STROUDWATER

Flex Monitoring Team

SUSTAINING RURAL LABOR & DELIVERY PROGRAMS

Strategies & Considerations

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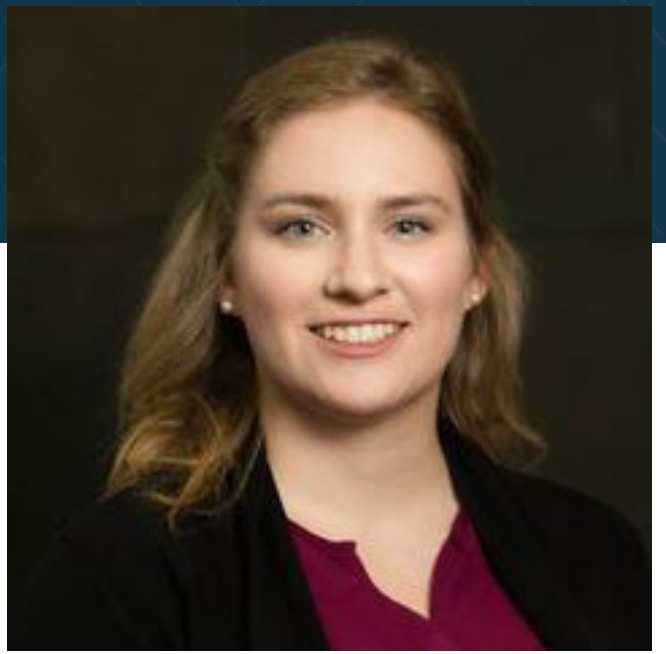

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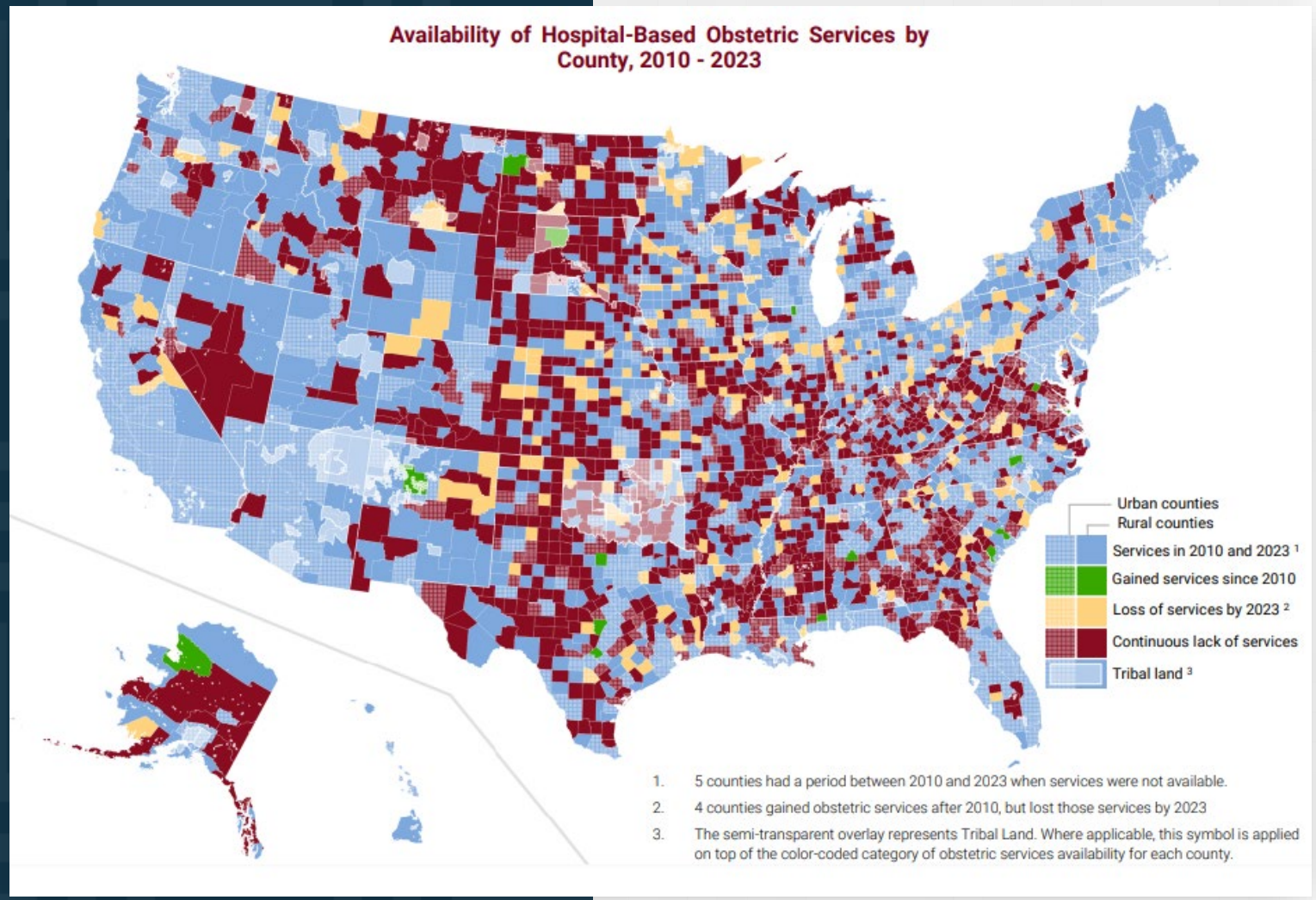
THE CHALLENGE

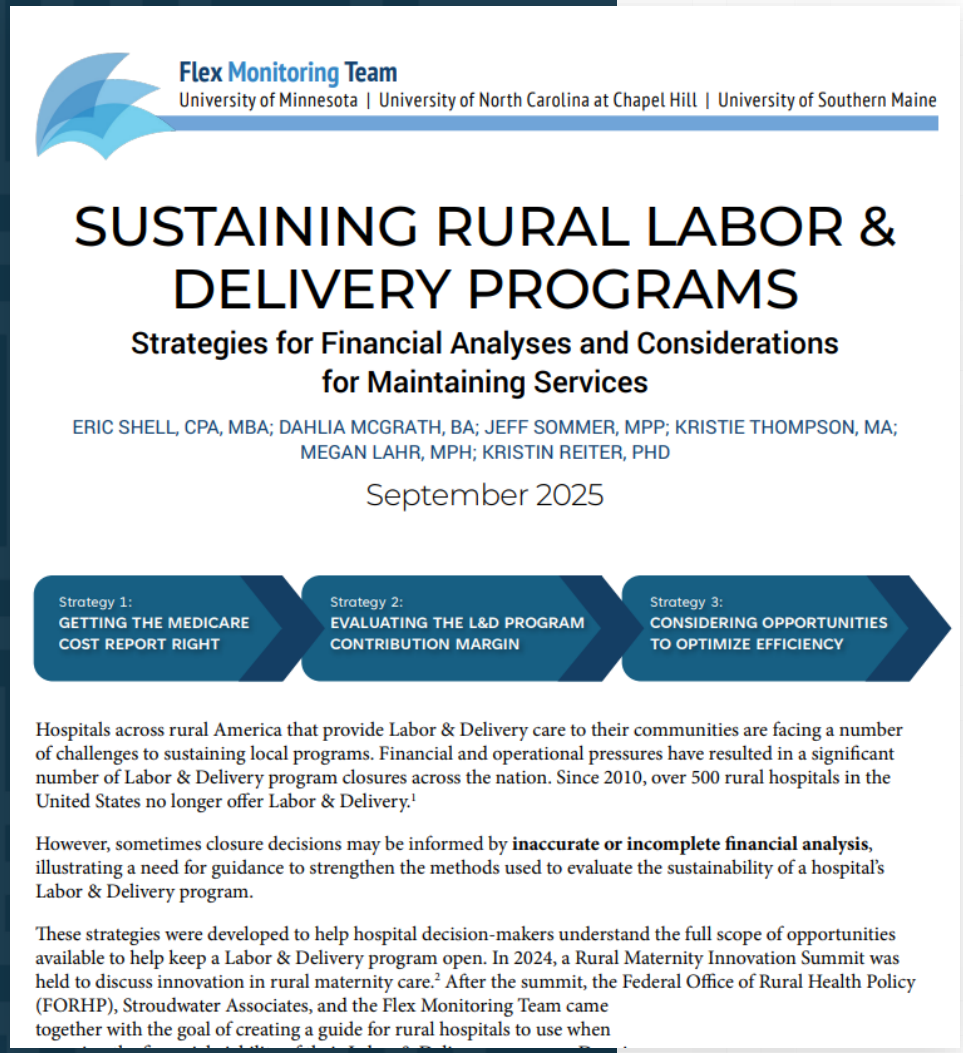


Map Source: "Availability of Hospital-Based Obstetric Services in the United States by County, 2010–2023: A State-by-State Report", https://rhrc.umn.edu/wp-content/uploads/2026/01/2010-2023-State-by-State-Report_1.5.26_fullquality.pdf

- Hospitals across rural America that provide Labor & Delivery (L&D) care to their communities are facing challenges to sustaining local programs.
- Financial and operational pressures have resulted in a significant number of Labor & Delivery program closures across the nation.
- Between 2010 and 2022, 238 rural hospitals lost their obstetrics programs.

Source: "Obstetric Care Access at Rural and Urban Hospitals in the United States", https://jamanetwork.com/journals/jama/fullarticle/2827543

However, sometimes closure decisions may be informed by **inaccurate or incomplete financial analysis**, illustrating a need for guidance to **strengthen the methods used to evaluate the sustainability** of a hospital's Labor & Delivery program.



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SUSTAINING RURAL LABOR & DELIVERY PROGRAMS

Strategies for Financial Analyses and Considerations for Maintaining Services

ERIC SHELL, CPA, MBA; DAHLIA MCGRATH, BA; JEFF SOMMER, MPP; KRISTIE THOMPSON, MA; MEGAN LAHR, MPH; KRISTIN REITER, PHD

September 2025

Strategy 1: GETTING THE MEDICARE COST REPORT RIGHT

Strategy 2: EVALUATING THE L&D PROGRAM CONTRIBUTION MARGIN

Strategy 3: CONSIDERING OPPORTUNITIES TO OPTIMIZE EFFICIENCY

Hospitals across rural America that provide Labor & Delivery care to their communities are facing a number of challenges to sustaining local programs. Financial and operational pressures have resulted in a significant number of Labor & Delivery program closures across the nation. Since 2010, over 500 rural hospitals in the United States no longer offer Labor & Delivery.[1]

However, sometimes closure decisions may be informed by **inaccurate or incomplete financial analysis**, illustrating a need for guidance to strengthen the methods used to evaluate the sustainability of a hospital's Labor & Delivery program.

These strategies were developed to help hospital decision-makers understand the full scope of opportunities available to help keep a Labor & Delivery program open. In 2024, a Rural Maternity Innovation Summit was held to discuss innovation in rural maternity care.[2] After the summit, the Federal Office of Rural Health Policy (FORHP), Stroudwater Associates, and the Flex Monitoring Team came together with the goal of creating a guide for rural hospitals to use when

BACKGROUND

- The Federal Office of Rural Health Policy (FORHP), Stroudwater Associates, and the Flex Monitoring Team came together to create a resource for rural hospitals to use when assessing the financial viability of their Labor & Delivery programs.
- Drawing on case studies from previous Stroudwater engagements, this resource outlines a series of strategies that may bring a Labor & Delivery program **closer to sustainability** and **prevent unnecessary closure of services in rural areas**.

ABOUT THIS RESOURCE

- This resource is for Critical Access Hospital (CAH) CEOs, CFOs, and State Flex Programs to share with their hospitals.
- The framework provides information to support **informed decision-making** and **optimize resource allocation** to improve financial sustainability and ensure continued access to care.

SUSTAINING RURAL LABOR & DELIVERY PROGRAMS

UNDERSTANDING PROFITABILITY VS. SUSTAINABILITY

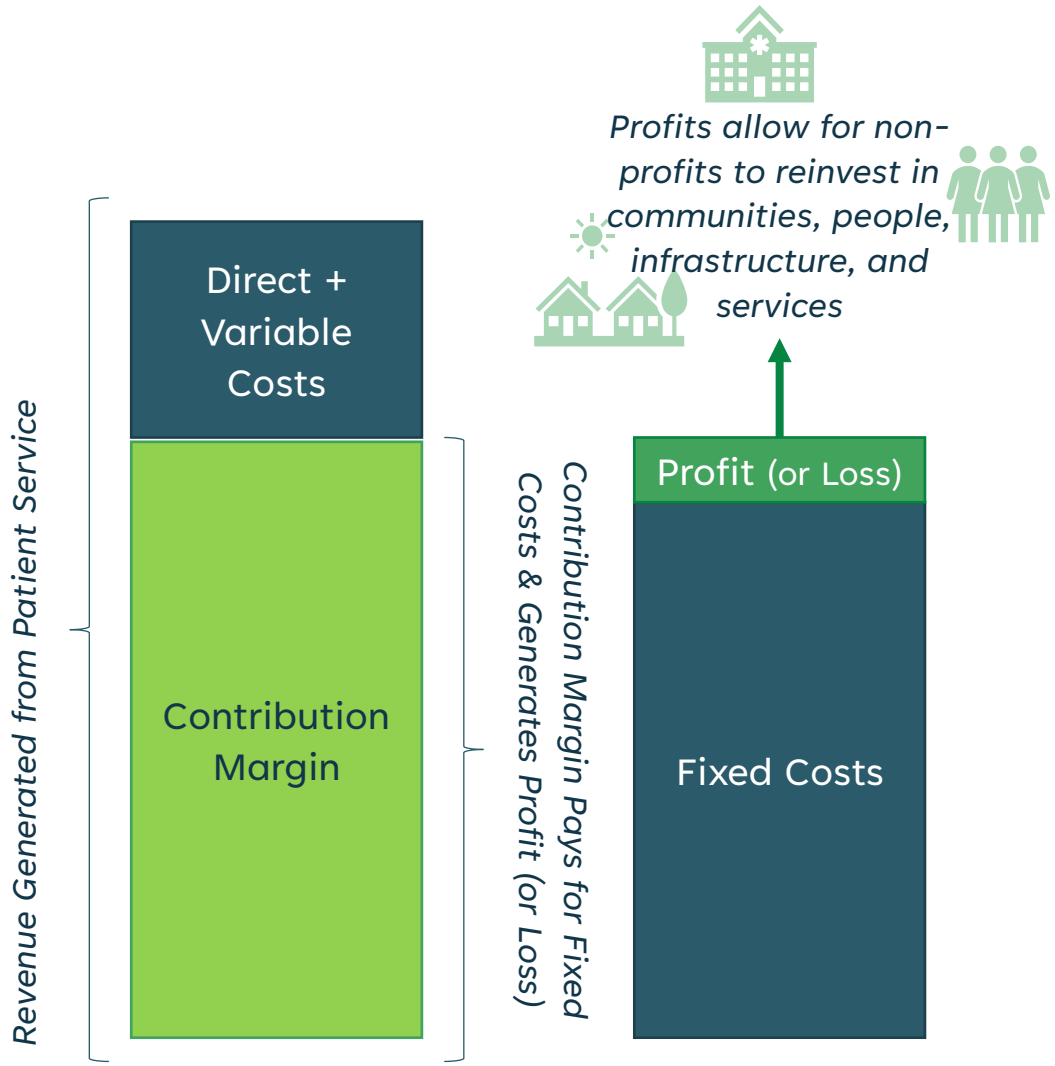
- **Profitability** is determined by the revenue that remains after deducting all costs (variable, direct, fixed, and overhead).
- **Sustainability** is based on contribution margin.
- A program is considered sustainable if it either:
  - generates a positive contribution margin, or
  - operates at a loss small enough that it does not threaten other essential programs or the organization's ability to carry out its mission.

STROUDWATER'S IMPORTANT FRAME OF REFERENCE:

In our experience, community hospitals succeed when their commitment centers on **abundance, growth, and incremental contribution margin gains** as opposed to a focus on expense management and cost reductions in the existing care model.

STROUDWATER'S IMPORTANT FRAME OF REFERENCE

- Value is unlocked by incremental volume growth in a high fixed-cost environment.
- Nearly all paying services create a positive contribution, which is used to pay for fixed costs and create a profit (if applicable).
  - Those that do not should be examined closely and may be deemed unviable.
- Economic imperative to develop thousands of "mini contribution margins" to cover all the fixed costs of the hospital.



ECONOMIC PHILOSOPHY

Understand the difference between contribution margin and profit on fully allocated costs:

- **Variable Cost**
  - ***Definition:*** Expenses that change with changes in activity
  - ***Examples:*** *Pharmaceuticals, reagents, film, food*
- **Fixed Cost**
  - ***Definition:*** Expenses that do not change with changes in activity
  - ***Examples:*** *Salaries and benefits (??), rent, utilities*
- Hospitals have inordinately high fixed costs relative to revenue (e.g., ER standby, acute-care nursing costs, etc.).
- **Unit Contribution Margin**
  - ***Definition:*** The amount from each unit of service available to cover fixed costs and provide operating profits
  - ***Example:*** If Department X's unit service price is $200 and its unit variable cost is $30, the unit contribution margin is $170 ($200 – $30)
  - A rural hospital is made up of thousands of Unit Contribution Margins

THE IMPACT OF HIGH HOSPITAL FIXED-COST RATIOS ON RURAL POPULATIONS

- RUPRI studied the fixed-to-total cost ratios for hospitals of different sizes.
  - Study extends a RUPRI analysis from 2023, evaluating whether hospitals in rural areas have higher fixed-to-variable cost ratios.
  - Current study reviewed cost report data between 2011 and 2020 for 4953 hospitals.
  - This model estimated fixed and variable costs using the simple definition of a variable cost as one that varies with volume.
    - Costs that tracked with adjusted patient days were considered variable.
- **Important Findings:**
  - The median ratio for all hospitals in metropolitan UICs is 0.733, while the median ratios in all other UICs are markedly higher and increase as hospital locations become more rural.
  - CAHs tended to have the highest estimated fixed-to-total-cost ratios, while Low Volume Hospitals (LVHs) tended to have lower ratios, but still higher than those of hospitals with neither designation.
- **Conclusions:**
  - Hospital payment policy and payment model development may benefit from considering hospital fixed-to-total-cost ratios, particularly in places where economies of scale are unattainable.

RUPRI Center for Rural Health Policy Analysis

Rural Policy Brief

Brief No. 2025-3 JUNE 2025 http://www.public-health.uiowa.edu/rupri/

The Impact of High Hospital Fixed-Cost Ratios on Rural Populations

by Abigail Barker, PhD; Eliot Jost, MBA, MPH; Timothy McBride, PhD; and Keith Mueller, PhD

Purpose

This brief focuses on rural hospitals with high fixed-to-total-cost ratios and describes characteristics of those hospitals and the communities they serve. The brief extends a recent RUPRI Center analysis[1] of whether hospitals in rural areas have higher fixed-to-total-cost ratios, a characteristic that has implications for financial stability under different payment models. We describe how this measure varies across the United States, the demographic characteristics associated with hospitals at different ratio levels, and the share of nonmetropolitan hospitals that have Critical Access Hospital (CAH) or Low-Volume Hospital (LVH) designations.

Table 1. Average County Population Density, Median, 25th and 75th Percentiles of Fixed-to-Total-Cost Ratios for all Hospitals by UIC Group

UIC Group	Number of Hospitals	Average Population Density	Median Ratio of Hospitals in UIC Group	25th percentile	75th percentile
Metropolitan (UIC = 1,2)	2,976	671.7/mi^2	0.733	0.602	0.861
Micropolitan (UIC = 3,5,8)	797	69.8/mi^2	0.847	0.778	0.895
Noncore adjacent to large metro or with town of 2500+ (UIC = 4,6,9,11)	857	40.1/mi^2	0.901	0.866	0.929
Noncore without town of 2500+ (UIC = 7,10,12)	332	13.3/mi^2	0.933	0.886	0.957

Source: http://www.public-health.uiowa.edu/rupri/

KEY ELEMENTS

- Getting the Medicare Cost Report Right
- Evaluating the L&D Program Contribution Margin
- Considering Opportunities to Optimize Efficiency

Strategies for Sustainability

Strategy 1:

GETTING THE MEDICARE COST REPORT RIGHT

The first step to sustainability is to ensure that the Medicare Cost Report accurately captures costs to support appropriate reimbursement of Labor & Delivery care. Ensuring that costs are properly allocated can significantly increase the sustainability of the Labor & Delivery program. In the section below, Case Study 1 describes the benefits of proper cost allocation on the Medicare Cost Report.

Key Actions:

Below, we describe steps for reviewing the Cost Report to make sure that the cost of the program is appropriately reflected:

1. **Understand the Cost Report Structure**

The first step is to review and understand basics of Cost Report structure and logic and its application to the Labor & Delivery program. Key Cost Report worksheets include the following:

Worksheet A: Attributes direct expenses (salary and non-salary) to departments.

Worksheet A-6: Covers reclassification of expenses/costs.

Worksheet B, Part I: Allocates costs from non-revenue producing departments to revenue producing departments based on statistics. Values are stated in terms of dollars.

CASE STUDY 1

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of costs. On their Cost
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By properly reallocatin
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would have received ir
payments of $2.5 milli
have offset more than
estimated loss on the

STRATEGY 1:

GETTING THE MEDICARE COST REPORT RIGHT

1. **Understand the cost report structure and its impact on the Labor & Delivery department**
2. **Determine appropriate cost allocation**
   - I. Use the recommended formula
   - II. Evaluate cost report items for proper allocation

APPROPRIATE COST ALLOCATION FOR LDRPS

[(Time in active delivery) / (Total time of stay)] *

100 = % of Costs and Statistics Allocated to Labor & Delivery Ancillary Department

STRATEGY 1:

GETTING THE MEDICARE COST REPORT RIGHT

Areas for evaluation of proper allocation include:

- Salary & Non-Salary Expenses
- Medical-Surgical Costs
- Statistics
- Related Dollar Amounts for allocated costs

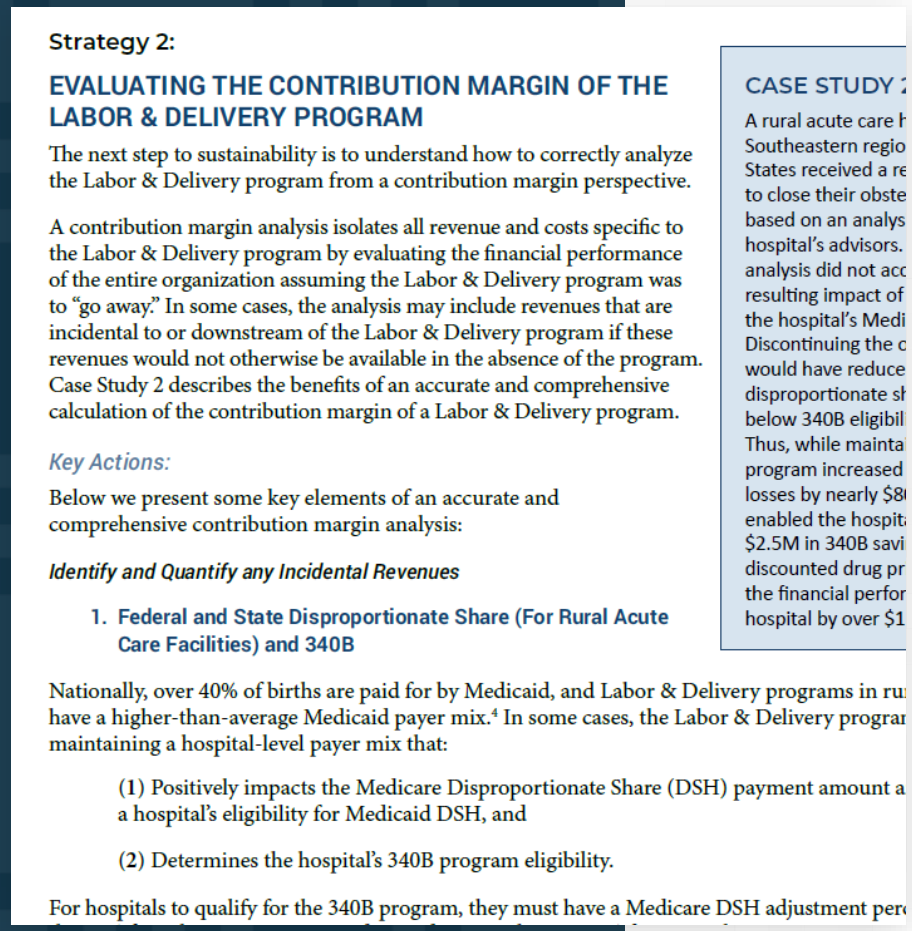
CASE STUDY

Western Critical Access Hospital

This hospital decided to discontinue its OB program, primarily because it identified a $3.0 million loss in obstetrics services. However, a significant portion of this apparent loss was due to a misallocation of costs.

On their Cost Report, $6.0 million of obstetrics program costs had been allocated to the Labor & Delivery ancillary department, which has no cost-based reimbursement.

By properly reallocating these costs, the hospital would have received incremental cost-based payments of $2.5 million, which would have offset more than 80% of the program's initially estimated loss.



Strategy 2:

EVALUATING THE CONTRIBUTION MARGIN OF THE LABOR & DELIVERY PROGRAM

The next step to sustainability is to understand how to correctly analyze the Labor & Delivery program from a contribution margin perspective.

A contribution margin analysis isolates all revenue and costs specific to the Labor & Delivery program by evaluating the financial performance of the entire organization assuming the Labor & Delivery program was to "go away." In some cases, the analysis may include revenues that are incidental to or downstream of the Labor & Delivery program if these revenues would not otherwise be available in the absence of the program. Case Study 2 describes the benefits of an accurate and comprehensive calculation of the contribution margin of a Labor & Delivery program.

Key Actions:

Below we present some key elements of an accurate and comprehensive contribution margin analysis:

Identify and Quantify any Incidental Revenues

1. **Federal and State Disproportionate Share (For Rural Acute Care Facilities) and 340B**

CASE STUDY 2

A rural acute care h
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to close their obste
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resulting impact of
the hospital's Medi
Discontinuing the c
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Thus, while mainta
program increased
losses by nearly $8
enabled the hospit
$2.5M in 340B savi
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the financial perfor
hospital by over $1

Nationally, over 40% of births are paid for by Medicaid, and Labor & Delivery programs in ru
have a higher-than-average Medicaid payer mix.[4] In some cases, the Labor & Delivery progra
maintaining a hospital-level payer mix that:

(1) Positively impacts the Medicare Disproportionate Share (DSH) payment amount a
a hospital's eligibility for Medicaid DSH, and

(2) Determines the hospital's 340B program eligibility.

For hospitals to qualify for the 340B program, they must have a Medicare DSH adjustment per

STRATEGY 2:

EVALUATING THE CONTRIBUTION MARGIN OF THE LABOR & DELIVERY PROGRAM

1. Identify and quantify any incidental revenues
2. Appropriate consideration of costs

STRATEGY 2:

EVALUATING THE CONTRIBUTION MARGIN OF THE LABOR & DELIVERY PROGRAM

- **Federal & State Disproportionate Share & 340B**
  - In some cases, the Labor & Delivery program may be key to maintaining a hospital-level payer mix that:
    - Positively impacts the Medicare Disproportionate Share (DSH) payment amount and/or determines a hospital's eligibility for Medicaid DSH, and
    - Determines the hospital's 340B program eligibility.
- **Incidental services**
  - Ultrasounds
  - Lab work
  - Clinic visits
  - Gynecological surgery

STRATEGY 2:

EVALUATING THE CONTRIBUTION MARGIN OF THE LABOR & DELIVERY PROGRAM

Appropriate consideration of costs

- **Exclusion of non-incremental costs**
  - An accurate contribution margin analysis considers revenues and costs that would be different if the Labor & Delivery program were closed versus maintained.
- **Proper allocation of operating costs**
  - In performing the Labor & Delivery program contribution margin analysis, the appropriate allocation of fixed and “stand-by” costs is essential.

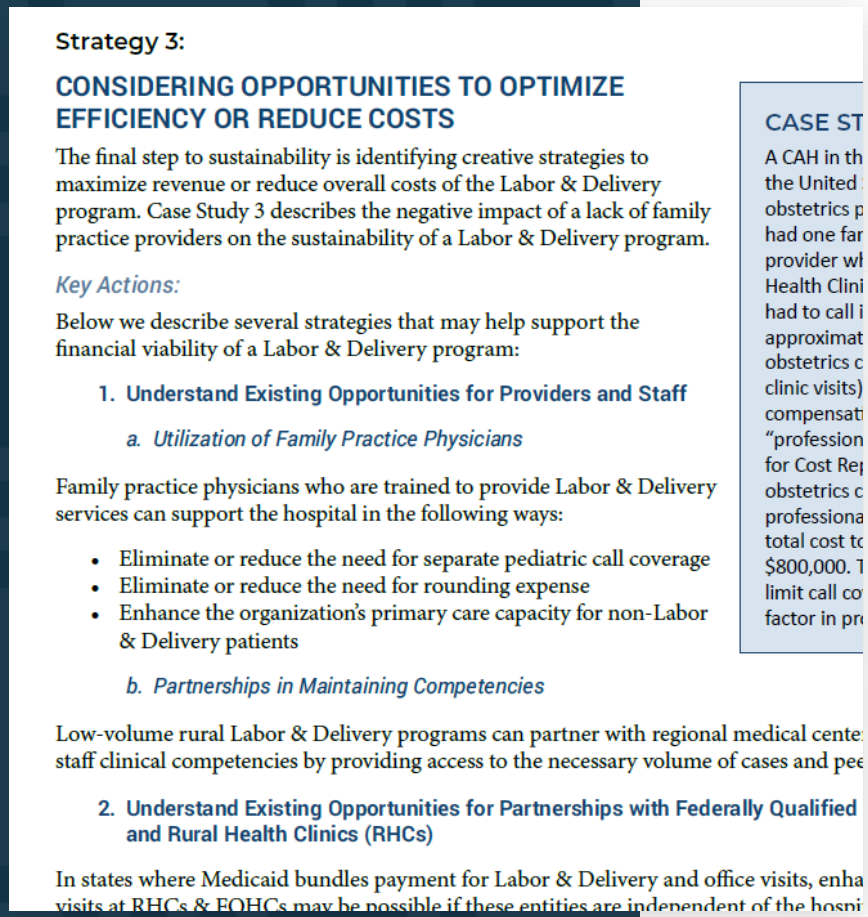
CASE STUDY

Southeastern Acute (PPS) Hospital

This hospital received a recommendation from advisors to close its obstetrics program. However, the analysis did not account for the resulting impact of the closure on the hospital's Medicaid payer mix.

Discontinuing the obstetrics program would have reduced the hospital's disproportionate share percentage below 340B eligibility requirements.

While the obstetrics program increased direct patient care losses by nearly $800K, the program enabled the hospital to access to $2.5M in 340B savings. It improved the hospital's financial performance by over $1.7M.



Strategy 3:

CONSIDERING OPPORTUNITIES TO OPTIMIZE EFFICIENCY OR REDUCE COSTS

The final step to sustainability is identifying creative strategies to maximize revenue or reduce overall costs of the Labor & Delivery program. Case Study 3 describes the negative impact of a lack of family practice providers on the sustainability of a Labor & Delivery program.

Key Actions:

Below we describe several strategies that may help support the financial viability of a Labor & Delivery program:

1. **Understand Existing Opportunities for Providers and Staff**

   a. Utilization of Family Practice Physicians

Family practice physicians who are trained to provide Labor & Delivery services can support the hospital in the following ways:

- Eliminate or reduce the need for separate pediatric call coverage
- Eliminate or reduce the need for rounding expense
- Enhance the organization's primary care capacity for non-Labor & Delivery patients

   b. Partnerships in Maintaining Competencies

Low-volume rural Labor & Delivery programs can partner with regional medical cente
staff clinical competencies by providing access to the necessary volume of cases and pe

2. **Understand Existing Opportunities for Partnerships with Federally Qualified and Rural Health Clinics (RHCs)**

In states where Medicaid bundles payment for Labor & Delivery and office visits, enha
visits at RHCs & FQHCs may be possible if these entities are independent of the hospi

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STRATEGY 3:

CONSIDERING OPPORTUNITIES TO OPTIMIZE EFFICIENCY OR REDUCE COSTS

1. Understand existing opportunities for providers and staff
2. Understand existing opportunities for partnerships with FQHCs and RHCs

STRATEGY 3:

CONSIDERING OPPORTUNITIES TO OPTIMIZE EFFICIENCY OR REDUCE COSTS

Understand existing opportunities for providers and staff.

- **Utilization of Family Practice Physicians**
  - Family practice providers who are trained to provide Labor & Delivery services can support the hospital in the following ways:
    - Eliminate or reduce the need for separate pediatric call coverage
    - Eliminate or reduce the need for rounding expense
    - Enhance the organization's primary care capacity for non-Labor & Delivery patients
- **Partnerships in maintaining competencies**
  - Low-volume programs can partner with regional medical centers to maintain provider and staff clinical competencies by providing access to the necessary volume of cases and peer learning opportunities.

STRATEGY 3:

CONSIDERING OPPORTUNITIES TO OPTIMIZE EFFICIENCY OR REDUCE COSTS

Understand existing opportunities for partnerships with FQHCs and RHCs.

- **RHC:** Payment bundling for states that support additional reimbursement
- **FQHC:** Medical Malpractice Insurance Cost Reduction & potential access to 330 grant funds for expanded services

CASE STUDY

Southeastern Critical Access Hospital

This hospital discontinued its obstetrics (OB) program because it had only one family practice obstetrics provider who worked out of a Rural Health Clinic (RHC).

The hospital had to call in additional providers approximately 60% of the time for obstetrics call coverage (excluding clinic visits). Thus, 100% of call compensation was considered “professional” and not allowable for Cost Report purposes.

Between obstetrics call compensation and the professional cost of anesthesia, the total cost to the hospital was roughly $800,000. The lack of providers to limit call-coverage costs was a key factor in the program's closure.

ADDITIONAL NOTES

- It is important to note that even if a hospital adheres to all the recommendations in this document, it may still incur a material financial loss on its Labor & Delivery program.
- In such cases, the question shifts to the community: how should a vital public resource be supported?
- The immediate next step for hospital leaders is to bring the wider community into the conversation to identify other ways to support the program.
- State Flex Programs can be helpful to CAHs, specifically in understanding challenges with services and working to connect CAHs with additional support or resources where available.

ACCESS THIS RESOURCE:

Attendees of this webinar will receive an email with a link to access the resource following this presentation.

It can also be found by scanning this QR code or using the link below:

www.flexmonitoring.org/tool/sustaining-rural-labor-delivery-programs

SCAN QR CODE:

ADDITIONAL RESOURCES:

Other resources available through the Flex Monitoring Team website:

- **Availability of Obstetric Simulation Training by State**
- **Maternity Care Innovation in Critical Access Hospitals**
- **Reporting and Performance of Maternity-related Quality Measures in Critical Access Hospitals**

AVAILABILITY OF OBSTETRIC SIMULATION TRAINING BY STATE

SCAN QR CODE:

We recommend that State Flex Programs and Critical Access Hospitals use this resource to identify available training in their state or neighboring states, foster new partnerships with organizations offering simulation training, or access examples of rural-specific training programs.

www.flexmonitoring.org/publication/rural-resource-availability-obstetric-simulation-training-state

MATERNITY CARE INNOVATION IN CRITICAL ACCESS HOSPITALS

This case series describes interviews with six high-performing CAHs, including the benefits of their PQCs, use of safety bundles, ongoing obstetric training for staff, and other strengths of their maternity care services.

www.flexmonitoring.org/publication/delivering-quality-maternity-care-innovation-critical-access-hospitals

SCAN QR CODE:

SCAN QR CODE:

REPORTING & PERFORMANCE OF MATERNITY-RELATED QUALITY MEASURES IN CAHS

In this brief, the FMT describes characteristics of Critical Access Hospitals (CAHs) with and without labor and delivery services and then illustrates CAH reporting and performance on five key quality measures related to maternity care and birth outcomes.

www.flexmonitoring.org/publication/reporting-and-performance-maternity-related-quality-measures-critical-access-hospitals

Q&A

STROUDWATER

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THANK YOU

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