

March 5, 2026

Health Resources and Services Administration  
Bureau of Health Workforce  
Division of Policy and Shortage Designation  
Attn: Matthew Patterson  
5600 Fishers Lane  
Mail Stop 15SWH03  
Rockville, MD 20857

*Submitted via [sdb@hrsa.gov](mailto:sdb@hrsa.gov)*

**Re: Request for Public Comment on the Updated Criteria for Determining Maternity Care Health Professional Target Areas (Docket No. 2026-02130 (91 FR 4927))**

Dear Mr. Patterson:

On behalf of March of Dimes, the nation's leading nonprofit organization fighting for the health of all moms and babies, we thank you for this opportunity to provide comments regarding proposed changes to maternity care target areas (MCTAs) by the Health Resources and Services Administration (HRSA).

**As further described below, March of Dimes offers two recommendations in response to the proposed MCTA criteria:**

- 1) HRSA should maintain the Social Vulnerability Index (SVI) as an important determinant of the health and well-being of communities, in addition to the clinical access measures in the MCTA.**
- 2) HRSA should incorporate family medicine physicians who provide obstetric care as part of the count of maternity care clinicians in a community.**

## **Background**

The maternal and infant health crisis in the United States is not improving, and in many communities — particularly maternity care deserts, under resourced areas and rural communities — it is getting worse. While the 2023 maternal mortality rate returned to pre-pandemic levels, the 669 maternal deaths<sup>1</sup> are only part of the story with an estimated 30,000 women having experienced life-threatening complications during childbirth in 2022.<sup>2</sup> The 2024 national rate of preterm birth remains unchanged at 10.4%, representing nearly 380,000 babies and their families. Access to early prenatal care continues to decline, with nearly one in four women beginning care after the first trimester, missing critical opportunities to detect and address risks early in pregnancy. Infant mortality, a critical indicator of a nation's health, remains unchanged at 5.6 deaths per 1,000 live births, amounting to over 20,000 infant deaths each year.<sup>3</sup>

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<sup>1</sup> Hoyert DL. Maternal mortality rates in the United States, 2023. NCHS Health E-Stats. 2025. DOI:

<https://dx.doi.org/10.15620/cdc/174577>.

<sup>2</sup> Agency for Healthcare Research and Quality. Healthcare Cost and Utilization Project (HCUP) Fast Stats. Severe Maternal Morbidity Among In-Hospital Deliveries. <https://datatools.ahrq.gov/hcup-fast-stats/?tab=special-emphasis&dash=92>.

<sup>3</sup> 2025 March of Dimes Report Card: The State of Maternal and Infant Health for American Families. March of Dimes. 2025.

<https://www.marchofdimes.org/reportcard>.

Furthermore, approximately 20,000 infants are stillborn each year.<sup>4</sup> Despite these challenges, progress is possible. Evidence-based policies, programs, and metrics make a real difference, close gaps, and improve outcomes.

Over 35% of U.S. counties are considered maternity care deserts.<sup>5</sup> Maternity care deserts are counties where there is no access to birthing hospitals, birth centers offering obstetric care, or obstetric clinicians. These areas are often populated by residents who have lower socioeconomic status and higher reliance on public insurance. Lack of access and economic disadvantages contribute to the observed increase in risk for poor birth outcomes, including maternal and infant mortality.

Hospital and labor and delivery unit closures are increasing across the U.S. and one of the main causes of the acceleration is the shortage of obstetric clinicians. This issue is common in rural areas and among those impacted by socioeconomic factors. HRSA's obstetric workforce projections indicate a shortage of OB-GYNs of 46% in non-metro areas in 2036 with an overall expected national shortage of over 7,500 OB-GYNs by 2038.<sup>6</sup> Over the past 15 years, more than 150 rural hospitals have closed with many citing provider shortages as the reason for the closure.<sup>7</sup> The MCTA framework helps identify areas with provider shortages.

Federal data collection is foundational to government agencies and other stakeholders tackling the maternal and infant health crisis in the U.S. It creates a common, accurate, and scientifically verified portrayal of at-risk populations, causes of adverse events, and which interventions work to address adverse events. National data systems, including the Pregnancy Mortality Surveillance System (PMSS)<sup>8</sup> and Pregnancy Risk Assessment Monitoring System (PRAMS)<sup>9</sup> have shown that federally supported and standardized multi-state data collection efforts can effectively and efficiently identify preventable causes of maternal and infant morbidity and mortality, and monitor trends in key risk factors. The way federal MTCA criteria and data requirements are defined will directly shape where attention and resources are targeted. It is vital that any reforms to MTCA criteria explicitly protect and leverage specialized maternal and child health data systems and datasets rather than sideline them.

### **Concerns Regarding Proposed MTCA Scoring Criteria**

In the Federal Register Notice announcing the proposed changes, HRSA proposes removing the Social Vulnerability Index (SVI) and proposes reallocating points previously assigned to SVI to provider density and travel time/distance estimates. HRSA suggests that "reallocating a point to the population-to-provider ratio strengthens the weight of areas with provider shortages, which is a key aspect of shortage designation, and reallocating a point to the travel time/distance strengthens the weight of geographic barriers, which directly impacts access to care especially in rural communities."<sup>10</sup>

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<sup>4</sup> Gregory ECW, Valenzuela CP, Hoyert DL. Fetal mortality: United States, 2023. Natl Vital Stat Rep; 2025 Jun;74(8):1–22. DOI: <https://dx.doi.org/10.15620/cdc/174593>. <https://www.cdc.gov/nchs/data/nvsr/nvsr74/nvsr-74-08.pdf>.

<sup>5</sup> Stoneburner A, Lucas R, Fontenot J, Brigance C, Jones E, DeMaria AL. Nowhere to Go: Maternity Care Deserts Across the US. (Report No 4). March of Dimes. 2024. <https://www.marchofdimes.org/maternity-care-deserts-report>.

<sup>6</sup> Health Resources & Services Administration. Health Workforce Projections. <https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand>.

<sup>7</sup> The University of North Carolina at Chapel Hill. Cecil G. Sheps Center for Health Services Research. <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.

<sup>8</sup>Data from the Pregnancy Mortality Surveillance System. <https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance-data/index.html>.

<sup>9</sup> PRAMS Data to Action Success Stories. <https://www.cdc.gov/prams/php/success-stories-data-to-action/index.html>.

<sup>10</sup> Federal Register. Request for Public Comment on the Updated Criteria for Determining Maternity Care Health Professional Target Areas. <https://www.federalregister.gov/documents/2026/02/03/2026-02130/request-for-public-comment-on-the-updated-criteria-for-determining-maternity-care-health>.

**March of Dimes is concerned that excluding the Social Vulnerability Index (SVI) from the proposed methodology could shift prioritization away from socioeconomically disadvantaged communities, widening disparities in access to care by emphasizing healthcare supply metrics alone.** While the proposal may enhance focus on clinical accessibility in maternity care deserts, it risks undermining support for under-resourced populations, particularly those facing barriers such as limited transportation, housing instability, or food insecurity, many of which are already maternity care deserts. While clinical care is necessary to improve maternal health, it is well-known that clinical care alone is not sufficient to improve health.<sup>11, 12, 13</sup> Other important community factors, including those represented in the SVI, collectively have a greater impact on health.

The SVI is specifically designed to capture community-level factors, including poverty, unemployment, education, housing conditions, and transportation access — all of which influence delayed or foregone prenatal care, elevated stress, and difficulty accessing high-quality healthcare services. Research consistently shows that residents of socially vulnerable counties experience significantly higher rates of maternal and pregnancy-related mortality, preterm birth, and chronic health conditions. These communities also have higher proportions of younger residents, lower educational attainment, and greater reliance on programs such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) — all associated with poorer maternal and infant outcomes.<sup>14</sup>

Weakening the federal government’s ability to target areas where social and systemic inequities most threaten maternal and infant health contradicts HRSA’s stated goal of “understanding the root causes that stand in the way of good health and providing the right services at the right time.”<sup>15</sup> March of Dimes’ analyses show that where people live, what coverage they have, and what barriers they face are closely linked to birth outcomes. The [Report Card](#) and the [Nowhere to Go: Maternity Care Deserts Across the U.S.](#) report examine the association between measures like the Maternal Vulnerability Index (MVI), county-level maternity care access, and insurance patterns, and outcomes like preterm birth, infant mortality, and maternal mortality. These analyses show that counties facing greater socioeconomic disadvantages have worse maternal and infant outcomes, with the poorest outcomes concentrated in historically disadvantaged regions such as parts of the Southeast, Appalachia, and the rural Midwest. This empirical picture undercuts any notion that clinical capacity alone is sufficient; social vulnerability is itself a powerful predictor of risk.

Federal policy changes must be grounded in accurate, comprehensive data that strengthens maternal and child health (MCH) programs. Excluding measures of social vulnerability from prioritization frameworks would not achieve this goal and could potentially exacerbate maternity care deserts. Our policies and programs must recognize that factors such as poverty, housing instability, and lack of transportation often determine whether mothers and infants can access quality prenatal and postpartum care. Ignoring these realities risks worsening provider shortages and increasing maternal and infant morbidity and mortality.

**Additionally, March of Dimes is concerned that the proposed methodology, which excludes family physicians who provide obstetric care, results in an undercount of maternity care clinicians.**

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<sup>11</sup> McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Aff.* 2002; 21(2):78-93. Lower left: Remington PL, Catlin BB.

<sup>12</sup> Gennusko KP. The County Health Rankings: rationale and methods. *Popul Health Metr.* 2014; 13:11.

<sup>13</sup> Park H et al. Relative Contributions of a Set of Health Factors to Selected Health Outcomes *Am J Prev Med* 2015;49(6):961–969.

<sup>14</sup> Kawakita T, Hayasaka M, Robbins L, Martins J, Saade G. Association Between the Social Vulnerability Index and Adverse Pregnancy Outcomes. *Obstet Gynecol.* 2025;145(5):503-510. [doi:10.1097/AOG.0000000000005890](https://doi.org/10.1097/AOG.0000000000005890).

<sup>15</sup> Health Resources & Services Administration. How We Improve Maternal Health. <https://www.hrsa.gov/maternal-health>.

The score for population-to-full-time-equivalent maternity care health professional ratio is calculated based on the number of reproductive aged women compared to the number of maternity care health professionals in the service area. Maternity care professionals are defined as OB/GYNs and Certified Nurse Midwives. While OB-GYNs comprise over 70% of the obstetric workforce, family physicians also play a critical role, especially in rural areas. Approximately 7% of family physicians reported delivering babies in the U.S., however, in rural counties family physicians account for 1 in 4 obstetric clinicians, compared to just 1 in 20 in urban counties.<sup>16</sup> Decades ago, almost half of family physicians reported delivering babies. While this number has declined sharply, recent federal investments in obstetric training programs for family physicians in rural areas could have a positive impact on the obstetrical workforce in the future.<sup>17</sup>

Under the current federal definition of MCTAs, family physicians who provide obstetric care are not counted as maternity care clinicians in the core ratio that determines shortage status. Research mapping priority maternity care deserts and MCTAs found that nearly a quarter of high-need rural maternity care desert counties had at least one family physician providing obstetric care during delivery (17%), yet those physicians were not reflected in the MCTA provider supply definition.<sup>18</sup> In addition, we recommend considering validation of clinician data using other available and more timely data sources and transparency around how clinicians are counted. These changes would capture more clinicians with incomplete or inaccurate American Medical Association survey (AMA) data, thus refining the precision of the MCTA measure and better supporting communities.

### **Recommendations to Strengthen Proposed Methodology**

March of Dimes respectfully offers the following recommendations to strengthen the proposed methodology for calculating maternity care target areas:

- 1) HRSA should continue to incorporate the Social Vulnerability Index (SVI) in the MCTA calculation.
- 2) HRSA should incorporate family physicians who provide obstetric care into the count of maternity care clinicians.
- 3) Should HRSA decide not to continue utilizing SVI, March of Dimes recommends:
  - a. Replacing SVI with existing comparative data that focuses on inclusion of socioeconomic factors, such as estimates from the American Community Survey. In addition, HRSA could consider including timelier, validated sources of data to accurately measure community-level resources.
  - b. Carefully monitoring populations that may be impacted by these data collection changes. This includes shifts in county-level scores, impact on underserved communities, trends in funding allocation and provider recruitment, and any widening disparities in care access.

### **Conclusion**

March of Dimes sincerely appreciates the longstanding efforts of HRSA to improve population health, and specifically to improve the health of America's mothers and children. The maternity care target area designations play a vital role in assuring that communities with the greatest need—and often those with the worst outcomes—have the best shot at improving maternal and infant health. We are grateful for your consideration of our above recommendations. We are

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<sup>16</sup> Stoneburner A, Lucas R, Fontenot J, Brigance C, Jones E, DeMaria AL. Nowhere to Go:

Maternity Care Deserts Across the US. (Report No 4). March of Dimes. 2024. <https://www.marchofdimes.org/maternity-care-deserts-report>

<sup>17</sup> Rosenblatt RA, Cherkin DC, Schneeweiss R, et al. The structure and content of family practice: current status and future trends. *J Fam Pract.* 1982;15(4):681-722.

<sup>18</sup> Topmiller M, Carrozza M, Jetty A, Rankin J, Huffstetler A. Maternal Care Target Areas (MCTAs), Family Physicians, and the Expansion of Obstetrical Care in High-Need Areas. *Ann Fam Med.* 2023 Nov;21(Suppl 3):5030. [doi: 10.1370/afm.22.s1.5030](https://doi.org/10.1370/afm.22.s1.5030).

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BABIES.**



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available for further discussion on these recommendations, and we look forward to continuing collaboration with HRSA to improve the health of all moms and babies.

Sincerely,

A handwritten signature in black ink that reads "Stacey Y. Brayboy".

Stacey Y. Brayboy  
March of Dimes Sr. Vice President, Public Policy & Government Affairs