



**MATERNAL AND OBSTETRIC CARE  
CHALLENGES IN RURAL AMERICA**  
POLICY BRIEF AND RECOMMENDATIONS TO THE SECRETARY

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**MAY 2020**

**NACRHHS**

National Advisory Committee on Rural Health and Human Services

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**EDITORIAL NOTE**

During its 87th meeting in Atlanta, Georgia, the National Advisory Committee on Rural Health and Human Services (hereinafter referred to as “the Committee”) examined maternal health and obstetric care challenges in rural America. Throughout the course of the meeting, the Committee heard from subject matter experts on maternal health care delivery at the national and state levels. As part of the Committee’s meeting, members traveled to Macon, Georgia and Mercer School of Medicine. There, members heard from health and human service providers that serve throughout Georgia, and discussed the challenges and opportunities to improve maternal health in the state.

**ACKNOWLEDGEMENTS**

The Committee acknowledges all those whose participation helped make the May 2020 convening in Atlanta, the site visit at Mercer University, and this policy brief possible.

The Committee expresses its gratitude to each of the presenters for their contributions to the meeting and for their subject matter expertise. These individuals are: Dr. Peiyin Hung (Department of Health Services Policy and Management, Arnold School of Public Health at the University of South Carolina); Dr. Michael Warren (Maternal and Child Health Bureau); Carlis Williams (Administration of Children and Families); Dr. Jean Sumner (Mercer Medical School); Diane Durrence (Georgia Department of Public Health).

The Committee thanks Dr. Jacob Warren and Dr. Bryant Smalley, and the staff at Mercer University for hosting the Maternal Health and Obstetric Care Challenges site visit. The Committee also expresses its gratitude to all the health and human services providers that came from across Georgia to serve on the panels. The information shared and conversations that developed were greatly appreciated.

Finally, the Committee extends its gratitude and appreciation to Anne Hall for coordinating the activities of this meeting, summarizing the Committee’s findings, and contributing to this policy brief.

## POLICY RECOMMENDATIONS

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**Recommendation 1:** The Committee recommends the Secretary encourage the adoption of comprehensive, integrative, and intensive case management within the Healthy Start, Early Head Start, and the Maternal, Infant, and Early Childhood Home Visiting Programs.

**Recommendation 2:** The Committee recommends the Secretary develop guidelines and implement safety and treatment protocols in rural hospitals and clinics, both with and without OB services, to respond to obstetric complications. In addition, the Committee recommends that the Secretary encourage states to utilize and implement the Alliance for Innovation on Maternal Health (AIM) bundles, particularly the AIM Maternal Safety Bundle for the Reduction of Peripartum Racial/Ethnic Disparities.

**Recommendation 3:** The Committee recommends that the Secretary enhance CDC funding for both the CDC Levels of Care Assessment Tool (LOCATe) program and the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program to ensure all states have standardized assessments of levels of maternal and neonatal care and Maternal Mortality Review Committees.

**Recommendation 4:** The Committee recommends that the Secretary work with states to standardize scope of practice laws between and within maternal health care providers, and to expand the scope of practice for nurse midwives. This issue is of particular concern in rural areas given the shortage of obstetric providers. Certified Nurse Midwives can play a critical role if allowed to practice to the extent of their training.

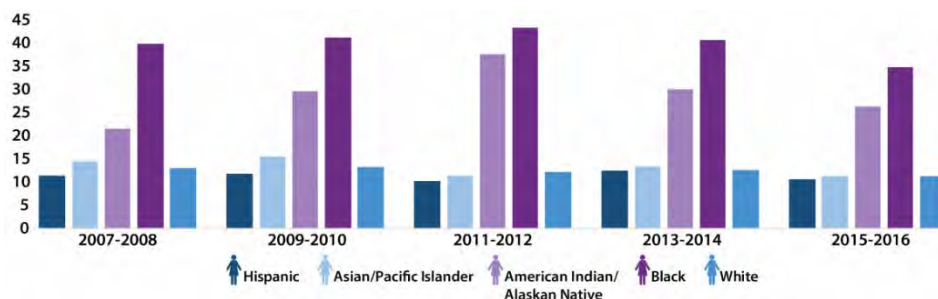
**Recommendation 5:** The Committee recommends that the Secretary, in support of the Administration's broader graduate medical education goals, include an expansion of the current statutory cap on Medicare-supported residencies that allows for support of new rural residencies in high-need areas like primary care and obstetrics.

**Recommendation 6:** The Committee recommends that the Secretary address the obstetrical workforce shortage by working with Congress to increase support for the National Health Service Corps to expand the number of physicians, nurses and certified nurse midwives working in rural and underserved areas.

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## INTRODUCTION

More than 700 women a year die of complications related to pregnancy in the U.S., and two-thirds of these deaths are preventable.<sup>1</sup> As of 2016, the U.S. pregnancy-related mortality ratio was 16.9 per 100,000 live births.<sup>2</sup> However, there are significant racial disparities within this calculated statistic (see Figure 1).



**Figure 1:** Trends in pregnancy-related mortality ratios among race from 2007-2016.<sup>3</sup>

This figure demonstrate that maternal mortality is disproportionately affecting black and American Indian/Alaska Native women in the U.S. Additionally, there are disparities between rural and urban populations. According to publicly available data from the U.S Center for Disease Control and Prevention (CDC) analyzed by *Scientific American*, rural areas had a pregnancy-related mortality ratio of 29.4 per 100,000 live births versus 18.2 in urban areas in 2015.<sup>4</sup> In Georgia, rural black women have a 30 percent higher maternal mortality rate than urban black women, and rural white women have a 50 percent higher risk than urban white women.<sup>5</sup>

CDC Pregnancy Mortality Surveillance System data from 2011-2016 shows that the five leading causes of pregnancy-related deaths are cardiovascular conditions (15.7 percent ), infection/sepsis (12.5 percent ), cardiomyopathy (11 percent ), hemorrhage (11 percent ), and other non-cardiovascular conditions (13.9 percent ).<sup>2</sup> When combined, cardiovascular conditions were responsible for more than one-third of pregnancy-related deaths from 2011-2016.<sup>2</sup>

While pregnancy-related death is highlighted to discuss the quality of maternal health care in the U.S., for many women, maternal morbidity is as equally concerning. In 2014, for every woman who died from pregnancy-related complications, seventy-one suffered from severe maternal morbidity.<sup>6</sup> Severe maternal morbidity (SMM) includes unexpected outcomes of labor and delivery that result in significant short-or long-term consequences to a woman's health.<sup>6</sup> SMM has been steadily increasing in recent years and in 2014, it affected more than 50,000 women in the US.<sup>6</sup> Furthermore, the risk of maternal morbidity may be higher for rural women. One study found that when controlled for sociodemographic factors and clinical conditions, rural residents had a nine percent greater probability of severe maternal morbidity and mortality, compared with urban residents.<sup>7</sup> Researchers have identified both clinical factors (workforce shortages) and social determinants of health (transportation, housing, poverty, food security, racism, violence, and trauma) as significant challenges faced by rural patients.<sup>7</sup> Both the rates of maternal mortality and of morbidity among rural residents highlight the importance of transforming our health care system to ensure that birth is not a deadly or traumatic experience for any woman, regardless of race, geographic location, socio-economic status (SES), and health insurance status.

## BACKGROUND

### Maternal Circumstances and Social Factors

The World Health Organization defines social determinants of health (SDH) as, “the conditions in which people are born, grow, live, work, and age, and the wider set of forces and systems shaping the conditions of daily life.”<sup>8</sup> SDH can significantly affect the prevalence of disease(s) and/or health issue(s), and as mentioned in the Committee brief on [Social Determinants of Health in 2017](#), rural communities often fare worse than their urban and suburban counterparts.<sup>9</sup> Important social determinants of health for rural communities include lack of access to health and human services, transportation challenges, lack of educational and employment opportunities, and poverty.

The impact of these SDH contribute to a variety of health issues in rural communities including those related to maternal health. Although most maternal health research has concentrated on risk factors such as poverty, SES, limited access to prenatal care and poor physical and mental health –these disparities do not fully account for high maternal mortality rates, especially among black women.<sup>4, 10, 11, 12</sup> Researchers have indicated that the chronic stress experienced by women over their life primarily affects their overall health, and consequently, a healthy pregnancy and safe delivery.<sup>13</sup> Social and environmental risk factors such as substandard housing and housing instability, concentrated poverty, food insecurity, neighborhood safety, air quality and environmental stresses, intimate partner violence, police violence, and historical trauma all contribute to chronic stress experienced by rural women, especially women of color, and their families.<sup>11</sup> This chronic exposure to stress, can consequently lead to *allostatic* load, or greater wear on the body’s adaptive systems.<sup>14</sup> The impacts of stress on the body have been well documented, and in women, can lead to increased blood pressure and heart rate, obesity, mental health issues, and more.<sup>15</sup> During pregnancy, chronically elevated levels of the stress hormone cortisol lead to immune suppression, which increases women’s risk of perinatal infections and life-threatening pregnancy complications such as preeclampsia.<sup>8</sup>

As the Committee has observed over the years, rural populations tend to have worse health outcomes than those living in urban areas. While maternal health disparities for black and Native American/Alaska Native women and/or rural women are significantly influenced by the mothers’ life circumstances growing up, these disparities are exacerbated by the lack of primary care providers and other health care professionals available to them before, during, and after pregnancy. Residents of small towns, farms, Tribal reservations, and frontier areas often have less direct or local access to primary care providers. Without primary care, it is difficult to address and manage chronic health issues that often stem from structural determinants of health, and the health complications that often follow, as seen with maternal mortality and morbidity.

### Structural and Systemic Issues

#### Insurance Coverage

In the U.S., access to quality health care depends primarily on the patient’s ability to acquire comprehensive insurance. In 2010, Medicaid covered 45 percent of babies born in the US.<sup>16</sup> In rural areas, 50 percent to 60 percent of births were covered by Medicaid.<sup>17</sup> This finding is consistent with the fact that Medicaid covers nearly one in four nonelderly individuals in rural areas.<sup>18</sup> These statistics

demonstrate that more than half of women giving birth in Rural America are covered under Medicaid, Pregnancy-related Medicaid, or Children’s Health Insurance Program (CHIP). While the federal statute requires coverage of prenatal care, delivery, postpartum care, and family planning through 60 days postpartum, after that period, individual states determine whether coverage through Medicaid continues. In several states, many new mothers become uninsured because they do not meet the state’s Medicaid income eligibility requirements for parents. As a result, many of these women become uninsured after pregnancy-related coverage ends 60 days postpartum.

The postpartum period is an important time for both mothers and infants. Women may be dealing with a host of medical conditions, such as maternal morbidity complications, pain, postpartum depression and anxiety– all while caring for a newborn. In fact, women are more likely to die of pregnancy-related conditions in the time following birth than during pregnancy or delivery.<sup>19</sup>



**Figure 2** Percentage of maternal deaths before, during, and after childbirth in the United States from 2011-2013 <sup>16</sup>

Therefore, it is worthwhile to explore the importance of states expanding Medicaid coverage from 60 days postpartum to 365 days, to ensure care for women who have delivered a baby. According to a new study conducted by Georgetown University Health Policy Institute, expanded access to Medicaid was associated with 1.6 fewer maternal deaths per 100,000 live births.<sup>20</sup> Thirty-seven states and the District of Columbia have extended Medicaid coverage for new mothers beyond 60 days, but fourteen have yet to do so.<sup>21</sup> Given that rural populations face significant challenges in health care coverage and access, expanding Medicaid rules to cover care one year postpartum would significantly help new mothers and their children in rural areas.

### Hospital Closures and Loss of Obstetric Services

Maternity care in rural areas also is dependent on hospital infrastructure. Over 120 rural hospitals have closed their doors since 2010, and nearly 700 rural hospitals are financially vulnerable and are at a high risk of closure.<sup>22</sup> These hospital closures significantly affect rural maternal health care access. The percent of all rural counties in the US without hospital obstetric services increased from 46 percent in 2004 to 55 percent in 2014.<sup>23</sup> Furthermore, it is important to note that black communities had higher odds of hospital closures (4.73 adjusted odds ratio for non-Hispanic black vs 1.0 for non-Hispanic white).<sup>24</sup> These closures force millions of women of reproductive age to travel long distances to the nearest hospital, which may or may not provide obstetric services.

Even more significant than rural hospital closures in reducing access to obstetrical care has been the closure of obstetrical units in hospitals that remain open. In the period of 2004-2014, the closure of 14 rural hospitals with obstetrics units left the counties where they were located with no obstetric services

at all. In that same period, hospitals that remained open closed 165 obstetric units leaving their counties with no available obstetric services.<sup>20</sup>

The impact of hospital closures and loss of accessible obstetric service and increased distance to travel to care has been associated with increased risk of non-indicated induced Cesarean section (which can lead to more complications), postpartum hemorrhage, prolonged hospital stay, and/or postpartum depression.<sup>25</sup> These complications are largely due to the low number of births in rural hospitals that often prevent them from preparing to deal with rare, maternal complications. Furthermore, in hospitals that do provide obstetric services, medical errors, ineffective treatments, and lack of care coordination by clinicians are major causes of preventable maternal deaths.<sup>26</sup>

Lack of care coordination and expertise is exacerbated by hospitals and states limiting midwives' ability to provide care for expecting women. Midwives attend over 30 percent of deliveries in rural hospitals (compared to 10 percent nation-wide) and Center for Medicare and Medicaid Services research shows that midwife care improves maternal and newborn health, reduces rates of unnecessary intervention, and saves money.<sup>27</sup> Despite these improved outcomes, many medical professionals worry whether midwives are a safe alternative, saying that they lack sufficient oversight.<sup>26</sup> Across the US, midwives face resistance when they seek to transfer patients to hospitals and face a number of barriers with varying regulations. For example, many states require supervision or a collaborative agreement from a partnering physician rather than allowing them to practice independently.<sup>28</sup> Considering that states that integrate midwives into their health care system have better outcomes for mothers and babies, the regulations limiting midwives in hospitals creates an impediment to the quality of rural maternal health care.<sup>25</sup>

## Workforce Shortages

Ideally, maternal health care is delivered by an array of providers. Specialty providers, primary care providers, midwives, advanced practice nurses, nurses, pharmacists, community health workers and doulas all play a critical role in providing maternal health care before, during, and after pregnancy. Currently, the US faces a significant shortage of maternal health care providers nationwide. As of 2020, there is a shortage of 9,000 obstetricians-gynecologists, which is projected to increase to 22,000 by 2050.<sup>24</sup> Fifty percent of US counties do not have an obstetrician-gynecologist (OBGYN) and 56 percent of US counties do not have a nurse midwife.<sup>24</sup> Furthermore, a 2014 analysis revealed a significantly higher number of primary care physicians worked in an urban location (53.3 per 100,000 population) compared to a rural area (39.8 per 100,000 population).<sup>29</sup> In addition to the shortages, physician turnover tends to be higher for counties that lack a hospital, have a small population, and a low supply of primary care physicians, all hallmarks of rural communities, which makes workforce recruitment and retention challenging.<sup>30</sup>

While medical schools have been increasing the number of students admitted, state residency slots have remained nearly constant (only 1 percent growth per year since 2002) limiting the number of practicing physicians.<sup>31</sup> Without re residency slots, shortages will continue to grow, specifically in rural areas. Currently, these shortages leave approximately 10 million women left to travel far distances to receive maternal care. The combination of obstetric unit closures, maternal health care workforce shortages, and resulting lack of services significantly affect maternal health before, during, and after pregnancy, ultimately comprising the factors associated with maternal mortality.



## THE ROLE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Addressing maternal mortality and improving maternal health is a priority for the U.S. Department of Health and Human Services (HHS). In late January 2020, the U.S. Surgeon General issued a report, calling all members of maternity care teams at the national, state, and community levels to work together to reduce the risk of poor health and outcomes for mothers and their babies.

Across the U.S. Department of Health and Human Services (HHS), several agencies that administer programs that support and enhance maternal health care. While there may be other agencies and programs within HHS that address maternal health and well-being, the ones that the Committee identified were the Health Resources and Services Administration (HRSA), Administration for Children and Families (ACF), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), and the National Institute of Child Development (NICD). The programs within these agencies provide essential services to mothers and their families all across America.

### HRSA Programs

With the goal of increasing access to quality health care services for geographically, economically or medically underserved populations nationwide, HRSA supports funding, training, technical assistance, and research initiatives to address a variety of issues that affect primary care, rural health, workforce development, maternal and child health, and HIV/AIDS. Programs that support maternal health care within HRSA, are found in the Maternal and Child Health Bureau (MCHB), the Bureau of Primary Health Care (BPHC), and the Federal Office of Rural Health Policy (FORHP).

The mission of MCHB is to improve the health and wellbeing of America's mothers, children, and families. MCHB relies upon evidence-based strategies to implement programs and monitor their effectiveness through data-driven means. These programs include the [Maternal, Infant, and Early Childhood Home Visiting \(MIECHV\) Program](#), [Healthy Start, Alliance for Innovation on Maternal Health \(AIM\) Initiative](#), [State Maternal Health Innovation \(State MHI Program\)](#), and the [Remote Pregnancy Monitoring Challenge](#) among many others. Additionally, MCHB runs the [Title V Maternal and Child Health Services Block Grant Program](#) which seeks to create federal and state partnerships that support access to quality health care for mothers and children, including prenatal and postnatal care, health promotion efforts, health assessments, preventive and child care services, as well as meet their nutritional needs. These programs are critical to providing the necessary care for mothers and their children throughout the United States.

The Bureau of Primary Health Care funds Community [Health Centers](#), which are community and patient-directed organizations that deliver comprehensive, culturally competent, high-quality primary health care services. Health centers overcome geographic, cultural, linguistic, and other barriers to care by delivering coordinated and comprehensive primary and preventive services. Health Centers provide comprehensive primary care to over 28 million people, of whom roughly 1 in 5 are rural residents. Health centers help address disparities in primary and prenatal care for underserved populations across America.

The Federal Office of Rural Health Policy administers several [community-based programs](#), through which grantees may focus their activities on maternal health care coordination. FORHP also oversees funding for [telehealth networks](#), which can play a pivotal role in addressing the disparity in the supply of rural OBGYNs, circumventing long distances, and improving care coordination for rural patients. Finally, in

collaboration with MCHB, FORHP administers the [Rural Obstetrics Management Strategies \(RMOMS\) program](#), which funds rural hospitals to pilot, test, and develop models that improve access to and continuity of, maternal obstetrics care in rural communities.

### **CDC Programs**

As the nation's public health agency, the CDC conducts research and surveillance, and provides health information to safeguard the public from disease and other health threats. Within the CDC, the Division of Reproductive Health (DRH), National Center for Chronic Disease Prevention and Health Promotion, provides scientific leadership in the promotion of women's health and infant health, before, during, and after pregnancy. In addition, DRH works to reduce disease and death among mothers and babies, with special attention to reducing racial and ethnic differences in these health outcomes. While they do not specifically focus on rural maternal health, they support rural communities through their various programs. Through the [Pregnancy Mortality Surveillance System](#), the DRH is able to not only track, but learn more about the causes of pregnancy-related deaths and the risk factors associated with those deaths. Furthermore, the DRH provides support for state-based [Perinatal Quality Collaboratives](#) (PQCs). PQCs are state or multi-state networks of teams in both urban and rural facilities that work together to improve the quality of care for mothers or babies. PCQ members identify health care processes that need to be improved and use the best available methods to make changes as quickly as possible.

In order to better assess and monitor levels of care among states, the CDC developed [the CDC Levels of Care Assessment Tool \(LOCATe\)](#). This is a tool, implemented through web-based platforms, that helps states and other jurisdictions create standardized assessments of levels of maternal and neonatal care by facility. Risk-appropriate care is a strategy developed to improve health outcomes for pregnant women and their infants. Many states have developed coordinated regional systems to ensure that pregnant women and infants at high risk of complications receive care at the birth facilities that is best prepared to meet their needs. Further, the CDC has made awards to support states in developing [the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality \(ERASE MM\) Program](#). This funding directly supports agencies and organizations that coordinate and manage Maternal Mortality Review Committees to identify, review, and characterize maternal deaths; and identify prevention opportunities.<sup>32</sup> These programs supported by the Division of Reproductive Health are not only improving data measurements on pregnancy-related deaths but also addressing the maternal mortality crisis through strengthening networks and review committees.

### **CMS Programs**

As the administrator of health care services for Medicare and Medicaid beneficiaries, CMS regulates coverage of care before, during, and after pregnancy. By law, all states provide Medicaid coverage for pregnancy-related services to pregnant women with incomes up to 133 percent of the federal poverty level (FPL) and cover them up to 60 days postpartum. All states must provide some level of maternity care free of cost-sharing to eligible pregnant women, although there are state level variations in the scope and type of services that states offer. In addition, many states extend eligibility to pregnant women with incomes considerably higher than this threshold. States are required to provide prenatal care, delivery, postpartum care, and family planning, as well as services for conditions that may threaten carrying the fetus to delivery.<sup>33</sup>

Rural maternal health care is an administration priority and CMS is focused on improving rural maternal health outcomes. Specifically, CMS has aligned health policies to its Rural Health Strategy and its new Rethinking Rural Health Initiative, and has released its first Medicaid and Children’s Health Insurance Program (CHIP) Scorecard to evaluate state progress on maternal health outcomes. The Scorecard includes a measure related to postpartum care and may eventually include other maternal and infant health outcomes.

## **Administration for Children and Families**

The Administration for Children and Families (ACF) promotes the economic and social well-being of families, children, individuals and communities with funding, strategic partnerships, guidance, training and technical assistance. A number of ACF’s programs help support both the physical and social well-being of mothers, including [Head Start](#), [Temporary Assistance for Needy Families \(TANF\)](#), and the [Healthy Marriage and Responsible Fatherhood \(HMRP\) initiative](#). These programs play an integral role in supporting families as they address numerous social determinants of health such as food insecurity, persistent poverty, and familial and community support. As mentioned previously, it is imperative to address social determinants of health when preventing maternal mortality and morbidity as the mother’s environment and situation can have a significant effect on her and her child’s health outcome.

## **POLICY RECOMMENDATIONS**

The Committee believes that to improve maternal health across the life span and reduce maternal mortality and morbidity, HHS needs an intersectional, comprehensive, multi-dimensional strategic approach. The Committee envisions that every women in rural America should be able to access affordable, quality, patient-centered, and non-discriminatory health care throughout her life. To reduce rural maternal mortality disparities, the Committee presents the following recommendations, which focus on enhancing care coordination between health and human services, improving health care delivery and quality measures, and addressing workforce issues. Subject matter experts and stakeholders presented to the Committee during its March 2020 meeting in Atlanta and the subcommittee’s site visit to Mercer University in Macon, GA. Their input helped to inform the Committee’s work.

### **Enhance Care Coordination between Health and Human Services**

At its site visit to Mercer University in Macon, GA, the Committee consistently heard about the challenges rural women in Georgia face navigating pregnancy and the years following. Many women are single mothers and lack support from their family and/or partner. Therefore, there is great need to support social service programs such as Healthy Start, Early Head Start, and the Maternal, Infant, and Child Home Visiting Program as these human services programs provide holistic care for mothers and help them navigate the challenges that arise before, during, and after childbirth. These programs address multiple social determinants of health for mothers as they provide a wide array of health and human services. From assisting mothers on how best to breastfeed and care for their babies to promoting positive parenting to working with mothers to set goals for the future, continue their education, and find employment and childcare solutions – these programs address the physical, emotional, and social wellbeing of the mother and child. Yet, these programs, especially in rural areas, continue to be underfunded and lack adequate resources and support.

Given the importance of addressing social determinants of health to reduce maternal mortality, the Committee encourages HHS agencies to continue investing these human services programs within the

Maternal and Child Health Bureau and The Administration for Children and Families. During the site visit, Committee members heard about the need for strengthened human service programs delivered by HHS. Therefore, the first recommendation is:

**Recommendation 1:** The Committee recommends the Secretary encourage the adoption of comprehensive, integrative, and intensive case management within the Healthy Start, Early Head Start, and the Maternal, Infant, and Early Childhood Home Visiting Programs.

### **Improving Maternal Health Care Delivery and Quality Measures**

Because of low patient volumes and lack of obstetric providers in rural areas, many rural hospitals (especially those without OB services) are not prepared to handle complications that arise both during and after childbirth. The Committee believes treatment protocols should be developed and implemented in critical access hospitals in order to prevent both maternal mortality and morbidity. As mentioned in the programs under the Maternal and Child Health Bureau, the Alliance for Innovation on Maternal Health (AIM) is a national data-driven maternal safety and quality improvement initiatives based on proven implementation approaches to improve maternal safety and outcomes in the US. Currently, AIM works through state teams and health systems to align national, state and hospital -level quality improvement efforts to improve maternal health outcomes. AIM is funded through a cooperative agreement with MCHB and although they offer numerous safety bundles on a range of issues, there no bundle specifically addressing hospitals and clinics that do not have OB services. To increase the preparedness of rural hospitals, the Committee suggests its second recommendation:

**Recommendation 2:** The Committee recommends the Secretary develop guidelines and implement treatment protocols in rural hospitals and clinics, both with and without OB services, to respond to obstetric complications. In addition, the Committee recommends that the Secretary encourage states to utilize and implement the AIM bundles, particularly the AIM Maternal Safety Bundle on the Reduction of Peripartum Racial/Ethnic Disparities.

By creating and implementing treatment protocols for rural hospital and clinics to be able to offer OB services, the Committee believes that the risk of maternal mortality and morbidity will be reduced because health care providers will be more equipped when a pregnancy complication arises. Furthermore, by encouraging the use and utilization of the AIM Maternal Safety Bundle on the Reduction of Peripartum Racial/Ethnic Disparities, the Committee believes that the disparities among racial groups, specifically black and Native American/Alaska Native women, can be reduced.

In addition to implementing treatment protocols, the Committee believes attention needs to be focused on perinatal regionalization of care to ensure that all pregnant women are receiving timely access to risk-appropriate care. The American College of Obstetricians and Gynecologists (ACOG) and the Society of Maternal-Fetal Medicine has established Levels of Maternal Care to help providers identify the most appropriate locations for each birth within their region based on perinatal risk factors.<sup>34</sup> Levels of Maternal Care are important to rural communities in identifying and referring high-risk women to providers with the appropriate skills for their needs. One example is the previously mentioned CDC [Levels of Care Assessment Tool \(LOCATe\)](#) to support decision making about risk-appropriate care for women in rural areas. The Committee believes that there needs to be improvement in care coordination among health providers, especially as it relates to high-risk pregnancy. With improved care coordination and better risk assessments of pregnancies, the Committee believes maternal mortality and morbidity can be reduced.

Additionally, the Committee recognizes the importance of Maternal Mortality Review Committees (MMRC) as they bring together a wide range of professionals together to facilitate an understanding of the drivers of maternal mortality and complications of pregnancy and the associated disparities. MMRCs also inform the implementation of initiatives in the right place for families and communities who need them most. Currently, the CDC supports 25 states in the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality Program. The Committee believes the ERASE MM Program should be implemented in all states. Therefore, the third recommendation is:

**Recommendation 3:** The Committee recommends that the Secretary enhance CDC funding for both the CDC Levels of Care Assessment Tool (LOCATe) program and the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program to ensure all states have standardized assessments of levels of maternal and neonatal care and Maternal Mortality Review Committees.

### Addressing Workforce Issues

To improve maternal health care delivery, rural communities need to leverage all providers, from OBGYNs to primary care physicians to advanced practice nurses to clinical nurse midwives. During the site visit at Mercer, the Committee consistently heard of the importance of certified nurse midwives (CNMS) as they often meet an essential gap in the lack of both primary care physicians and OGBYNS. However, as discussed previously, nurse midwives face many restrictions in their scope of practice. For example, although all 50 states allow CNMS to practice, many states require supervision or a collaborative agreement from a partnering physician rather than allowing CNMS to practice independently. Practice laws between and within maternal healthcare professions are inconsistent across states. The Committee believes that there are opportunities to standardize laws both federally and among the states to ensure that women in rural communities have access to high-quality maternal health care. For example, the Interstate Medical Licensure Compact is an agreement between 26 states, one territory and 37 Medical and Osteopathic Boards, and allows licensed physicians to practice across state lines if they meet eligibility requirements. The Committee believes standardization such as this one can improve care coordination with a wide variety of maternal health care providers, ultimately making it easier for rural women to access high quality care. Therefore, the fourth recommendation is:

**Recommendation 4:** The Committee recommends that the Secretary work with states to standardize scope of practice laws between and within maternal health care providers, and to expand the scope of practice for nurse midwives. This issue is of particular concern in rural areas given the shortage of obstetric providers. Certified Nurse Midwives can play a critical role if allowed to practice to the extent of their training.

In addition to removing barriers that prevent providers from working together and taking care of patients, the Committee believes it is necessary to address the shortage of healthcare providers. During the site visit, the Committee heard of the workforce shortages for maternal-fetal medicine physicians, OBGYNS, primary care physicians, nurses, midwives and doulas that disproportionately affect rural communities. This shortage is critical to address as it exacerbates the lack of access to care for rural women and their families, which can contribute to poor health outcomes.

Although medical schools have been consistently increasing their class size, the number of residency spots have remained relatively constant. Without increasing residency spots, the physician workforce shortage will continue to worsen. As mentioned previously, there already is a 9,000 OBGYN shortage nationwide and the American Association of Medical Colleges predicts that by 2032 there will be an expected shortage of 21,100 to 55,200 primary care physicians.<sup>35</sup> The Committee recognizes that it is imperative to address the nationwide shortage of physicians, particularly in rural areas. While recognizing that HHS has been examining the adequacy of residency positions and has proposed reforms to the Graduate Medical Education system, the Committee sees the cap on residency slots as a major barrier to an adequate rural health care workforce. Therefore, the fifth recommendation is:

**Recommendation 5:** The Committee recommends that the Secretary, in support of the Administration’s broader graduate medical education goals, include an expansion of the current statutory cap on Medicare-supported residencies that allows for support of new rural residencies in high-need areas like primary care and obstetrics.

Additionally, to address the workforce shortage specifically for rural areas, the Committee believes that it is necessary to support loan repayment programs. Therefore, the sixth recommendation is:

**Recommendation 6:** The Committee recommends that the Secretary address the obstetrical workforce shortage by working with Congress to increase support for the National Health Service Corps to expand the number of physicians, nurses and certified nurse midwives working in rural and underserved areas.

## POLICY CONSIDERATIONS

In addition to the policy recommendations listed above, the Committee also sets forth several policy considerations to address maternal and obstetric care challenges in rural America. Policy considerations consist of actions the Committee thinks should be taken that may involve work across multiple departments or to be outside the jurisdiction of HHS. These considerations also were informed by subject matter experts and site visit stakeholders.

### Medicaid Policy – Expanding Postpartum Coverage from 60 Days after Birth to 1 Year

During the site visit to Mercer University, the Committee heard clearly from stakeholders of the need to modify Medicaid coverage for women and families. Physicians, nurses, Healthy Start and Head Start directors, and CEOs of rural hospitals emphasized the necessity of increased access to insured care for low income women to address not only the lack of access to care but also the break in continuity of care. Considering that 50-60 percent of rural babies are born under Medicaid, the program plays an integral role in access to quality health care before, during, and after pregnancy for rural mothers and their children. The CMS studied rural access to maternal care in 2019 and issued, [Improving Access to Maternal Health Care in Rural Communities](#). The brief acknowledges, “There is a need for coverage beyond that immediate postpartum period, given the ongoing pregnancy-related risks and chronic conditions that women experience up to a year after giving birth.” The Committee supports efforts that benefit women in the vulnerable postpartum period. These observations lead the Committee’s first consideration:

**Consideration 1:** The Committee is aware that states now have the option to extend the period of Medicaid coverage to one year postpartum, and would benefit from considering it as an option to improve maternal health outcomes.

### **Investing and Strengthening a High-Functioning Maternal Health System**

In addition to strengthening standardized assessments of levels of maternal and neonatal care for maternal health, the Committee recognizes the importance of strengthening care coordination for maternal health. During the site visit, the Committee heard from CEOs of several rural hospitals and Federally Qualified Health Centers about the challenges they face in coordinated care delivery and ensuring access to obstetric services for rural women in Georgia. The Committee believes rural communities would benefit from the use of regionally networked models of obstetric care and supports the President's 2021 budget proposal to expand the Rural Obstetric Management Strategies program.

Furthermore, the Committee believes it is important to invest in the range of maternal health providers. In 2012, the US Department of Health and Human Services launched the Strong Start for Mothers and Newborns Initiative, which sought to reduce preterm births and improve outcomes for newborns and pregnant women. Women who received prenatal care in the Strong Start Birth Centers had better birth outcomes and lower costs relative to similar Medicaid beneficiaries not enrolled in Strong Start<sup>25</sup>. Given the findings from the Strong Start evaluation and other studies demonstrating the reduced costs and improved outcomes of perinatal service models that include midwifery, birth centers, and other providers (i.e. doulas, peer counselors, community health workers), the Committee believes that Medicaid agencies and private insurers can utilize and adopt these models to improve maternal health outcomes.

**Consideration 2:** The Committee suggests the Secretary consider visible support for the President's 2021 budget proposal to expand the Rural Obstetric Management Strategies program, while also supporting perinatal service models that include midwifery, birth centers, maternal medical homes, doulas, peer counselors and community health workers.

## **CONCLUSION**

The US has the highest maternal mortality rate out of all developed countries in the world.<sup>36</sup> Evidence points towards significantly high maternal deaths of black and Native American/Alaska Native women, especially those in rural areas. There are significant challenges facing rural women from accessing comprehensive, affordable, quality health and maternal health care. Given the scale and scope of the issue, through its recommendations, the Committee emphasizes the importance of investing in human service programs, strengthening care coordination and health care delivery, and addressing various workforce issues. Furthermore, the Committee highlights the challenges associated with Medicaid coverage and lack of networked models of maternal health care. The Committee understands that

addressing the maternal mortality and morbidity health crisis is a top priority within HHS. Although there are numerous programs that have been developed to improve maternal health outcomes, barriers such as persistent poverty, transportation challenges, lack of affordable quality health insurance, chronic health conditions, and workforce shortages have made it difficult to address a complex issue such as rural maternal health care. Through its policy recommendations and considerations, the Committee hopes that these barriers can be better addressed in order to ensure that every woman in rural America has safe and healthy pregnancy, delivery, and post-natal outcome.





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