Keeping Obstetrics Local Act

Senators Wyden, Hassan, Stabenow, Cantwell, Carper, Cardin, Brown, Bennet, Casey, Warner, Whitehouse, Cortez Masto, Warren, Helmy, Duckworth, Booker, Merkley, and Murray.

Hospital maternity units are closing at an alarming rate, and Americans in rural and medically underserved areas are bearing the brunt of this crisis. Closures of rural labor and delivery units force expectant mothers to travel long distances outside of their community to receive perinatal care, lead to more births outside of a hospital setting, and result in higher rates of preterm deliveries.[1]

Recent research highlights the devastating magnitude of the issue. From 2011 to 2021, 267 rural hospitals stopped providing obstetrics services.[2] That equates to roughly one out of every four rural hospitals in the country. Other research underscores the widening gaps in access to maternal health care. In 2022, over 2.3 million women of childbearing age lived in counties without an obstetric facility or clinician, and approximately 60 percent of maternity care deserts were in rural counties.[3]

The accelerating pace of closures coincides with a national maternal mortality crisis. The maternal mortality rate in the United States is 22.3 deaths per 100,000 live births.[4] This is the highest maternal mortality rate of any high-income country–and often more than double, sometimes triple the rate for most other countries.[5] Maternal mortality trends are even more alarming for Black, American Indian, and Alaska Native women, who face mortality rates two times higher than non-Hispanic White women.[6] Closures of hospital obstetrical units that serve high rates of people with Medicaid coverage and people of color have been found to exacerbate these racial and ethnic disparities in severe maternal morbidity.[7]

The epidemic of hospital closures of maternity centers is produced by several overlapping challenges, including the high fixed operating costs of these units, low volumes of births, and difficulties in attracting and retaining OB-trained clinical staff, all of which is exacerbated by inadequate reimbursement for labor and delivery services.

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[1] Kozhimannil, K et al, "Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States," March 2018. Available at: https://pubmed.ncbi.nlm.nih.gov/29522161/

[2] Chartis, "Rural America's OB Deserts Widen in Fallout From Pandemic," Dec. 2013. Available at: https://www.chartis.com/sites/default/files/documents/rural_americas_ob_deserts_widen_in_fallout_from_pandemic_12-19-23.pdf

[3] March of Dimes, "Nowhere to Go: Maternity Care Deserts Across The U.S. 2024 Report," Sept. 2024. Available at: https://www.marchofdimes.org/sites/default/files/2024-09/2024_MoD_MCD_Report.pdf

[4] CDC, "Maternal Mortality Rates in the United States, 2022," May 2024. Available at: https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2022/maternal-mortality-rates-2022.pdf

[5] The Commonwealth Fund, "Insights Into the U.S. Maternal Mortality Crisis: An International Comparison," June 2024, https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison

[6] CDC, "Disparities and Resilience among American Indian and Alaska Native People who are Pregnant or Postpartum," Nov. 2022. Available at: https://www.cdc.gov/hearher/aian/disparities.html

[7] McGregor, A et al, "Obstetrical unit closures and racial and ethnic differences in severe maternal morbidity in the state of New Jersey," November 202. Available at: https://pubmed.ncbi.nlm.nih.gov/34496307/

The Keeping Obstetrics Local Act would address the root causes of labor and delivery unit closures in rural and underserved areas by**:**

- Increasing Medicaid payment rates for labor and delivery services with enhanced federal financing for eligible rural and high-need urban hospitals
- Establishing a Medicaid labor and delivery revenue floor to cover the costs of staffing and maintaining obstetric services at low-volume hospitals
- Providing Medicaid payments to ensure low-volume hospitals meet the minimum revenue floor–with the requirement that additional funds are invested in labor and delivery services within the hospital's local community
- Mandating that each state study and report the costs of providing labor and delivery services in its rural and medically underserved areas and report its results to the Department of Health and Human Services
- Providing grants and technical assistance to support small rural obstetric hospitals for conducting the required state studies
- Expanding Medicaid flexibilities for innovative care delivery, including through maternal health homes
- Requiring states to provide coverage for postpartum women in Medicaid for 12 months
- Directing CMS to publish guidance supporting access to Medicaid-covered maternal health professionals such as midwives and doulas
- Incentivizing states to expand depression and anxiety screening before, during, and after birth
- Requiring states to allow qualified entities to screen pregnant women for presumptive eligibility.
- Providing hospitals with the option to request emergency obstetrics providers from the United States Public Health Service (USPHS) Commissioned Corps
- Simplifying out-of-state Medicaid screening and enrollment processes for obstetric care providers and requiring state Medicaid programs to enroll obstetric care providers in neighboring states
- Requiring hospitals to provide timely notification of an impending hospital obstetric unit closure to help communities prepare alternative options for safe maternal health care
- Adding new elements to Medicare cost reports to improve federal data collection on the costs of operating hospital obstetric units

The bill is endorsed by: The American Academy of Family Physicians, American College of Nurse Midwives, American College of Obstetricians and Gynecologists, America's Essential Hospitals, Catholic Health Association, Community Catalyst, Families USA, Hospital Association of Oregon, March of Dimes, National Partnership for Women & Families, National Rural Health Association, Oregon Perinatal Collaborative.

Keeping Obstetrics Local Act
Section-by-Section
Senators Wyden, Hassan, Stabenow, Cantwell, Carper, Cardin, Brown, Bennet, Casey, Warner, Whitehouse, Cortez Masto, Warren, Helmy, Duckworth, Booker, Merkley, and Murray.

Section 1. Short Title; Table of Contents
This section provides that the short title is "Keeping Obstetrics Local Act" and outlines a table of contents.

Title I – Enhancing Financial Support For Rural And Safety Net Hospitals That Provide Obstetric Services

Section 101. State studies and HHS report on costs of providing maternity, labor, and delivery services.
This section requires states to conduct a study on the costs of providing maternity, labor, and delivery services in hospitals and submit a report detailing the results of this study to the Department of Health and Human Services (HHS). State studies must examine the estimated costs of these services in hospitals serving a high percentage of Medicaid patients, hospitals with fewer than 300 births per year, and hospitals that ceased providing labor and delivery services in the last five years. State studies must also complete a comparative rate analysis for labor and delivery services paid through Medicaid, Medicare, and private health insurance.

States must complete studies within one year of enactment, and repeat the study every five years. HHS must submit a report to Congress that provides recommendations on improving data collection on maternity, labor, and delivery costs within two years of enactment.

This section also provides $10 million per year beginning in FY25 for grants and technical assistance to support small rural hospitals that provide obstetric services to assist these hospitals in compiling detailed information for state studies.

Section 102. Requiring adequate payment rates under Medicaid for maternity, labor, and delivery services at eligible hospitals.
This section increases the base Medicaid payment rate for maternity, labor, and delivery services, including behavioral health services provided in relation to maternity care, to 150 percent of the Medicare rate to eligible hospitals. Eligible hospitals include rural hospitals, Indian Health Service providers, and hospitals providing labor and delivery services to a majority of Medicaid, Medicare, and uninsured patients. The payment rate will be updated every 5 years based on an analysis of the costs of providing maternity, labor, and delivery services based on studies outlined in Section 101.

Section 103. Increased federal financial participation for maternity, labor, and delivery services furnished by eligible hospitals.
This section increases the federal medical assistance percentage (FMAP) for maternity, labor, and delivery services at eligible hospitals. This section provides that 100 percent of the costs of meeting the new rate benchmark defined in Section 102 are borne by the federal government, and provides the state's enhanced federal matching assistance percentage (E-FMAP) for all other spending on these services.

Section 104. Labor and delivery services anchor payments.
This section establishes a Medicaid labor and delivery revenue floor to cover labor and delivery costs at low-volume obstetric hospitals and provides supplemental payments to hospitals to meet the Medicaid

labor and delivery revenue floor. Low-volume obstetric hospitals are those with fewer than 300 births per year.

The Medicaid labor and delivery revenue floor would be based on the number of births paid by Medicaid in a fiscal year. Specifically, the Medicaid labor and delivery revenue floor would be calculated by:

- Multiplying a minimum additional revenue per birth (starting at $10,000 in FY27) by the total number of births in excess of 30
- Adding a standby capacity amount (starting at $1.2 million in FY27) meant to cover overhead costs maintaining labor and delivery services at all times, such as personnel, equipment, and facilities
- Multiplying the sum by the proportion of total births paid by Medicaid

State Medicaid programs would provide supplemental payments to cover the difference between the Medicaid labor and delivery revenue floor and the total Medicaid payments the low-volume obstetric hospital actually received in the fiscal year.

Hospitals would be required to keep the supplemental funding in the community it was intended for and pay the funds back if the hospital system decides to close the hospital or labor and delivery unit within two years of receiving the supplemental funding. The federal match rate for these payments is equal to the E-FMAP. Hospitals would receive these payments so long as they conduct skills maintenance and training activities for their workforce to support maintenance of obstetric skills.

Section 105. Application of adequate payment requirement and increased federal financial participation requirements to CHIP.
This section extends the enhanced payment rate and federal financial participation for maternity, labor and delivery services to the CHIP program.

Section 106: Disregarding increased and additional payments to hospitals for purposes of other supplemental payments and upper payment limits.
This section provides that increased and supplemental payments for maternity, labor, and delivery services under this legislation will not affect the eligibility for or amount of other supplemental payments (e.g., disproportionate share hospital payments). The payments under this legislation also do not affect federal caps on the aggregate amount of supplemental payments to states, such as the upper payment limit.

<u>Title II – Expand Coverage of Maternal Health Care</u>

Section 201. Requiring 12-month continuous, full benefit coverage for pregnant individuals under Medicaid and CHIP.
This section mandates states provide 12 months of continuous coverage of full benefits for pregnant and postpartum individuals under Medicaid and CHIP, replacing the current state option.

Section 202. Health homes for pregnant and postpartum women.
This section creates an option for state Medicaid programs to provide, and receive enhanced federal funding for, a “health home” for pregnant and postpartum women. Health homes allow a designated provider to coordinate care for the patient amongst a group of providers and ensure individualized, comprehensive and culturally appropriate patient-centered care. A health home integrates primary, acute, behavioral health, health-related social needs services, and long-term services and supports to treat the whole person.

Section 203. Guidance on supporting and improving access to Medicaid and CHIP coverage of services provided by doulas and other maternal health professionals.
This section instructs the HHS Secretary to issue guidance for supporting and improving access to coverage of and payment to doulas, certified midwives, and other maternal health professionals in rural areas, across a continuum of care and among varied provided settings and payment and care models under the Medicaid program.

Section 204. Medicaid and CHIP increased financial support for depression and anxiety screening during the perinatal and postpartum periods.
This section increases the FMAP by one percentage point for screening for depression and anxiety during the perinatal and postpartum periods.

Section 205: Presumptive eligibility for pregnant individuals
This section requires states to allow qualified entities to screen pregnant women for a presumptive eligibility period, which is currently a state option.

Title III – Invest in The Maternal Health Care Workforce

Section 301. Emergency obstetric workforce support.
This section establishes a new statutory authority for the HHS Secretary to deploy obstetrics-trained providers from the Commissioned Corps of the U.S. Public Health Service (USPHS) to certain hospitals and states with urgent maternal health care needs, such as in cases of hospital closures or the loss of maternal health care services or workforce. This section outlines requirements for hospitals, the federal government, and states to cover the cost of these workers. This section authorizes $150,000,000 in annual funding for activities of the Commissioned Corps for the new statutory authority outlined in this bill and for broader activities.

Section 302. Streamlined screening and enrollment of Medicaid providers of labor and delivery services in neighboring States.
This section requires state Medicaid programs to establish a process through which qualifying out-of-state obstetric providers may enroll as participating Medicaid providers for five years without undergoing additional screening requirements.

Title IV – Requiring Public Communication of Obstetrics Data and Unit Closures

Section 401. Timely notifications of impending hospital obstetric unit closures.
This section requires a hospital planning to close its obstetrics unit to submit a report to the HHS Secretary and State and local agencies, at least 180 days prior to closure, a report analyzing the impact the closure will have on the community. This report will include data on any projected adverse health outcomes and increase in costs related to obstetric services for the community, steps the hospital will take to identify other health care providers that can alleviate any service gaps, the cause of the obstetric unit closure, and information on transportation costs related to obstetrics services for the community.

Section 402. Collection of data relating to hospital labor and delivery.
This section amends the Medicare cost reports to require hospitals to report certain metrics on maternal, labor, and delivery services. These metrics include the number of cesarean and vaginal births, the number of antenatal and postpartum transfers to other hospitals, the number and characteristics of the staff of the hospital's obstetric unit, the costs of providing labor and delivery services, and the amount and revenue sources for labor and delivery services, including payments from Medicaid, private insurance, and through self-pay.