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2026 Nowhere to Go: Maternity Care Deserts Across the U.S.

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Maternity care access designations

Data sources and variables used

The 2026 maternity care designation analysis used various county level data sources (Table 1).

Labor and delivery units were identified using the 2024 American Hospital Association (AHA) Annual Survey and the Centers for Medicare & Medicaid Services (CMS) Provider of Services (POS) file (Q4 2024). Birth center information was obtained from the American Association of Birth Centers (AABC) registry and reflects all operating birth centers across the U.S. as of December 2024.

Obstetric clinicians included obstetrician-gynecologists (OB-GYN, MD and DO), certified nurse-midwives (CNMs), certified midwives (CMs), and family physicians who reported delivering babies. OB-GYN counts were obtained from the 2024-2025 Health Resources and Services Administration's (HRSA) Area Health Resource File (AHRF). Counts of CNMs and CMs were estimated using the November 2024 National Provider Identifier (NPI) file from CMS using methods described here. Counts of family physicians who reported delivering babies were obtained from the American Board of Family Medicine (ABFM) workforce survey and included responses between 2021 and 2024.

Population denominators for women aged 15–44 years (women of reproductive age) were obtained from 2024 U.S. Census Bureau population estimates. Data on U.S. births were obtained from the National Centers for Health Statistics (NCHS), 2024 final natality data. Insurance coverage was measured using 2024 American Community Survey (ACS) 5-year estimates and defined as the percentage of females aged 19–54 years uninsured.

Table 1. Maternity care access designation components and data sources

Component	Data Source	Year(s)
Labor and delivery units	American Hospital Association (AHA) Annual Survey; CMS Provider of Services (POS) file	2024 (Q4)
Birth centers	American Association of Birth Centers (AABC) registry	2024 (Dec)
OB-GYN workforce (MD, DO)	HRSA Area Health Resource File (AHRF)	2024–2025
CNMs and CMs	CMS National Provider Identifier (NPI) file	2024 (Nov)
Family physicians delivering babies	American Board of Family Medicine (ABFM) workforce survey	2021–2024
Reproductive-age (women 15–44)	U.S. Census Bureau population estimates	2024
Live births	National Center for Health Statistics (NCHS) natality data	2024
Insurance coverage	American Community Survey (ACS) 5-year estimates	2024

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Maternity care access designations (continued)

Designation criteria

Counties were classified into four mutually exclusive categories using the following criteria:

Maternity care desert: no labor and delivery hospitals, no birth centers, and no obstetric clinicians.

Low access: fewer than 2 hospitals or birth centers offering labor and delivery services, fewer than 60 obstetric clinicians per 10,000 births, and the proportion of women aged 19-54 without health insurance was 10 percent or greater.

Moderate access: fewer than 2 hospitals or birth centers offering labor and delivery services, fewer than 60 obstetric clinicians per 10,000 births, and the proportion of women aged 19-54 without health insurance was less than 10 percent.

Full access: two or more hospitals or birth centers offering labor and delivery services *or* 60 or more obstetric clinicians per 10,000 births.

Calculations

All analyses were done using SAS Software version 9.4 (SAS Institute Inc). Percentages of counties, women of reproductive age, and live births were calculated among maternity care access designations. Sociodemographic characteristics were analyzed by access designation, including the average median household income, and percentage for uninsured rates and rurality.

Limitations

The use of labor and delivery hospitals and birth centers did not account for the provision of prenatal care in other clinical settings (i.e., hospital satellite clinics) or for other clinicians who may provide care (i.e., nurse practitioners, certified professional midwives). Our analysis does not account for the quality of the health care received, nor the appropriateness of the level of care an individual might receive. Designations of access are made at the county level and therefore may generalize the availability of care in large or diverse counties (e.g., metropolitan counties with substantial within-county variation or large rural and frontier counties). Additionally, maternity care access designations do not account for individual contributors to access, such as time to reach care, vehicle/transportation availability, or other barriers to receiving care. National datasets may also contain reporting delays or incomplete information on clinicians and facilities.

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Maternity care access designations (continued)

Regional, geographic, and demographic variables

Regions

U.S. regions were defined according to the U.S. Census Bureau regional classification. States were grouped into four regions as follows:

Region 1: Northeast — Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New Jersey, New York, and Pennsylvania.

Region 2: Midwest — Illinois, Indiana, Michigan, Ohio, Wisconsin, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota.

Region 3: South — Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, District of Columbia, West Virginia, Alabama, Kentucky, Mississippi, Tennessee, Arkansas, Louisiana, Oklahoma, and Texas.

Region 4: West — Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, Alaska, California, Hawaii, Oregon, and Washington.

Rural–urban status

Rural–urban status was defined using the U.S. Department of Agriculture (USDA) Economic Research Service 2023 Rural–Urban Continuum Codes (RUCC) at the county level. Counties were classified as urban if they were metropolitan (codes 1–4) or nonmetropolitan but adjacent to a metropolitan area with an urban population of 2,500 to 19,999 (code 6). Counties were classified as rural if they were nonmetropolitan and either not adjacent to a metropolitan area with an urban population of 20,000 or more (code 5) or were completely rural or more remote nonmetropolitan counties (codes 7–9).

Average median income

Median household income data were obtained from the 2023 Small Area Income and Poverty Estimates (SAIPE) program, as reported in the 2024–2025 AHRF. Median household income was summarized by averaging county-level median household income estimates within each maternity care access designation category.

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Maternity care access trends

Trend analysis (2016-2024)

A longitudinal trend analysis was conducted to assess changes in maternity care access designations over time. The same classification framework, variable definitions, and calculation methods described previously (pg. 1-2) were applied to historical data for 2016. Data for the 2016 designations included the following: 2016 AHA Annual Survey and CMS POS file (Q4 2016), 2016 birth centers from AABC registry, 2015-2016 HRSA AHRF, November 2016 NPI, and 2016-2019 ABFM workforce survey. Population data included 2016 ACS for estimates for females aged 15-44 years, 2016 ACS 5-year insurance estimates for females 19-54, and NCHS 2016 final natality data.

Analysis

County-level maternity care access designations for 2016 were generated using the same thresholds and definitions applied to 2024 data to ensure comparability. Changes in designation status between 2016 and 2024 were analyzed to assess shifts in maternity care access at the county level over time.

County designations were compared across the two time periods. Counties were classified as having increased access if they moved to a higher access category (e.g., from a maternity care desert to low access). Conversely, counties were classified as having decreased access if they moved to a lower access category (e.g., from full to moderate access). Counties with the same designation in both years were considered unchanged.

For counties that experienced a change in access (increase or decrease), individual components of the designation were examined to identify the factors driving the change. This assessment used the underlying component categories that define each designation. For example, if a county's clinician ratio increased from 50 to 65 clinicians per 10,000 births between 2016 and 2024, this change would be identified as a driver of improved access, as the designation criteria distinguish between counties with fewer than 60 clinicians per 10,000 births and those meeting or exceeding that threshold.

Specific state examples within this section were selected based on the percentage and/or number of total counties that either gained or lost maternity care desert designation.

Limitations

Designation changes reflect shifts in categorical classification rather than linear changes in underlying system capacity. Counties may remain in the same designation category despite meaningful changes in clinician composition (e.g., declines in family physicians offset by increases in midwifery workforce) or facility staffing patterns. Second, designation status is sensitive to changes in birth volume, as clinician supply is standardized per 10,000 births. Therefore, counties experiencing declining fertility may appear to experience improved access even in the absence of increases in absolute clinician supply, and vice versa. Third, designation changes may be influenced by data source updates, reporting differences, and changes in provider enumeration methods between 2016 and 2024, particularly for clinician workforce datasets derived from administrative or survey-based sources.

Counties were matched across years using Federal Information Processing Standards (FIPS) codes. Where county code changes, consolidations, or geographic boundary modifications occurred between 2016 and 2024, counties were reconciled to maintain comparability over time.

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Obstetric clinicians

Data sources and variables used

Obstetric clinician data were gathered from a variety of sources. CNM and CM counts were estimated using the November 2024 NPI file from CMS. OB-GYNs, both MDs and DOs, were obtained from the 2024-2025 AHRF, provided by HRSA. Counts of family physicians who reported delivering babies were provided by the ABFM and included responses between 2021 and 2024. NCHS natality data from 2016 and 2024 were used to assess the percentage of births attended by certified nurse-midwives and certified midwives.

Calculations

Counts of OB-GYNs, CNM/CMs, and family physicians were aggregated at the county and state level and were used to create overall obstetric clinician ratios per 10,000 live births. Counts of obstetric clinicians were used to generate county-level maps, presented as areas with no clinicians, only 1 clinician, or more than 1 clinician, and stratified by rurality. Percentages of births attended by CNM/CMs were calculated from NCHS natality data to compare trends from 2016 to 2024 among hospital births.

Limitations

Regarding CNM/CMs, with limited data from the NPI, certification and education of providers lacking credential information could not be verified. Additionally, though each provider has a single NPI throughout their career, there is no data to confirm the location information was up to date. State licensure variations may also cause misclassification of some midwives. For family physicians, the ABFM data relies on survey responses. Because of this, there is the potential that not all eligible family physicians were captured. This analysis is limited to clinician types included in the maternity care access designation methodology (CNMs/CMs, family physicians trained in obstetrics, and OB-GYNs) and does not include other clinicians who may provide prenatal, intrapartum, postpartum, or specialty maternity care services, such as nurse practitioners (NPs), maternal-fetal medicine specialists (MFMs), or certified professional midwives (CPMs).

Midwifery policies

Data sources and variables used

Data presented on supportive midwifery policies are provided from the American College of Nurse Midwives (ACNM) and reflective of state policy updates as of March 3, 2026.

Calculations

The total count of state supportive midwifery policies included: independent practice, prescribing authority, hospital admitting privileges, pay parity, and licensure of CMs. States were categorized as having no policies, 1–2 policies, or 3–4 policies, or all 5 policies. Individual state data for each policy are available in Appendix A.

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Appendix A: supportive midwifery policies by state

State	Independent Practice Authority	Prescribing Authority	Medicaid Parity	Hospital Admitting Privileges	Certified Midwife Licensing
Alabama	No	No	No	No	No
Alaska	Yes	Yes	No	Yes	No
Arizona	Yes	Yes	No	Yes	No
Arkansas	Yes	No	No	No	Yes
California	No	No	Yes	No	No
Colorado	Yes	Yes	Yes	Yes	Yes
Connecticut	Yes	Yes	Yes	Yes	No
Delaware	Yes	Yes	Yes	Yes	No
District of Columbia	Yes	Yes	Yes	Yes	Yes
Florida	No	No	No	Yes	No
Georgia	No	No	Yes	No	No
Hawaii	Yes	Yes	Yes	No	Yes
Idaho	Yes	Yes	No	No	No
Illinois	No	No	Yes	No	No
Indiana	No	No	No	Yes	No
Iowa	Yes	Yes	No	Yes	No
Kansas	Yes	Yes	No	No	No
Kentucky	Yes	No	No	Yes	No
Louisiana	No	No	No	No	No
Maine	Yes	Yes	Yes	Yes	Yes
Maryland	Yes	Yes	Yes	No	Yes
Massachusetts	Yes	Yes	No	Yes	No
Michigan	No	No	Yes	Yes	No
Minnesota	Yes	Yes	Yes	Yes	No
Mississippi	No	No	No	Yes	No
Missouri	Yes	No	Yes	Yes	No
Montana	Yes	Yes	No	Yes	No
Nevada	Yes	Yes	Yes	Yes	No
New Hampshire	Yes	Yes	Yes	Yes	No
New Jersey	No	No	Yes	Yes	Yes
New Mexico	Yes	Yes	Yes	Yes	No
New York	Yes	Yes	No	Yes	Yes
North Carolina	Yes	No	Yes	No	No

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Appendix a: supportive midwifery policies by state continued

State	Independent Practice Authority	Prescribing Authority	Medicaid Parity	Hospital Admitting Privileges	Certified Midwife Licensing
North Dakota	Yes	Yes	Yes	Yes	No
Ohio	No	No	Yes	No	No
Oklahoma	Yes	No	Yes	Yes	Yes
Oregon	Yes	Yes	Yes	Yes	No
Pennsylvania	No	No	Yes	No	No
Rhode Island	Yes	Yes	Yes	Yes	Yes
South Carolina	No	No	Yes	No	No
South Dakota	Yes	Yes	Yes	Yes	No
Tennessee	Yes	No	Yes	No	No
Texas	Yes	No	No	No	No
Utah	Yes	Yes	Yes	No	No
Vermont	No	No	Yes	No	No
Virginia	Yes	Yes	Yes	No	Yes
Washington	Yes	Yes	Yes	Yes	No
West Virginia	Yes	No	Yes	Yes	No
Wisconsin	Yes	Yes	Yes	Yes	No
Wyoming	Yes	Yes	Yes	Yes	No

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Labor and delivery hospitals

Data sources and variables used

Hospital-level data were obtained from the 2024 AHA Annual Survey. Because labor and delivery services are self-reported in the AHA survey and may be missing or inconsistently reported, hospital records were linked to the CMS Provider POS file (Q4 2024) to validate the presence of labor and delivery units. Hospital identification methods were informed by prior research (Interrante et al., 2025) and expanded through additional validation procedures developed by the Perinatal Data Center.

Hospitals were classified as providing labor and delivery services if they met one or more of the following criteria:

1. AHA criteria

- Reported providing obstetric services (OBHOS = 1) and
- Reported at least one obstetric bed (OBBD ≥ 1) and
- Reported at least 10 births during the reporting year (BIRTHS ≥ 10) and
- Reported an obstetric level of care designation (OBLEV ≥ 1).

2. CMS criteria

- Indicated the provision of obstetric services in the CMS POS file (OB_SRVC_CD≥ 1) and met at least one AHA indicator of obstetric activity, including reported obstetric services, obstetric beds, or at reported at least 10 births during the year, provided the hospital did not report that obstetric services were unavailable.

Federal facilities

- Military and Indian Health Service facilities were included if they reported at least 10 births during the reporting year and met AHA or CMS criteria for providing of obstetric services.

Manual Review

Hospitals that did not clearly meet inclusion criteria but had evidence of partial inclusion criteria underwent manual review. Facilities selected for review included hospitals that:

- Reported at least one criteria for obstetric services, obstetric beds, labor and delivery rooms, or at least 10 births in AHA survey but lacked CMS confirmation of obstetric services (OB_SRVC_CD=.);
- Were identified as providing obstetric services in CMS but had incomplete or missing obstetric information in AHA;
- Reported more than 10 births and labor and delivery rooms but did not report an obstetric unit;
- Had conflicting information between AHA and CMS data sources (e.g. AHA reported obstetric services and CMS reported no obstetric services).

Manual review was conducted using hospital websites, health system directories, publicly available maternity care service information, and direct outreach, when necessary. Hospitals were included only when evidence of active labor and delivery services was confirmed.

Hospital subsidiary review

To identify additional labor and delivery unit locations not captured through parent hospital reporting, a list of subsidiary and affiliated hospitals provided by AHA was reviewed. Each subsidiary location was manually evaluated using hospital websites and publicly available information to determine whether labor and delivery services at additional locations were available. Manually verified locations were included in the final hospital count.

Historic datasets were used for obstetric units in 2016 using the same methods above to make comparisons over time (see Trend Analysis.pg. 4).

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Labor and delivery hospitals continued

Calculations

Labor and delivery unit counts were aggregated at the county and state levels for 2016 and 2024 data to compare total hospital-based labor and delivery unit changes over time. County level counts were compared by rurality.

Limitations

Response rates for the AHA hospital data vary across states and health systems; however, validation using CMS data allowed for additional identification of hospitals providing obstetric care nationwide. Hospitals reporting fewer than 10 annual births were generally excluded from classification and may therefore underrepresent small, low-volume facilities, particularly when data were not reported to AHA. While this threshold was applied to reduce misclassification resulting from reporting errors, inactive obstetric units, or emergency department deliveries, some low-volume facilities providing labor and delivery services may not have been captured. Additionally, hospital status and service availability may change during the reporting year because of openings, closures, mergers, acquisitions, health system restructuring, or temporary service suspensions. Although AHA and CMS data were supplemented through manual review and subsidiary hospital validation, variations in reporting practices, reporting timing, and the availability of public information may have resulted in some labor and delivery units being misclassified or not captured in the final count.

Travel time to care

Data sources and variables used

Travel time (minutes) from residential locations to the nearest labor and delivery unit hospital is provided in the report.

Travel time analyses were conducted using census tract-level birth data from the U.S. Census Bureau 2024 ACS 5-year estimates. Hospital locations were derived from validated AHA labor and delivery unit dataset described above. Census tract and block group geographic boundaries were based on 2020 U.S. Census geography.

Creation of birth-weighted census tract centroids

Birth-weighted census tract centroids were created and used as the origin locations for all travel analyses.

Census tract-level counts of women who gave birth in the previous 12 months were obtained from the U.S. Census Bureau 2024 American Community Survey (ACS) 5-year estimates. Because birth data are not available below the census tract level, block group-level estimates of women aged 15–49 years from the 2024 ACS were used to estimate the distribution of births within each tract.

For each census tract, births were allocated to block groups based on the proportion of women aged 15–49 years residing within each block group. Block group polygons were converted to interior point locations, and the estimated number of births assigned to each block group was used as a weighting variable to calculate weighted mean centers for each census tract. The resulting birth-weighted centroids incorporated the distribution of the reproductive-age female population within census tracts and served as the origin locations for all travel time analyses.

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Travel time to labor and delivery hospitals continued

Calculations

All geospatial analyses were conducted using ArcGIS Pro version 3.2 and the Network Analyst extension. Hospital locations were geocoded using latitude and longitude coordinates obtained from the AHA Annual Survey, and unmatched locations underwent manual validation and were re-geocoded.

Travel time was calculated along U.S. road networks using the ArcGIS StreetMap Premium Custom Roads dataset. A Destination Cost Matrix analysis was used to identify the nearest labor and delivery unit for every birth-weighted census tract centroid. For each origin tract, the analysis generated the shortest travel time to the closest labor and delivery unit within the road network. Travel times were calculated using default network travel speeds and did not incorporate time-of-day traffic conditions. This approach was intended to estimate typical travel conditions and maintain comparability across geographic areas.

Census tract-level travel times were subsequently aggregated to the county level for reporting. Rural–urban classifications and maternity care access designations were matched to each census tract based on the county FIPS code. Group comparisons were then conducted using tract-level travel time estimates within these classifications.

Limitations

Travel time to birth center locations is not included in the calculations. In addition, travel time to labor and delivery units is not a factor used in the classification of maternity care access designations (pg. 1).

Travel estimates represent modeled driving conditions and may not reflect actual travel experiences. Factors such as traffic congestion, weather conditions, road closures, transportation availability, ferry schedules, and geographic barriers may increase or decrease actual travel times. In geographically isolated areas, particularly Alaska, modeled estimates reflect road-based travel only and may not capture real-world travel requirements such as air transport, which is often necessary for accessing care in these settings.

Birth-weighted centroids provide an improved representation of the spatial distribution of births compared with geometric tract centroids; however, they rely on the assumption that births are distributed proportionally to the population of women aged 15–49 years within each census tract.

Travel analyses assume that individuals seek care at the geographically closest labor and delivery unit. In practice, patients may choose hospitals based on provider affiliation, insurance coverage, service availability, perceived quality, or clinical needs. As a result, actual travel patterns may differ from modeled estimates.

County-level estimates provided in report maps and graphics were derived from aggregated census tract results and may mask substantial variation in travel burden within counties, particularly in large rural counties and geographically diverse metropolitan areas.

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Closures of labor and delivery units

Data sources and variables used

To capture more recent changes in maternity care access not reflected in national hospital datasets (which are lagged through 2024 in the AHA Annual Survey), we constructed a supplemental dataset of publicly reported labor and delivery unit closures occurring between January 1, 2024 and May 1, 2026. This closure dataset was developed as a secondary analysis to reflect more recent and real-time changes in labor and delivery unit availability and was not used to define baseline hospital availability in the travel time models or the hospital counts used to create maternity care access designations.

Closure events were identified using multiple publicly available sources, including Becker's Hospital Review reports, hospital system announcements, and news media reports. Additional data for comparison on rural-only closures were obtained from the Center for Healthcare Quality and Payment Reform, 2024-2026. Each reported closure was manually reviewed and validated to confirm that the facility previously maintained labor and delivery services prior to closure. Closure dates were standardized based on the earliest consistent public reporting of service discontinuation.

For each closure event, publicly reported explanations for service discontinuation were abstracted when available. Reported reasons were categorized into the following themes: declining birth volume, workforce constraints, and financial pressures. Categories are not mutually exclusive, and multiple reasons could be reported for a single closure.

Rural-urban classification for closures

Rural-urban status was assigned at the census tract level using the HRSA rural-urban classification schema. Tracts were classified as rural or urban prior to aggregation and linkage to closure-related travel time estimates. This classification differs from county-level rurality descriptors used for maternity care access designation comparisons (pg. 3) and was selected to align with more granular tract-level travel time estimations. All comparisons of closure frequency, closure drivers, and travel time impacts by rurality were conducted using census tract-level classifications prior to aggregation.

Calculations

To estimate changes in geographic access associated with labor and delivery unit closures, we conducted a separate set of network calculations distinct from the primary travel time analysis. Using the same ArcGIS Pro Network Analyst framework and StreetMap Premium Custom Roads dataset (pg. 9), we recalculated the shortest travel time from each census tract centroid to the nearest remaining labor and delivery unit after removing closed facilities from the network.

This approach estimates the change in minimum travel time attributable to labor and delivery unit closures by comparing pre-closure and post-closure travel times under identical network assumptions. Travel time estimates are limited to census tracts within counties where a reported labor and delivery unit closure occurred. The analysis does not assess how closures may affect travel times in neighboring counties, except in selected state-level spotlights.

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Closures of labor and delivery hospitals continued

Limitations

Closure events were identified using publicly available sources and may not capture all labor and delivery unit closures during the study period. Reporting delays, incomplete documentation, and variation in media coverage may result in underestimation of closures, particularly for short-term service suspensions or phased service reductions.

Closure data were limited to hospital-based labor and delivery units and did not include birth centers, physician offices, or other outpatient facilities and clinics. Hospitals may have remained operational following closure of labor and delivery units to provided other hospital-based care.

Reported reasons for closure reflect publicly stated or reported explanations and may not represent the full range of operational, financial, regulatory, or strategic factors underlying hospital decision-making. In addition, reported categories are not mutually exclusive and may reflect overlapping or sequential drivers.

If you are aware of additional closures not shown in this report, please help keep March of Dimes records current by reporting them through the March of Dimes Closure Reporting Survey.

Out-of-hospital births

Data sources and variables used

Data on out-of-hospital births are from NCHS final natality data for 2016 through 2024. Out-of-hospital births included birth records that list: birth center births, home births as intended, and home births as unintended. Hospital births, births for other non-hospital settings, and reporting for “other” were not included in the out-of-hospital birth analysis.

Calculations

The percentage of all out-of-hospital births by type was calculated from 2016–2024. State-level percentages of births occurring in birth centers and percentages of birth center births by race/ethnicity, insurance status, and educational attainment were also calculated.

Limitations

Birth center births are reported for any birth center using NCHS records, and there is no delineation of accreditation status as specified in separate sections of the report.

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Birth centers

Data sources and variables used

Data on individual birth center locations and total counts were obtained from the American Association of Birth Centers (AABC). The AABC is a professional organization that develops national standards for birth center care and supports the broader framework used for external evaluation of birth center quality and operations. These standards provide a uniform basis for assessing maternity care, neonatal care, safety, business operations, and continuous quality improvement across jurisdictions.

Accreditation of birth centers is conducted by the Commission for the Accreditation of Birth Centers (CABC), an independent accrediting body that evaluates facilities against these nationally established AABC-derived standards. Accreditation indicates that a birth center meets evidence-based benchmarks for safe, high-quality care and is subject to structured external review and ongoing quality assurance processes.
Birth center locations were identified using AABC-reported data sources and compiled listings used for research and field monitoring. These data capture freestanding birth centers as well as birth centers operating in hospital-affiliated or integrated settings where applicable.

Maternal race/ethnicity, education level, and insurance payer were assessed among birth center births using data from the NCHS 2024 final natality data.

Calculations

Counts of birth centers were aggregated to the county-level and state-level for comparisons by rurality and region. Percentages of women who delivered at a birth center by race/ethnicity (Hispanic and non-Hispanic White, Black, American Indian/Alaska Native, and Asian), education level (some college or more), and insurance payer (Medicaid) were calculated for the US and compared to those percentages among women who delivered in a hospital.

Limitations

Data include birth centers identified in AABC-derived listings, including both freestanding and hospital-affiliated models where applicable. Because inclusion is based on reported and tracked facilities, the dataset may not capture all operational birth centers nationwide, particularly those outside AABC-referenced systems or those not participating in the CABC accreditation process. Accreditation status may also vary across included facilities at the time of data capture.

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Insurance

Data sources and variables used

The percentage of uninsured women ages 19–54 years was estimated using ACS 5-Year Estimates, 2024 and 2013, from Table B27001. Estimates were calculated using the number of uninsured women ages 19–54 divided by the total population of women ages 19–54.

Insurance payment source at delivery was obtained from NCHS final natality files, 2024 and 2016, and reflects the primary payer recorded on the birth certificate.

State Medicaid expansion and postpartum coverage extension status were determined using sources from the Kaiser Family Foundation (KFF): expansion and extension.

Calculations

Percentages of uninsured women were calculated at the county, state, and national levels, and stratified by rurality and maternity care access designation. Changes in uninsured rates were compared between 2013 and 2024 to examine impacts among states since the Affordable Care Act (ACA). Uninsured rates were also stratified by state-level Medicaid expansion status (state had expanded, state had not expanded, expansion status not relevant [US and Puerto Rico]).

Limitations

ACS estimates are based on survey responses and are subject to sampling variability, reporting error, and imputation. The ACS 5-Year Estimates combine data collected over a five-year period to improve reliability for smaller geographic areas but may not fully capture recent changes in insurance coverage. The measure reflects insurance status at the time of survey collection and does not assess continuity, adequacy, or use of coverage.

Prenatal care

Data sources and variables used

First trimester prenatal care initiation data are from the NCHS 2024 final natality file. The variable reflects whether prenatal care began in the first trimester among live births, as recorded on the birth certificate.

Calculations

First trimester prenatal care initiation was calculated as the percentage of live births with prenatal care beginning in the first trimester. The denominator included all live births with non-missing prenatal care initiation data. Percentages were stratified by maternity care access designations, and a chi-square test was used to assess significant differences between groups. *P* values less than .05 indicated statistical significance ($P<0.001$).

Limitations

Birth certificate data are subject to reporting and documentation errors. First trimester prenatal care initiation reflects only when care began and does not capture the adequacy or quality of prenatal care received.

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