Maternity Care
Emergency Medical Services

Joint Labor, Health and Social Services
Interim Committee Meeting

Wyoming
Department
of Health

June 23rd, 2025

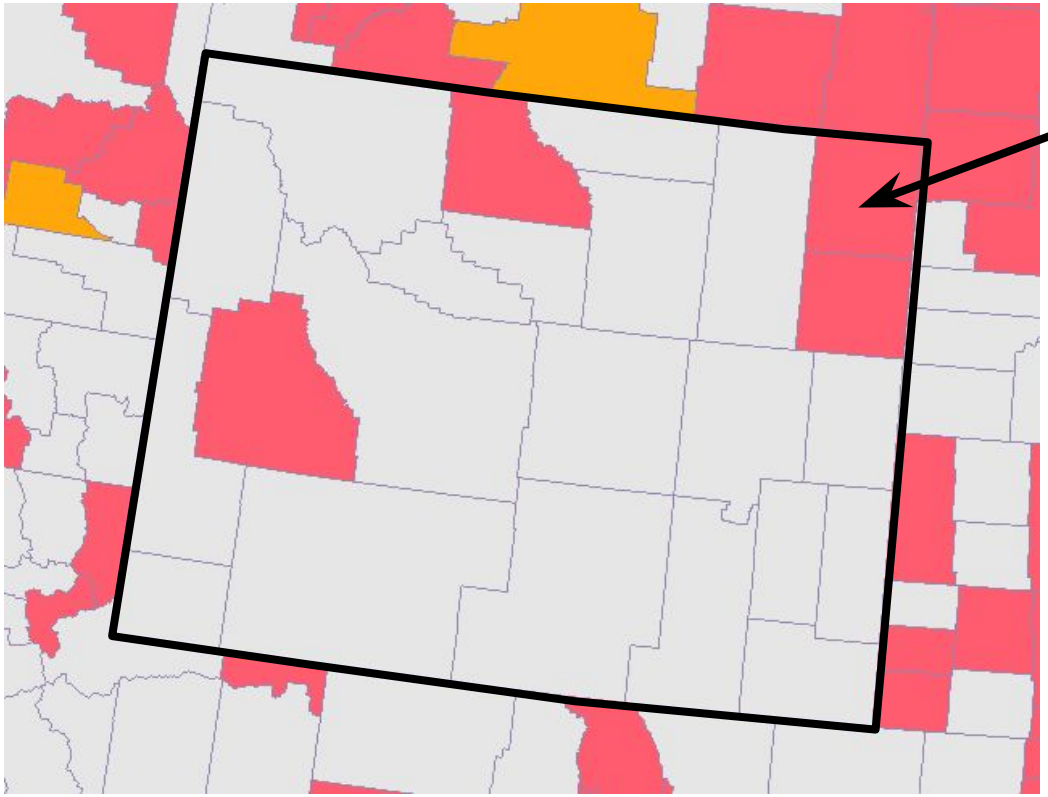
Agenda

- **Maternal health**
  - Updated map and data from 2024 JtLHSS brief
  - Recommendations
- **Emergency medical services (EMS)**
  - New report - highlights
  - Recommendations
- **Common problem**
  - Mismatch between high fixed costs, low volume

Maternity Care

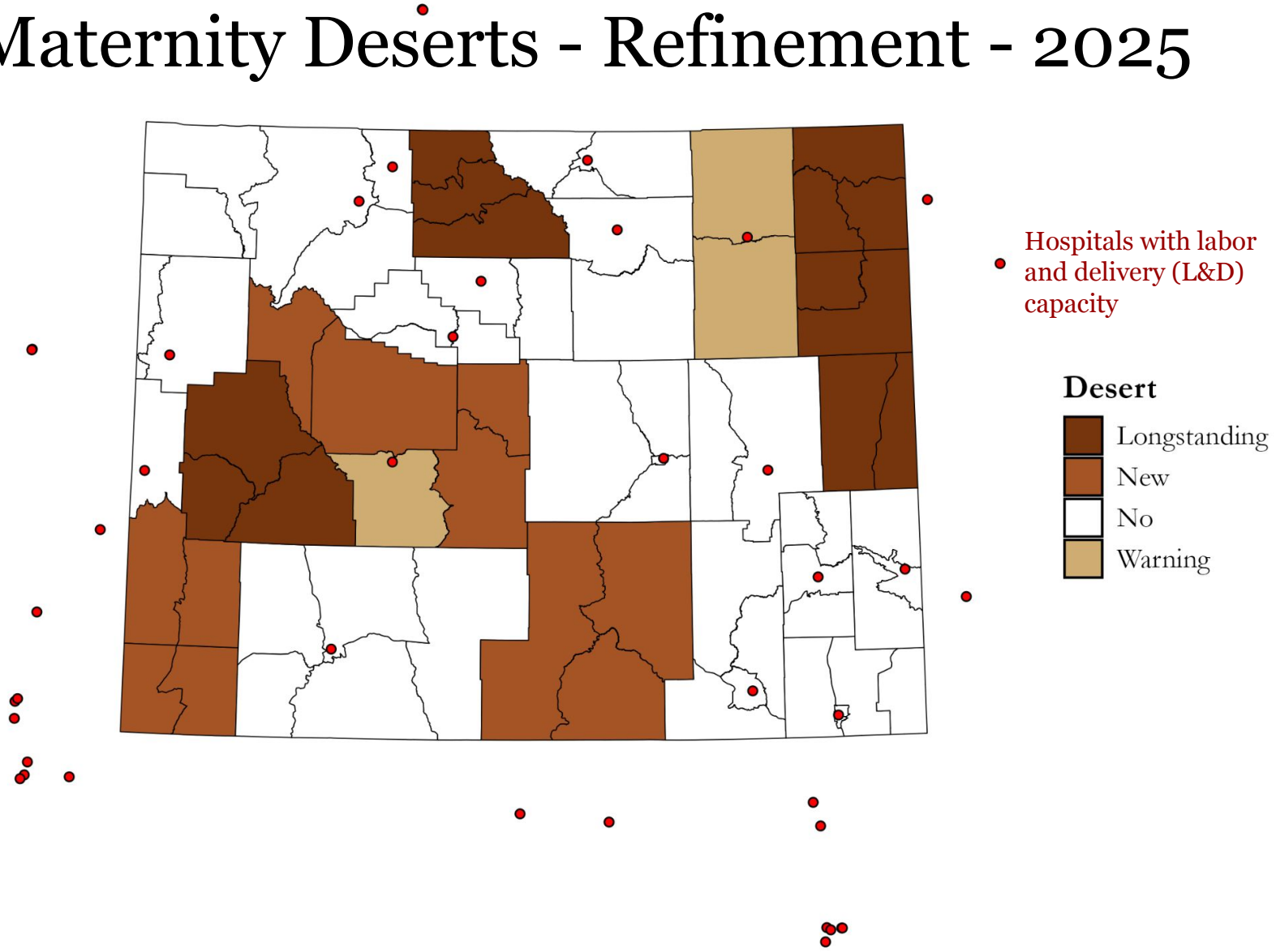
Wyoming Department of Health

March of Dimes (2024) Definition



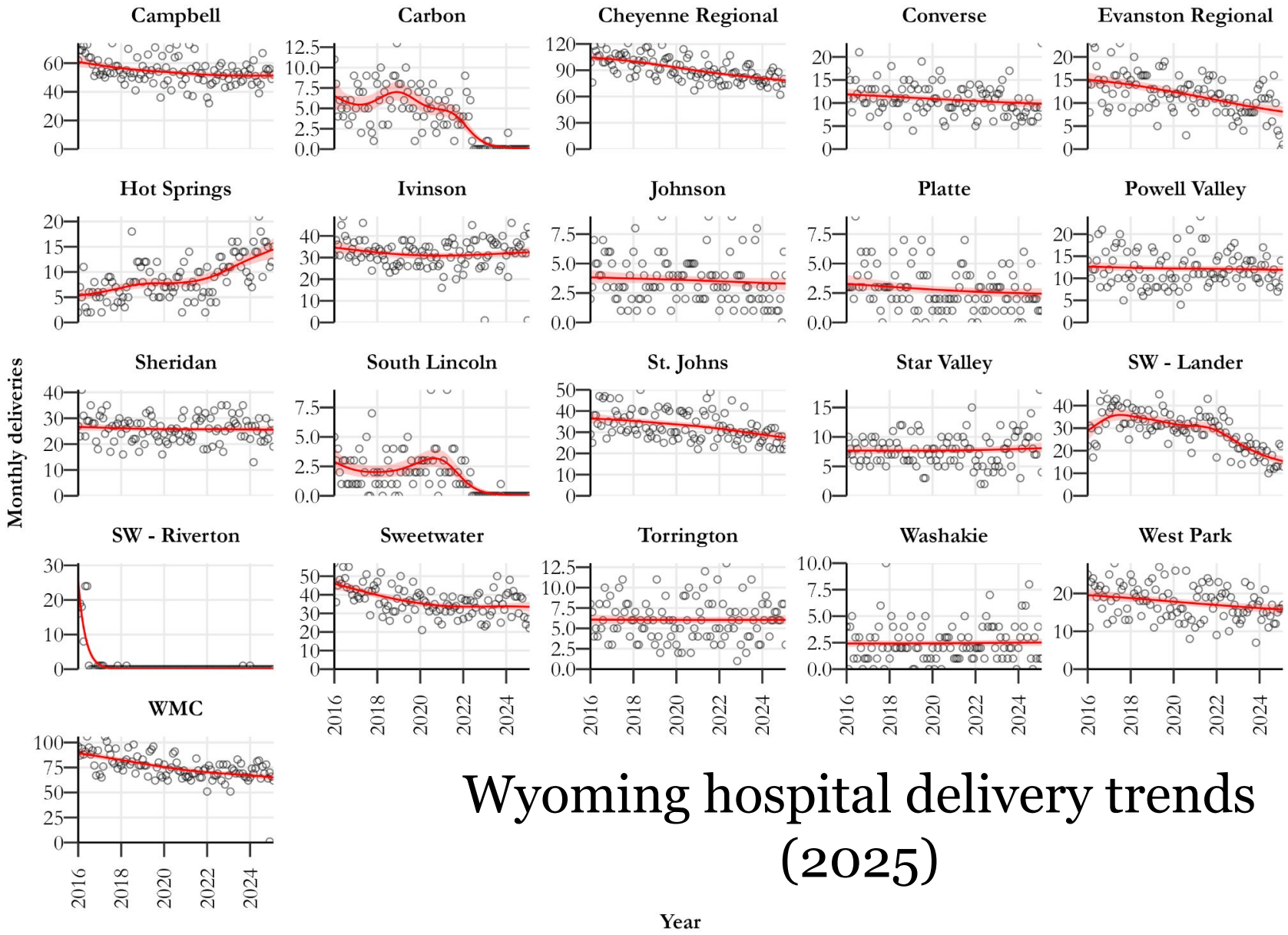
Maternity desert:
- No hospitals or birth centers
- No obstetric providers

Maternity Deserts - Refinement - 2025



Maternity deserts

- **"Warning" areas:**
  - **Lander** - declining births (many shifting to Thermopolis), low and declining provider ratio
  - **Gillette** - births stable, but low provider ratios and some evidence of market shifts out of State in Crook, Weston counties.
- **"New" maternity deserts** have had recent (last 5 years) closure of labor and delivery (L&D). Significant shift for communities in these areas.
- "**Longstanding" maternity deserts** have never had a hospital that does L&D - less of a concern



Wyoming hospital delivery trends (2025)

Primary problem: hospital viability

- Maternity deserts are first a **hospital viability problem**.
- Hospitals are the **community anchor** for labor and delivery.
  - Delivery infrastructure, nurse staffing and support is critical to successful perinatal care, esp. if things go badly.
  - Hospitals also recruit and retain OB and other delivering providers.
- L&D closures are a **symptom** of broader financial distress - load shedding unprofitable cost centers.

Underlying reasons: hospital viability

- **Higher costs**:
  - Nurse labor shortages post-COVID, reliance on agency staffing.
  - Provider recruitment (e.g. locum tenens)
- **Low and decreasing volume** - fewer women of childbearing age, fewer births.
- **Comparatively low Medicaid payment rates** (30% of births)
  - Average Medicaid paid for birth: ~ $7,500
  - Average private-pay paid: ~ $20,000
- **Hospital administration/management challenges**

Role of the State - policy options

- **Current role: options**
  - Increase Medicaid hospital payment rates for deliveries
    - Cost-based reimbursement to smaller (CAH) hospitals that offer L&D services
  - Increase Medicaid global maternity payments to delivering providers
  - Increase funding to provider recruitment programs
    - Loan repayment
    - Graduate Medical Education (GME) - UW
  - Increase provider education opportunities

Role of the State - policy options

- **Expanded role: options**
  - Financial and/or management assistance to distressed hospitals
  - Local control of private hospitals through licensure (2025 General Session HB0284)
  - Malpractice/tort reform
  - Malpractice risk pooling and quality improvement (Nebraska, Oregon)

Emergency Medical Services

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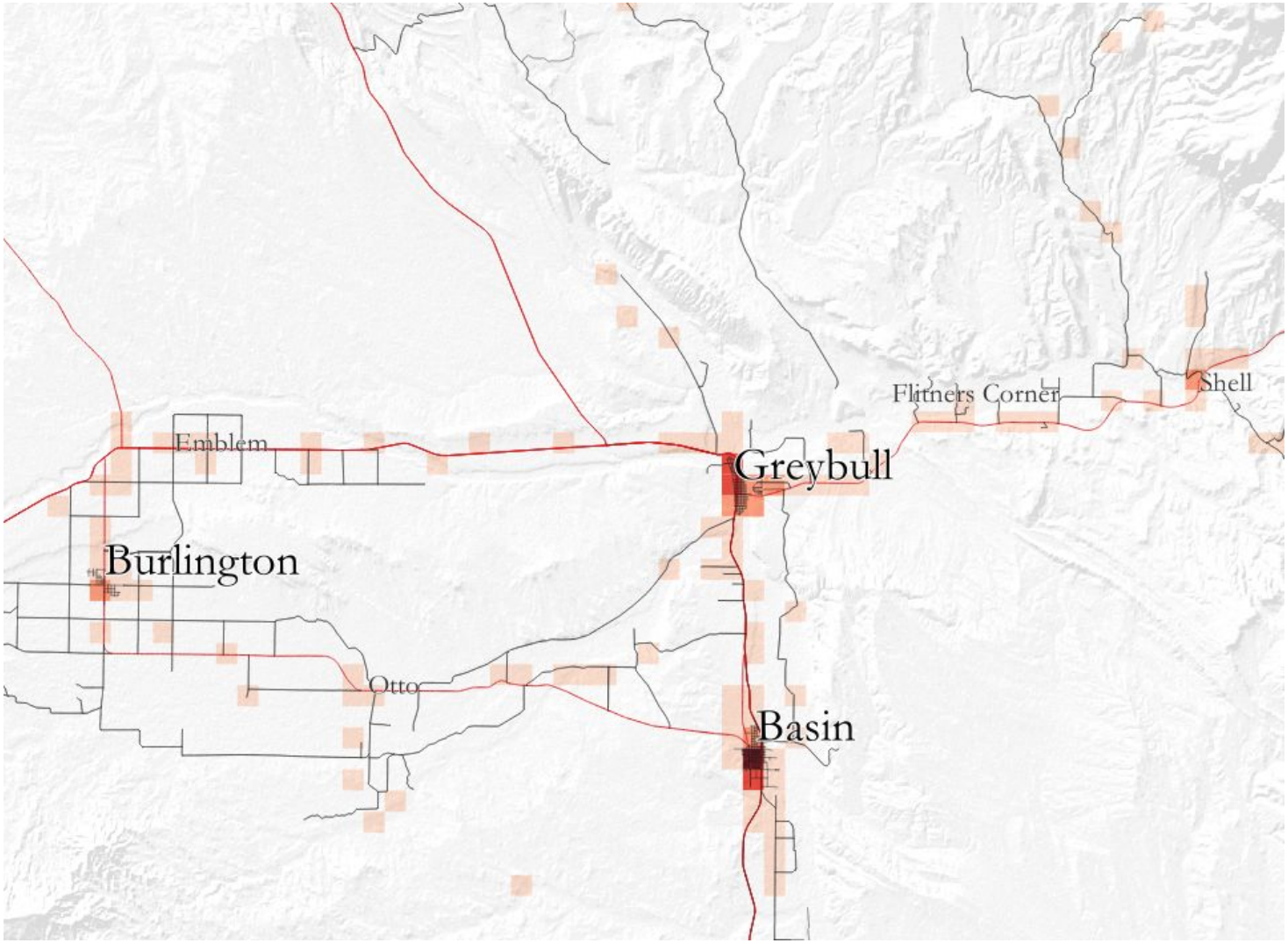
Findings

- **Volume and risk**
  - 44 EMS agencies respond to ~ 77.5K calls per year.
    - ~51K are reimbursable transports
    - The other ~34% are not
  - Most are local. Highway crashes only 1-2%.
  - Risk increases dramatically with age
    - Medicare is one of the largest payers (40-50%)

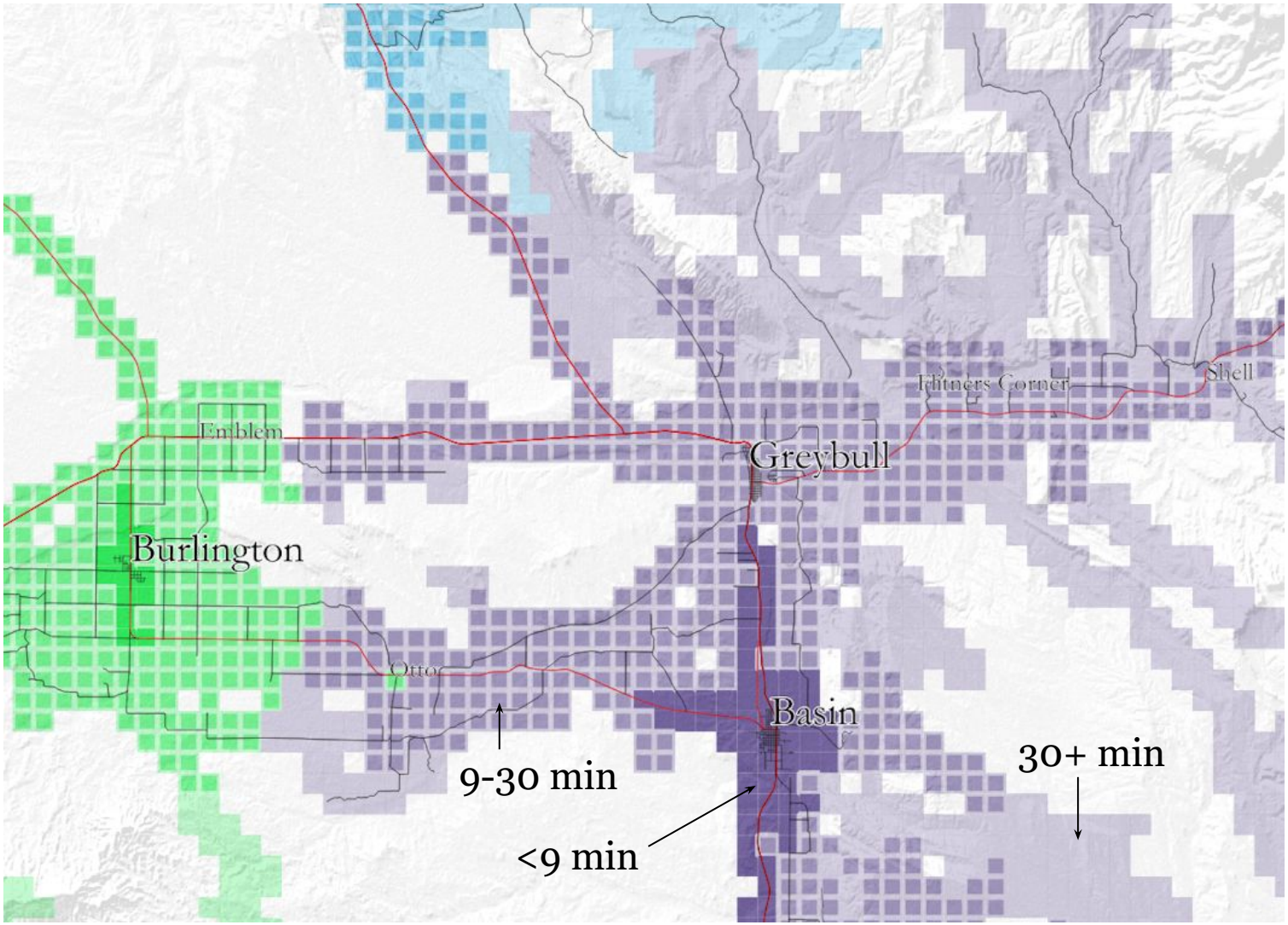
Findings

- **Response times**
  - Vary significantly, with biggest variable being “chute time” (dispatch to wheels rolling)
    - **~ 58%** of Wyoming’s population lives within 9 minute expected response time
    - **36%** live within 9-30 minutes;
    - **6%** outside 30 minutes;
  - Smaller, volunteer services have longer chute times.

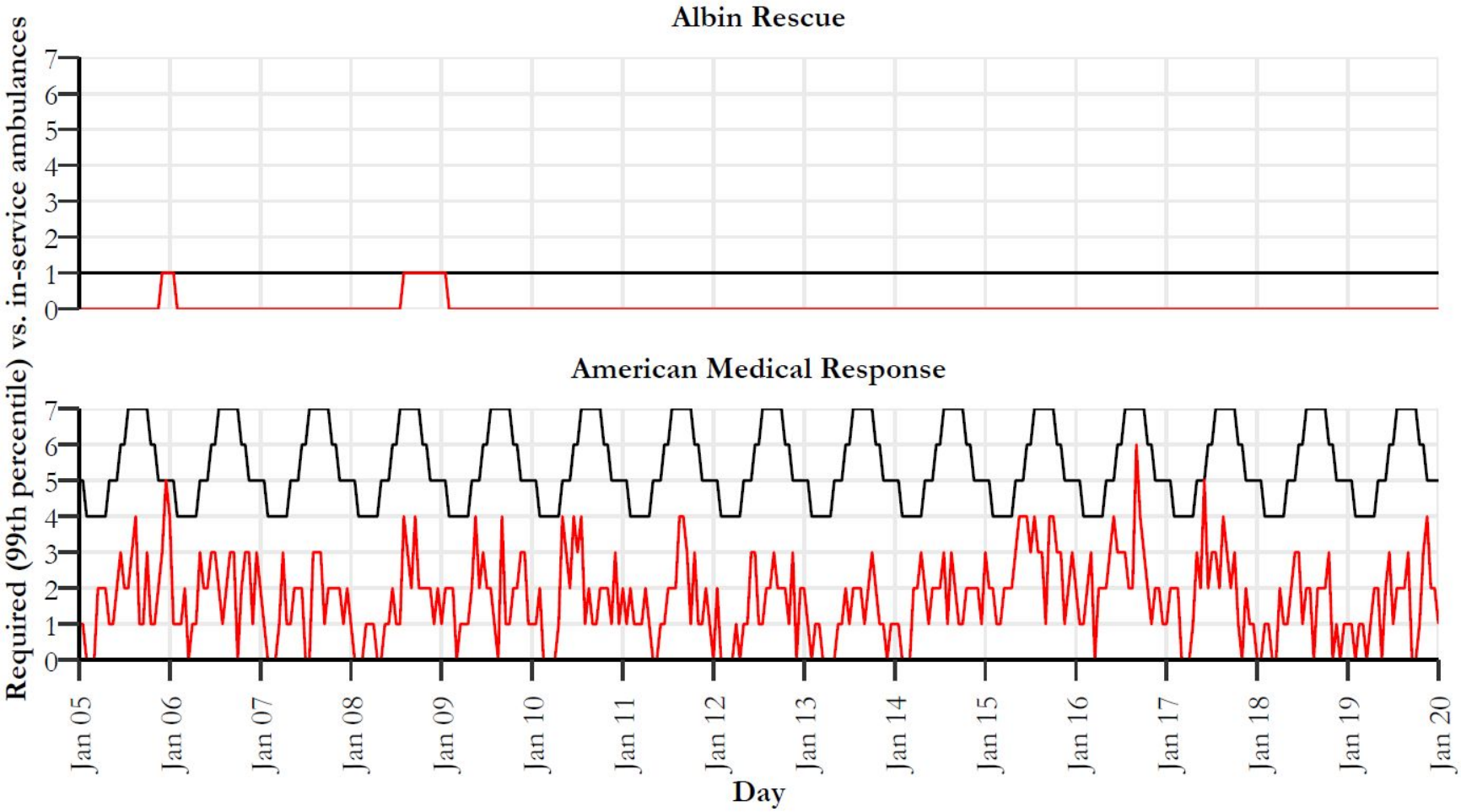
Volume maps


Flitners Corner
Shell
Emblem
Greybull
Burlington
Otto
Basin

Service area maps

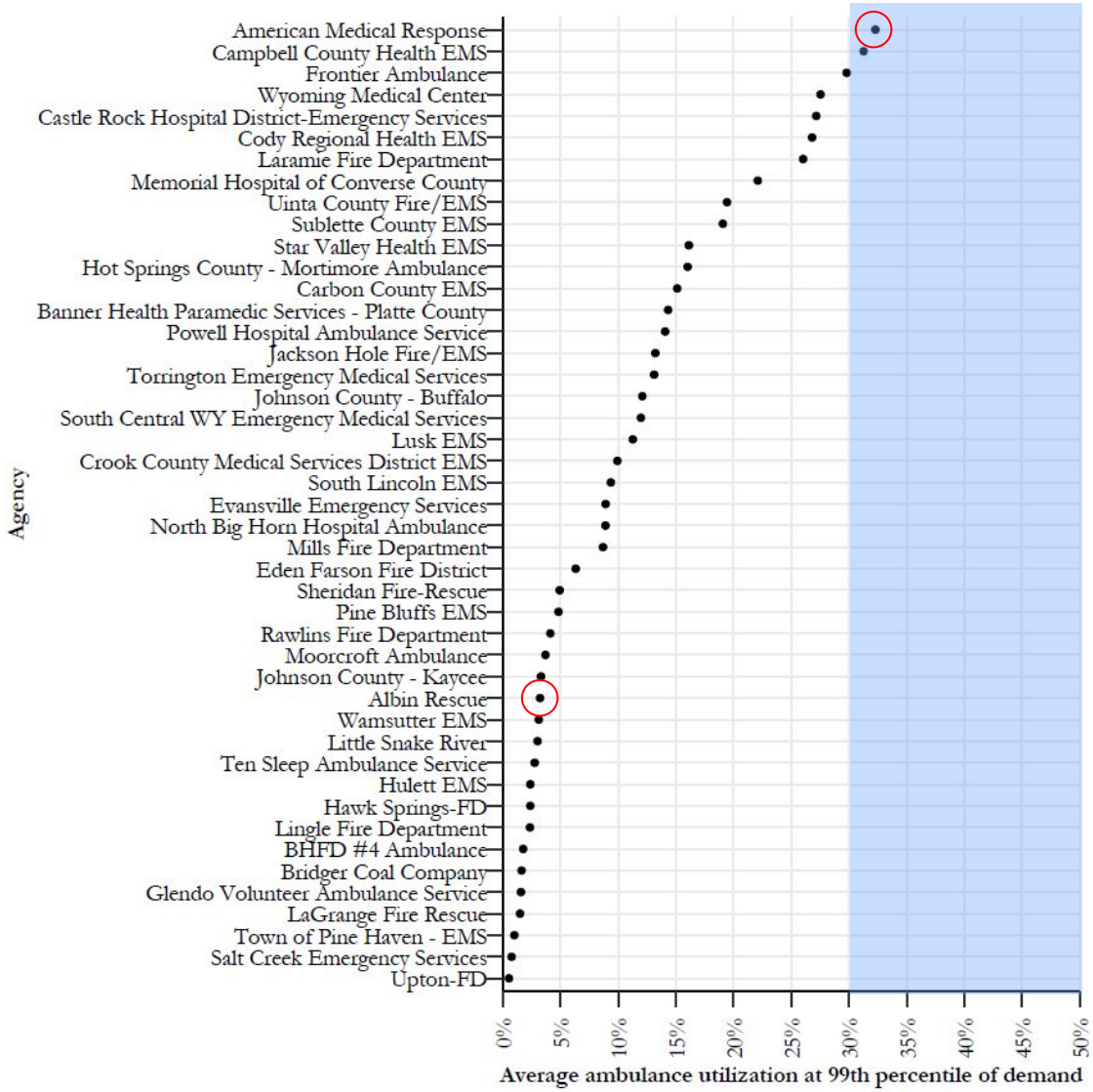


Readiness vs. volume example



- Albin Rescue requires 1 ambulance
- AMR needs ~ 4-7
- Volume is much higher in Cheyenne

Readiness vs. volume example



- 30-50% utilization is the sweet spot for ambulance operations nationally.
- Only largest services in Wyoming exceed 30% minimum.
- Combined with payer mix, affects viability based on service volume alone.

Problem

- **Problem**: Mismatch between fixed costs and variable service volume.
  - Est. **~$30M** annual gap between **~$67M** costs and **~$37M** potential revenue.
  - Only **3 large services** can expect to cover costs from service revenue
  - Gap currently filled by various **subsidies**
    - Volunteers
    - Tax revenue
    - Hospital-based
    - Fundraising/grants
  - Some subsidies are more **sustainable** than others

Recommendations

- **Maximize billing potential - explore procurement of billing contractor**
  - Use **existing data** (WATRS) to generate claims and bill payers
  - **Opt-in** for ambulance services
  - WDH would use contractor to bill for its own operations (facilities, laboratory, nursing) as well; provides **stable base** of volume to build upon.
  - Potential to:
    - **Reduce administrative costs** by deduplicating work
    - Obtain more **competitive pricing** through volume
    - **Lower barriers to entry**
    - Improve WATRS **data quality**

Recommendations

- **Use State funding to nudge EMS system towards more sustainable subsidy sources**
  - **Critical Access Hospitals** (smaller towns)
    - Cost-plus Medicare revenue
    - Must be only ambulance within 35 miles
  - **Professional fire departments** (larger cities)
    - Funding base from tax dollars
    - Already respond to a lot of EMS calls (often 80-90% of volume).
- These two options would allow most of Wyoming to be covered

Conclusion

- **Common problem**
  - Mismatch between high fixed costs, low volume
- **Similar levers**
  - Payment policies, funding
  - (De)regulation
  - Workforce supply