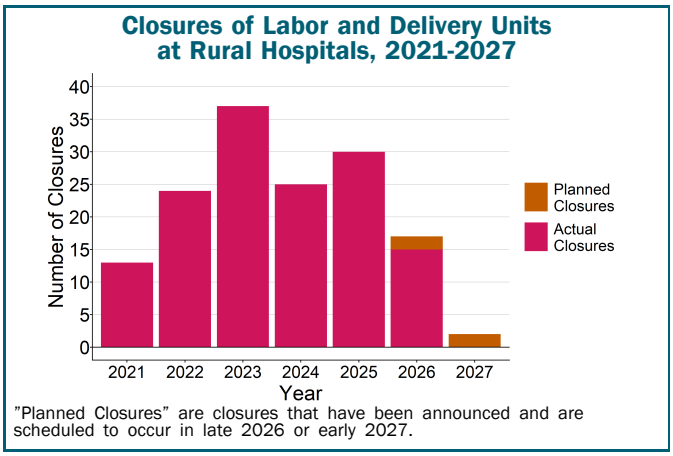
CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

STOPPING THE LOSS OF RURAL MATERNITY CARE

Over 140 Rural Labor & Delivery Units Have Closed Since 2020

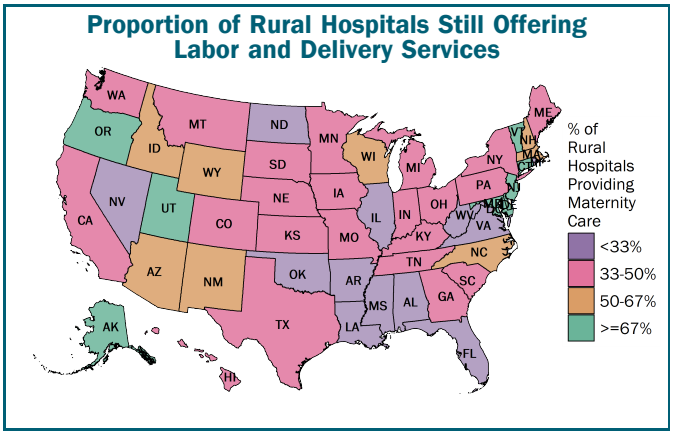
Since the end of 2020, 144 rural hospitals have stopped delivering babies and 4 more announced they will stop by early 2027, a 14% reduction in rural labor and delivery units. Over the past 6 years, rural obstetric units have closed in the majority of states, and in 5 states, 1/4 or more of the rural maternity hospitals stopped delivering babies. Over the past 6 years, there has been an average of more than 2 closures per month.



"Planned Closures" are closures that have been announced and are scheduled to occur in late 2026 or early 2027.

Most Rural Hospitals in the U.S. No Longer Deliver Babies

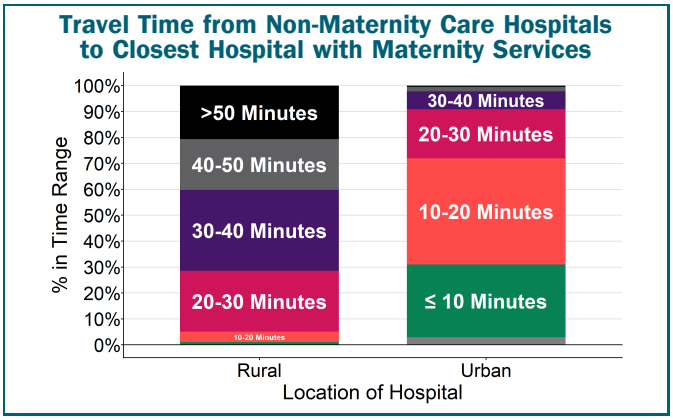
Less than half (40%) of U.S. rural hospitals still offer labor and delivery services; in 12 states, less than one-third do.



Maternity Care is Far Away for Mothers in Many Rural Communities

If the closest hospital does not offer labor and delivery services, a pregnant woman may have to travel to a different community to deliver her baby. In most urban areas, the travel time to a hospital with labor and delivery services is under 20 minutes, but in rural areas, the travel time is likely to be at least 30 minutes, and it is often 50 minutes or more.

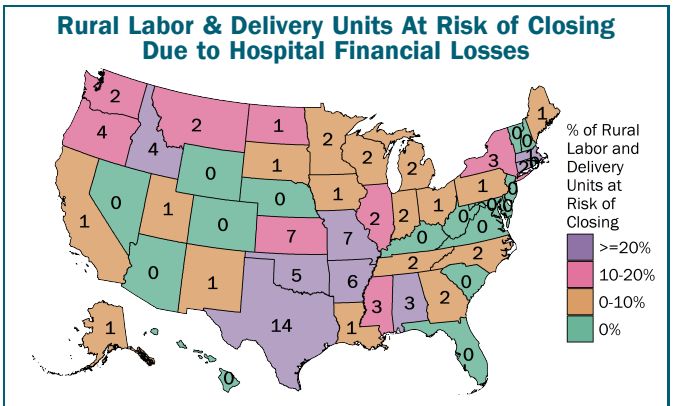
There is a higher risk of complications and death for both mothers and babies in communities that do not have local maternity care services. Women are less likely to obtain adequate prenatal and postpartum care when it is not available locally.



Many More Rural Communities Are at Risk of Losing Maternity Care

Payments from private insurance plans and Medicaid programs often do not cover the high cost of delivering safe, high-quality maternity care, particularly in rural areas. Many rural hospitals can't offset financial losses on maternity care because they aren't making profits on other types of services.

90 rural hospitals that are still delivering babies lost money overall in both of the two most recent years, and they could be forced to close labor and delivery services in order to survive. In 7 states, at least one-fifth of the rural maternity care hospitals are in this situation.



A Labor and Delivery unit is counted as "at risk of closing" if the hospital lost money on all patient services (not just labor and delivery services) in both of the two most recent years available and also had a negative total margin in both years.

RURAL MATERNITY CARE AT RISK

State	Closures of Rural Labor & Delivery			Rural Hospitals Without L&D Services		Rural Hospitals Still Planning to Provide Labor and Delivery (L&D) Services in 2027				
	# of L&D Units Closed Since 2020	# of Additional L&D Closures Currently Planned[1]	% of Rural Hospital L&D Units Closed	# of Rural Hospitals With No L&D in 2027	Median Driving Time (in Minutes) to Hospital With L&D Services	% of Rural Hospitals With L&D in 2027	# of Rural Hospitals With L&D Services	# of L&D Units at Risk of Closing[2]	% of L&D Units at Risk of Closing[2]	Median Minutes to Alternative L&D Hospital
Maine	7	1	42%	13	41	46%	11	1	9%	43
West Virginia	4	0	40%	28	43	18%	6	0	0%	51
Indiana	13	0	36%	31	30	44%	24	2	8%	34
Arkansas	6	0	27%	36	39	31%	16	6	38%	49
Connecticut	1	0	25%	1	31	75%	3	2	67%	38
Virginia	3	0	23%	24	42	27%	9	0	0%	44
Wyoming	4	0	22%	13	63	52%	14	0	0%	48
Ohio	9	0	22%	41	30	45%	33	1	3%	30
Pennsylvania	5	0	22%	33	38	37%	19	1	5%	38
Illinois	5	0	20%	59	32	25%	20	2	10%	39
Colorado	4	0	19%	26	44	40%	17	0	0%	51
New York	4	1	18%	31	38	43%	23	3	13%	45
California	5	0	17%	34	49	42%	25	1	4%	46
Idaho	3	0	17%	14	39	52%	15	4	27%	37
South Carolina	2	0	17%	12	39	45%	10	0	0%	44
Michigan	5	0	16%	39	35	40%	26	2	8%	46
Minnesota	8	1	16%	51	30	48%	47	2	4%	31
Iowa	5	1	15%	61	32	35%	33	1	3%	31
New Mexico	3	0	15%	11	63	61%	17	1	6%	58
Missouri	4	0	14%	35	35	41%	24	7	29%	44
Georgia	4	0	14%	49	36	34%	25	2	8%	41
Louisiana	2	0	13%	44	37	23%	13	1	8%	32
Wisconsin	6	0	13%	40	32	51%	41	2	5%	29
Tennessee	3	0	12%	33	36	40%	22	2	9%	40
Alabama	2	0	12%	36	45	29%	15	3	20%	39
Oregon	3	0	11%	10	37	71%	24	4	17%	51
South Dakota	2	0	11%	32	48	35%	17	1	6%	47
Vermont	1	0	10%	4	41	69%	9	0	0%	38
Washington	2	0	9%	25	39	44%	20	2	10%	39
Oklahoma	2	0	9%	58	39	27%	21	5	24%	46
Nebraska	3	0	8%	37	31	49%	35	0	0%	31
Kansas	3	0	8%	67	32	35%	36	7	19%	41
Texas	5	0	7%	96	37	40%	63	14	22%	40
Kentucky	2	0	7%	43	32	39%	28	0	0%	37
North Carolina	2	0	5%	20	33	64%	36	2	6%	38
Montana	1	0	5%	35	60	34%	18	2	11%	54
Mississippi	1	0	4%	51	35	31%	23	3	13%	35
Alaska	0	0	0%	5	>90	69%	11	1	9%	>90
Arizona	0	0	0%	13	50	52%	14	0	0%	80
Delaware	0	0	0%	0		100%	3	0	0%	27
Florida[3]	0	0	0%	20	50	9%	2	0	0%	>90
Hawaii	0	0	0%	7	38	46%	6	0	0%	68
Maryland	0	0	0%	2	48	78%	7	0	0%	43
Massachusetts	0	0	0%	3	32	57%	4	1	25%	76
Nevada	0	0	0%	10	56	29%	4	0	0%	>90
New Hampshire	0	0	0%	9	34	50%	9	0	0%	42
New Jersey	0	0	0%	0		100%	2	0	0%	28
North Dakota	0	0	0%	31	63	18%	7	1	14%	77
Rhode Island	0	0	0%	1	31	0%	0	0	0%	
Utah	0	0	0%	1	35	95%	21	1	5%	36
U.S. Total	144	4	14%	1,375	37	40%	928	90	10%	40

[1] Closures scheduled to occur by the end of 2026 or early 2027.
[2] A Labor and Delivery unit is counted as being "at risk of closing" if the hospital lost money on all patient services (not just L&D services) in both of the two most recent years available and also had a negative total margin in both years.
[3] Two rural Florida hospitals that closed their obstetric units were reclassified as urban in 2025, so they are no longer included here.

Data are current as of October 2026

Actions Needed to Preserve and Strengthen Rural Maternity Care

Rural hospitals can't provide labor and delivery services if they are unable to recruit an adequate number of qualified clinicians and staff, but they can't afford to employ those staff unless health insurance plans pay the hospital adequately for their services. Maintaining access to high-quality maternity care in rural areas requires addressing both the workforce recruitment and payment challenges facing rural hospitals.

Help Rural Communities Attract and Retain a Maternity Care Workforce

Safe, high-quality maternity care requires having physicians who can perform cesarean sections, physicians and/or midwives who can assist women with vaginal deliveries, nurses who are trained in obstetric and newborn care, and anesthesiologists and/or nurse anesthetists, all of whom are available on a 24/7 basis to manage deliveries and perform cesarean sections when necessary. Obstetricians and family physicians who can perform C-sections are increasingly unable or unwilling to be on call for a large number of nights and weekends every month. As a result, hospitals have to either employ more physicians, contract with additional physicians to cover on-call shifts, or change to entirely different models of staffing, such as hiring or contracting for ob-gyn hospitalists or laborists. In addition, all hospitals have been experiencing challenges recruiting and retaining registered nurses, but the challenges are greater for maternity care hospitals because they need nurses who have training and experience in obstetrics.

A national workforce shortage requires a national solution. Otherwise, filling a position at one small rural hospital may simply create or extend a vacancy at another hospital, and hospitals with greater financial resources may be filling their positions at the expense of hospitals in lower-income communities. A rural maternity workforce strategy must include:

- **Recruiting and Training for *Rural* Maternity Care.** It is not enough to simply train physicians, midwives, and nurses in maternity care and hope that they will be willing to work in rural areas. Medical and nursing students need to be recruited and trained specifically to deliver care in rural areas.
- **Remote Specialty Support for Rural Maternity Care Teams.** Physicians, midwives, and nurses will be better able and hopefully more willing to deliver obstetric care in rural areas if they have access to remote support from maternal-fetal medicine specialists and from staff who have had experience addressing infrequently-occurring complications.
- **New Staffing Models for On-Call Coverage.** Since the traditional model of long hours of on-call coverage is becoming less viable, new models of staffing and compensation must be developed that can be used to successfully recruit and retain physicians who can perform C-sections.

Pay Adequately for Maternity Care Services

Higher costs for maternity care staffing mean that higher payments are needed from insurance plans to cover those costs. Moreover, payments per birth that are adequate at a large hospital will be too low to support maternity care at a small rural hospital. The reason is that the total cost of having physicians, nurses, midwives, and anesthetists available 24/7 can be the same at a small hospital as a larger hospital, but since there are fewer births at the small hospital, the same payment per birth generates insufficient revenue to cover that cost.

It is often assumed that low Medicaid payments and uninsured patients are the reasons hospitals lose money on maternity services, but over 40% of births in rural communities are paid for by private health plans, so inadequate payments from private payers also threaten the viability of rural maternity care.

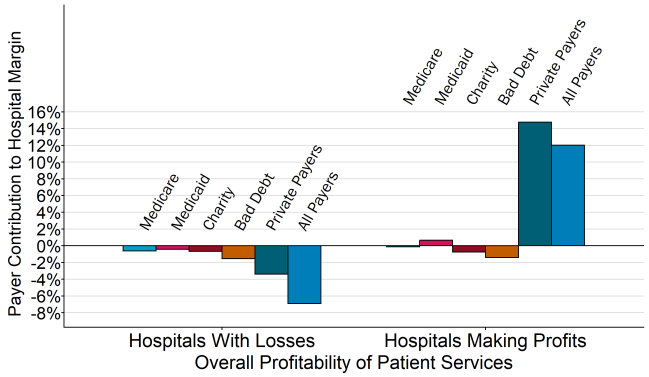
Employers should require their health insurance plans to demonstrate that their payments are adequate to cover the cost of rural maternity care services. Similarly, states should require Medicaid plans to pay adequate amounts for rural maternity care services. This includes payments for: (1) perinatal care services from physicians and midwives; (2) assistance during labor and delivery from appropriately-trained nurses; (3) anesthesia services (for pain relief and C-sections); and (4) telemedicine assistance from specialists for complex cases. Payment amounts must be higher in communities that have difficulty attracting staff, and payments must also be higher in communities with smaller numbers of births to ensure the hospital can afford the cost of on-call coverage.

Require Adequate Payments from Private and Public Payers for Other Rural Healthcare Services

It does little good to pay adequately for maternity care if losses on other services force a hospital to close completely. The majority of small rural maternity care hospitals are losing money on other services such as emergency care and primary care. Many small rural hospitals are at risk of shutting down because of the overall financial losses they have been experiencing. *Rural Hospitals at Risk of Closing* provides more information on the extent of this problem and how to address it.

The primary cause of these overall losses is *not* low Medicaid or Medicare payments or losses on uninsured patients. As shown in the chart below, the biggest problem is private insurance companies (including Medicare Advantage plans as well as commercial health insurance) paying rural hospitals less than what it costs to deliver services to patients. Conversely, the small rural maternity hospitals that avoid overall losses do so by receiving payments from private health plans that not only cover the costs of services (of all types) to the patients with private insurance but also offset the hospitals' losses on services to uninsured and Medicaid patients.

Payer-Specific Profits/Losses on Patient Services at Rural Maternity Care Hospitals



The bars show the median profit or loss on all services (both maternity and non-maternity) delivered to patients with each type of insurance.

Source: Hospital cost reports for 2025 at rural hospitals with labor & delivery services.

Employers and residents of rural communities should only choose health plans that pay adequately for services delivered at the rural hospital. It is particularly important to ensure that payments from insurance plans support the costs of primary care and gynecologic care as well as obstetric care:

- OB-Gyn physicians deliver care for gynecologic conditions as well as obstetric services, so adequate payments for both their gynecologic and obstetric services are needed. Adequate payments will also help ensure that all types of women's health services are available in rural communities.
- In many small rural communities, C-sections and other obstetric care will be delivered by family physicians rather than obstetricians. These physicians need to be paid adequately by health plans for the primary care services they deliver as well as for maternity care.
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can serve as an important way of supporting maternity care as well as primary care services in rural areas. However, private insurers and Medicaid programs need to pay them adequately for the cost of delivering maternity care, primary care, and other services to patients.

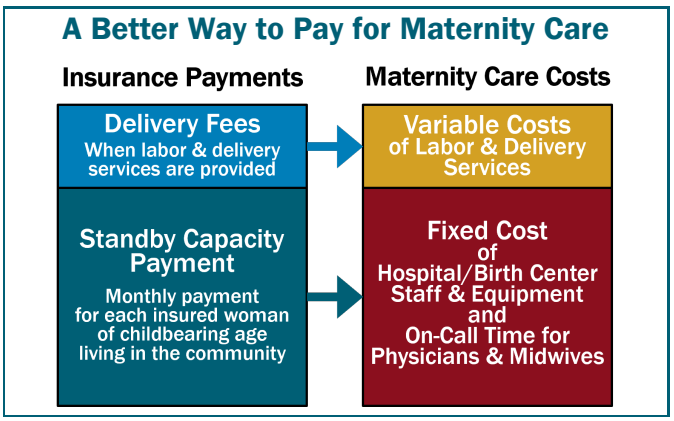
Create Standby Capacity Payments to Support the Fixed Costs of Maternity Care

Financial losses in maternity care are caused not only by the inadequate *amounts* paid by insurance plans, but by the problematic *method* currently used to pay for services. The physicians and staff at a maternity care hospital must be standing by, 24 hours a day, ready to deliver a baby at all times. Currently, however, they are only paid when they actually deliver a baby, even though there may be no deliveries at all on many days. As a result, when there is a small number of births, or fewer births than expected, the hospital and clinicians will lose money, even if payments would have been adequate for a larger number of births. Moreover, since payments are typically higher for C-sections, hospitals and clinicians that support natural childbirth and reduce their C-section rate could lose money as a result.

A better approach is for private insurers and Medicaid programs to pay for maternity care using a combination of two different types of payments instead of only paying after a birth occurs:

1. **Standby Capacity Payments.** If a rural hospital and its physicians and midwives maintain the round-the-clock staffing needed to deliver babies and perform C-sections at any time, a health insurance plan should pay them a monthly or quarterly *Standby Capacity Payment* for each woman of childbearing age who is insured by that health plan and lives in the hospital's service area. The amount of the Standby Capacity Payment should be equal to the amount needed to maintain adequate on-call staffing for labor and delivery services, divided by the total number of insured women ages 15-44 in the community. In aggregate, the Standby Capacity Payments from all private and public health plans would provide the hospital, physicians, and midwives with sufficient revenue to cover the fixed costs of labor and delivery services.
2. **Delivery Fees.** In addition to the Standby Capacity Payments, the hospital and clinicians should receive a *Delivery Fee* when labor and delivery services are provided to an individual mother. If the hospital's fixed costs for labor & delivery and the on-call costs for physicians and midwives are paid for through the Standby Capacity Payments, the Delivery Fee would only need to cover the extra (i.e., variable) time and costs associated with individual births. As a result, the Delivery Fee could be much smaller than current payments for labor and delivery. In addition, the Delivery Fee should be the same amount for a vaginal delivery and a C-section, so there is no financial penalty if the hospital, physicians, and midwives are able to safely increase the proportion of vaginal deliveries and reduce the number of C-sections.

Under this two-part payment system, spending for health plans and revenue for hospitals and clinicians would be far more predictable than under the current system of paying per birth.



More details on this approach to payment are described in *A Better Way to Pay Rural Hospitals*.

Immediate Action is Needed to Address the Crisis in Rural Maternity Care

Mortality rates for infants and mothers in the U.S. are among the highest in the world. Pregnant women are more likely to die in the U.S. than in Australia, Britain, Canada, France, Germany, and most other developed countries. Moreover, Black women in the U.S. are 2-3 times as likely to die for pregnancy-related causes as other racial and ethnic subgroups.

Over 80% of pregnancy-related deaths are preventable with appropriate prenatal, labor & delivery, and post-partum care. Although improvements in maternity care are needed in all parts of the country, one of the greatest challenges is in rural areas, because most rural hospitals are no longer providing maternity care at all. The problem will get worse if more rural communities lose maternity care.

Training Emergency Department staff in rural hospitals to deliver babies or providing rural women with prenatal care by telehealth are not adequate solutions. Rural communities need help to recruit and retain a sufficient number of obstetric-trained physicians, midwives, and nurses, and they need payments from insurance plans that cover the cost of delivering high-quality maternity care in a rural area.

Rural maternity care is in a state of crisis, and more women and babies in rural communities will die unnecessarily until the crisis is resolved. Federal and state government officials, health plans, and private employers must take immediate action to ensure that all rural communities have access to high-quality maternity care.