04/health-insurance-rural-america.html>

¹¹ Employment & Education - Rural Education | Economic Research Service. (2026). *Usda.gov*. <https://www.ers.usda.gov/topics/rural-economy-population/employment-education/rural-education>

¹² Bureau, U. S. C. (2019, October 22). *In Some States, More Than Half of Older Residents Live In Rural Areas*. *Census.gov*. <https://www.census.gov/library/stories/2019/10/older-population-in-rural-america.html>

¹³ Edgell, H., & Thayer, C. (2024, June 27). Manufactured homes are more affordable and safe than ever. Can they help solve the housing crisis? *KCUR - Kansas City News and NPR*; *KCUR*. https://www.kcur.org/2024-06-27/manufactured-homes-are-affordable-and-safer-than-ever-could-they-help-solve-the-housing-crisis?utm_source=chatgpt.com



average of 1.3 points and most geographic HPSAs will experience an average increase of 1.3 points. For rural HPSAs, decrease in MCTA scores associated with HRSA's proposed changes appear to be outweighed by the potential for increased scores.

NRHA Recommendation

NRHA appreciates HRSA's efforts to intentionally create a better opportunity to recruit practicing maternity care providers in rural areas through use of shortage designation that target access to care. Difficulties recruiting and retraining obstetric providers is one of the foremost challenges facing access to obstetric services. NRHA supports HRSA's proposal to reallocate the 2 SVI points to the travel time criteria and to the population/professional ratio criteria. These two criteria reflect the realities of seeking maternal care in rural areas and will likely lead to scores that better reflect rural needs. Given the unique vulnerability factors captured in the SVI that will no longer be represented in the MCTA calculation, NRHA requests HRSA monitor how accurately the revised MCTA scores reflect rural shortage and if appropriate, consider adding back in criteria that would capture socioeconomic, housing, and transportation indicators in a future rescoring effort.

Thank you for the chance to offer feedback on the proposed changes to MCTA scoring 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 or 202-639-0550.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan", written over a light grey grid background.

Alan Morgan
Chief Executive Officer
National Rural Health Association