STROUDWATER

Pathways to Sustainability for Rural Labor & Delivery Programs

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SUMMARY

This brief summarizes the best practices to follow and mistakes to avoid for improving the sustainability of rural labor and delivery programs based on relevant case studies from rural healthcare facilities across the nation. The goal of this extract is to help rural hospital and health system leaders analyze the performance of labor & delivery programs more accurately and identify strategies to enhance program sustainability.

KEY TAKEAWAYS:

The following takeaways are gleaned from the experiences of rural obstetrics (OB) programs across the United States:

- Sustaining access to obstetrics services in rural areas is critical to maternal and fetal health outcomes.
- An obstetrics service line can be sustainable for rural hospitals.

The information in this brief highlights the need for more accurate evaluation of service line performance to better inform decision-makers.

AN EVALUATION OF THE OB SERVICE LINE SHOULD INCLUDE:

- Accurate allocation of costs on the Medicare cost report for Critical Access Hospitals (CAHs)
- Leveraging independent Federally Qualified Health Clinics (FQHCs) and independent Rural Health Clinics (RHCs):
  - Depending on the guidance issued by individual states, independent FQHCs and RHCs can receive more favorable payment rates for Medicaid enrollees' pre- and post-natal clinic visits.
  - For example, in the state of Texas, independent FQHCs and RHCs can allow for unbundled[1] Medicaid pre- and post-natal visit payments.
  - The medical malpractice insurance cost for FQHC employed providers is significantly reduced due to the Federal Tort Claims Act.
- Accurate and comprehensive calculation of the contribution margin of an obstetrics service line, including:
  - Ancillary revenue
  - Impact on 340B program[2] eligibility
  - Evaluation of direct and variable costs
  - Exclusion of overhead costs from the analysis
- Spreading anesthesia standby costs between obstetrics and inpatient surgery volume

Hospital leaders can also employ the following strategies to enhance the sustainability of the program:

- Family practice physicians trained to provide obstetrics services ("FPOBs") can eliminate or reduce the need for separate pediatric call coverage and rounding expenses and enhance the organization's primary care capacity for non-obstetrics patients.
- Low-volume rural obstetrics programs can partner with regional medical centers to maintain provider and staff clinical competencies through access to the necessary volume of cases and peer learning opportunities.

CHALLENGES:

The primary challenges associated with obstetrics care in rural settings include the following:

- The ability to recruit obstetrics providers to rural communities
- High direct and standby costs (i.e., anesthesia, surgery, pediatrics call coverage, etc.) of obstetrics programs with limited volume to dilute mostly fixed costs
- Low relative Medicaid and Medicaid MCO payment, which often underpays relative to the actual costs of obstetrics programs
- Relatively low volume of deliveries, which challenges providers and nursing staff to maintain clinical competencies and adversely impacts program financial viability, especially when inpatient surgery volume is lacking

CASE STUDIES:

T01: East Coast Critical Access Hospital

A partnership between this East Coast Critical Access Hospital (CAH) and a local Federally Qualified Health Clinic (FQHC) created a sustainable obstetrics program. The CAH transferred the employed providers to the FQHC and agreed to provide ongoing financial assistance to sustain the obstetrics provider practice within the FQHC in return for transparency on the operations of that practice.

As a result of the partnership with the FQHC, the local labor and delivery program has improved sustainability through enhanced FQHC clinic visit payments for pre- and post-natal visits of Medicaid enrollees, access to Section 330 Grant[3] funds and relief from medical malpractice insurance costs since FQHC employees are considered federal employees and are, therefore, generally immune from medical malpractice claims.

[1]The term "Bundled payments" refers to a single Medicaid payment for the entire episode of care, including pre- and post-natal visits and labor and delivery.

[2]The 340B Drug Pricing Program is a federal program that allows Critical Access Hospitals and other qualifying healthcare organizations to purchase drugs at a discount from pharmaceutical manufacturers. The program was created in 1992 to help safety-net hospitals, which serve low-income patients and communities, manage rising drug prices.

[3]Section 330 grant funding supports ongoing care to the uninsured and underinsured, establishment of new sites, expansion of services and responses to emerging public health issues and priorities.

Both FQHCs and independent Rural Health Clinics (RHCs) can play a critical part in creating a sustainable pre- and post-natal clinic business model. Depending on the state, independent RHC and FQHC clinic visits can be paid at 2-3 times the standard Medicaid clinic visit rate. In 2022, 41.3%[4] of all deliveries nationally were covered by Medicaid, illustrating the potential significant benefits of independent RHC[5] and FQHC[6] payment rates to obstetrics programs.

02: Western Critical Access Hospital

This Western CAH, which serves a significantly isolated population, decided to discontinue its obstetrics program. Before closing the program, this CAH performed more than 400 deliveries annually, which is frequently sufficient volume to be financially viable and maintain the clinical competencies of key staff.

Hospital leadership made the decision primarily based on identifying of a $3.0 million loss on OB services. However, the apparent loss on obstetrics services was due to a misallocation of costs on the cost report; $6 million of obstetrics program costs were allocated to the labor & delivery ancillary department, which has no cost-based reimbursement. Approximately 75% of inpatient costs for inpatient obstetrics care (when patients are not in active labor or delivery) can be allocated to the medical-surgical cost center, which receives cost-based reimbursement.

By properly reallocating these costs to the medical-surgical cost center, the hospital would have received incremental cost-based payments of $2.5 million, making up more than 80% of the loss on the OB program. This analysis did not include potential impacts on spinoff ancillary services, which provides additional upside from retaining the program.

03: Southeastern Critical Access Hospital

A CAH in the southeast that performed 80 deliveries annually discontinued its obstetrics program because it only had one Family Practice (FP) obstetrics provider who operated out of an RHC. The hospital had to call in additional providers approximately 60% of the time for obstetrics call coverage (no clinic visits included), and thus, 100% of call compensation was "professional" and not allowable for cost report purposes. The total cost to the hospital of obstetrics call compensation and the professional costs for anesthesia totalled roughly $800,000 annually.

[4]Section 330 grant funding supports ongoing care to the uninsured and underinsured, establishment of new sites, expansion of services and responses to emerging public health issues and priorities.

[5]RHC Payment Rates: the all-inclusive rate for non-grandfathered RHCs is $139 in 2024. This amount will increase to $152 in 2025 with continued annual increases until reaching $190 in 2028.

[6]FQHC Payment Rates: FQHCs are paid a 2024 base rate of $195.99 per visit with adjustments based on regional costs, with a 34% increase for a first-time visit. There are additional adjustments for Preventive Physical Exams or Annual Wellness Visits. FQHC malpractice insurance is significantly reduced over others, and they often receive 330 expansion grants when providing/opening obstetrics services.

The lack of providers to limit call coverage costs was a key factor in program closure. Typically, three (FP) obstetrics providers are needed to provide a long-term sustainable call schedule for a labor & delivery program.

Utilizing (FP) obstetrics providers allows an organization to avoid pediatric call coverage and rounding expenses as the (FP) obstetrics providers can provide these services. The FP obstetrics providers also expand general primary care capacity for the rural health system, which can also be a critical need.

04: Southeastern Acute (PPS) Hospital

An acute-care hospital in the southeast maintained a successful obstetrics program. The hospital included obstetrics provider costs in its RHCs, offsetting a significant amount of call coverage costs.[7]

The hospital's advisors had analyzed the program and recommended closing it. However, this analysis did not account for the resulting impact on the Medicaid payer mix with the discontinuation of their obstetrics program, which would have reduced the hospital's disproportionate share percentage below 340B eligibility requirements. The loss of 340B program eligibility would reduce the hospital's bottom line by $2.5 million annually. This impact has not been included in the original analysis.

In other instances where a rural labor and delivery program has been evaluated, the financial feasibility analysis of the obstetrics program has included overhead costs, which will obscure whether the obstetrics program has a positive contribution margin (enhances overall hospital financial performance) or not. A proper analysis of service line performance should not include overhead costs and should include "spinoff" effects from related ancillary services. Ultrasounds, lab work, and clinic visits are some direct spinoff benefits from a labor and delivery program.

[7]Locating obstetrics providers in independent RHCs (or FQHCs) can also improves per visit reimbursement for Medicaid enrollees.

CONCLUSION:

There is a pathway to sustainability for many rural labor and delivery programs, even when confronting a challenging landscape. As the case studies reveal, mistakes in evaluating program performance and missed opportunities to enhance program sustainability can result in the unnecessary closure of these crucial programs. Each of the challenges regarding payment rates, provider shortages and staff shortages warrants additional focused interventions by policymakers at the state and national levels. Regardless of the policy environment, however, improving decision-making and program evaluation regarding rural OB program feasibility and pursuing proven strategies to enhance program sustainability are essential strategies for retaining existing rural OB programs.

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