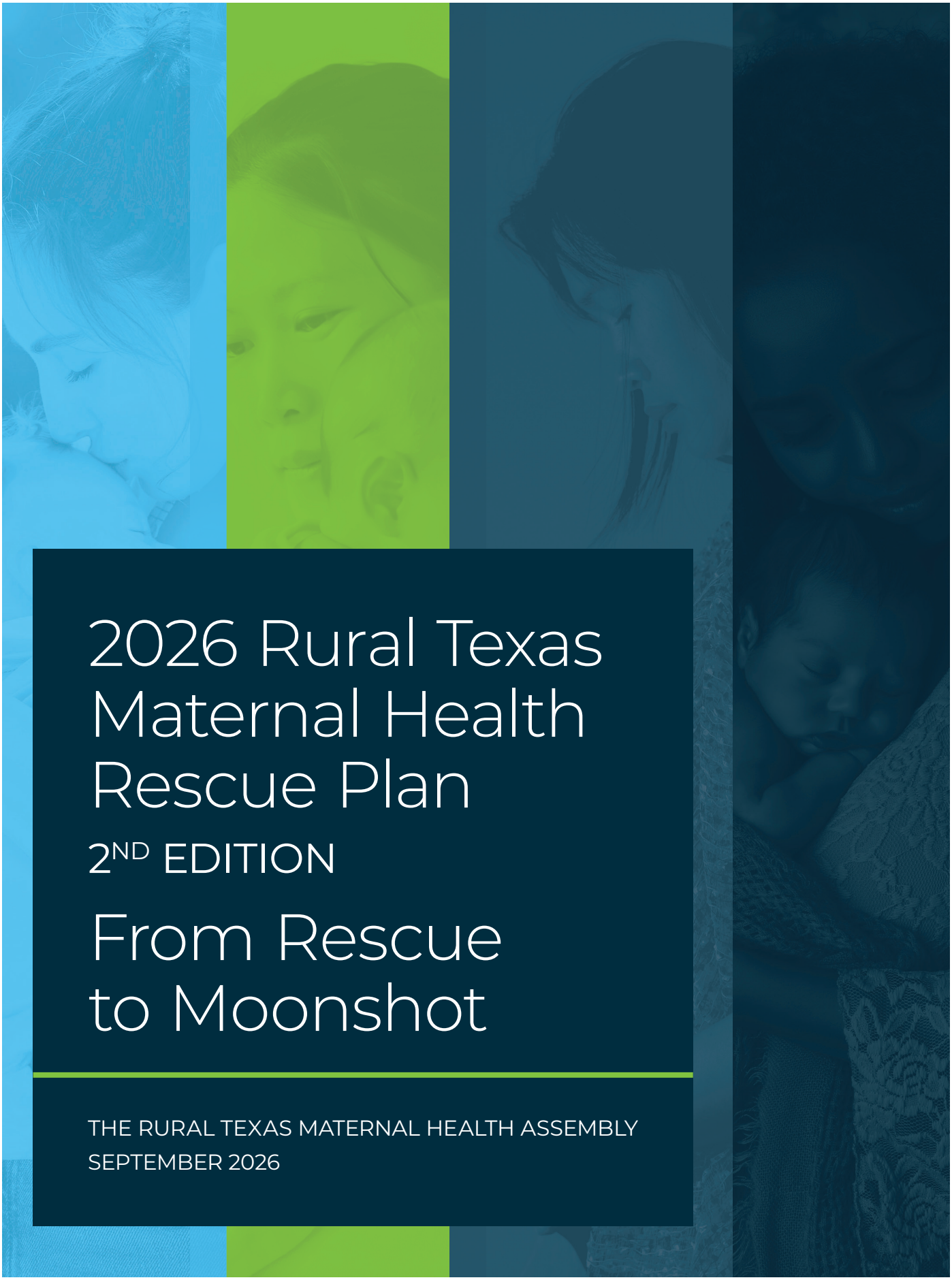


2026 Rural Texas Maternal Health Rescue Plan

2ND EDITION

From Rescue to Moonshot

THE RURAL TEXAS MATERNAL HEALTH ASSEMBLY

SEPTEMBER 2026

Rural Texas Maternal Health Rescue Plan, Second Edition — From Rescue to Moonshot

BY THE RURAL TEXAS MATERNAL HEALTH ASSEMBLY

SEPTEMBER 2026

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With generous support from the T.L.L. Temple Foundation

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Rural Maternal Health Assembly Background

Inspired by the first Texas Rural Health Rescue Act (71st Texas Legislature), in 2024, the Texas A&M Rural and Community Health Institute, Texas Academy of Family Physicians, Texas Organization of Rural and Community Hospitals, and Texas Health Institute, convened the Rural Maternal Health Assembly (RMHA), inviting more than 40 organizations representing rural health care clinicians, hospitals, academic institutions, consumer advocates, and foundations to identify a cohesive, consensus-driven menu of state policy reforms to improve access to rural maternal health. Then, as today, a precarious rural maternity care system placed the health of mothers, families, and communities at risk, requiring bold action.

Assembly members analyzed dozens of potential initiatives that lawmakers or state regulators could pursue to change the trajectory of Texas' rural maternal health system. Twelve priorities emerged. Members ranked each within three broad levels:

Code Red: Urgent reforms needed to address pervasive, longstanding issues that threaten rural maternal health viability and on which the success of all other reforms will depend.

Critical: Strategies to bolster the long-term viability of a rural maternal health system.

Essential: Approaches that will improve patient and family health outcomes by promoting innovative ways to increase availability of high-quality preventive and maternity care services.

Subsequently, the co-conveners incorporated these priorities into the 2025 Rural Texas Maternal Health Rescue Plan

Of the four Code Red priorities identified in 2025, lawmakers enacted three in whole or in part. These included Medicaid payment reform for rural hospitals, increases in funding for the rural maternal health workforce, and fully funding Texas' women's health programs. Lawmakers also adopted other recommendations within the report.

Following *sine die* of the 89th Texas Legislature, the original co-conveners, joined by the Texas Association of Community Health Centers, re-convened the Assembly to continue its momentum.

This report is the culmination of work initiated during the Rural Maternal Health Assembly, Phase I, and refined and elaborated upon during Phase II.

> "East Texas spans a large, mostly rural service area where distance, limited maternity capacity, and workforce shortages can delay routine prenatal care as well as urgent obstetric evaluation and transfer. By advancing the recommendations of the Rural Maternal Health Assembly, the Legislature can give local health systems greater capacity to provide timely, coordinated, and safer care for women and families across rural East Texas — and indeed, every rural county."
>
> — Stephen Patrick, MD
> Professor of Medical Education, Clerkship Director for Obstetrics & Gynecology, Department of Medical Education, UT Tyler School of Medicine

Rural Texas Maternal Health Rescue Plan 2026

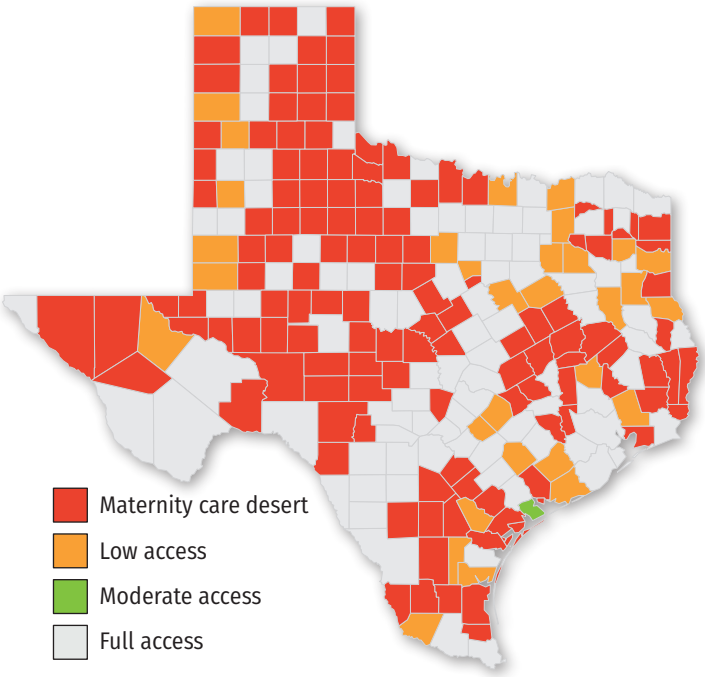
From Rescue to Moonshot

Rural[1] communities are the cultural and economic lifeblood of the state. When people envision Texas, it is rural Texas they see. Likewise, rural communities anchor Texas' economic vitality, contributing $200 billion annually to the state's economy.[2] Yet the slow degradation of Texas' rural maternal healthcare system threatens rural families' way of life.

Some 665,000 women ages 15 to 45[3] live in rural Texas, along with their families. When their communities lack women's preventive healthcare and maternity care services, women and families do not want to live there, meaning employers cannot thrive there. Consider these facts.

- **In Texas, 60% of rural counties and 51% of all counties remain "maternity care deserts," counties without maternity care services.[4] Over the past decade, 16 more gained that distinction — the largest increase nationally.[5]**
- **65% (96) of rural hospitals in Texas no longer provide maternity care, while 20% (13) remain at risk of halting labor and delivery services.[6]**
- **55% (84) of rural hospitals are at risk of closing, with 17% in immediate danger.[7]**
- **22.8% of Texas women receive inadequate or no prenatal care, compared to 16.1% nationally. In rural counties, the rate is even higher.[8]**
- **58% of rural counties lack sufficient primary care, with one in five having no primary care physician at all, although rural primary care clinics provide essential services before, during, and after pregnancy.[9]**
- **22% of rural women ages 19 to 49 are uninsured.[10]**

Access to maternity care in Texas



Source: March of Dimes. Maternity Care in Texas, 2026.

60%

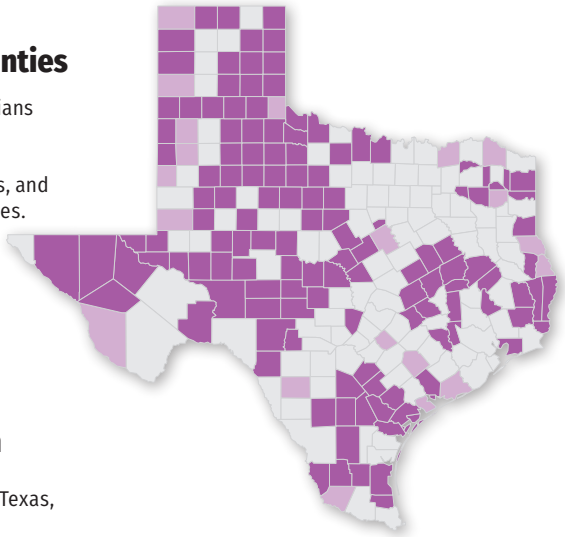
of rural Texas counties are defined as maternity care deserts.

Statewide, the maternity care crisis affects nearly 272,000 women and 18,000 births each year.

Number of Obstetric Clinicians in Texas Counties

- 0
- 1
- > 1

Obstetrical care clinicians include obstetrician-gynecologists, family medicine obstetricians, and certified nurse midwives.



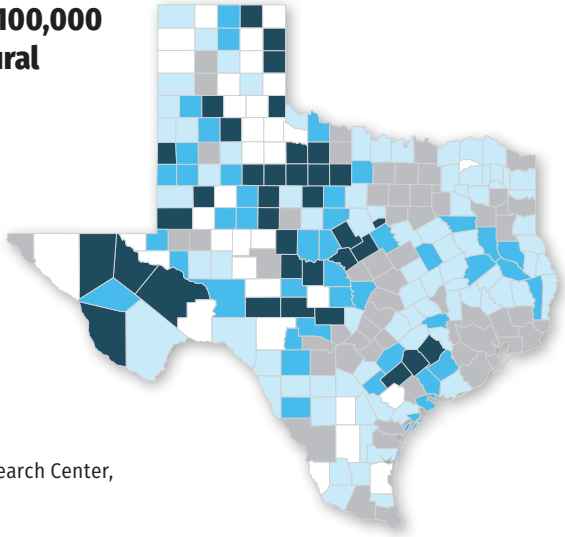
52% of counties have no obstetric clinician

7.9% of counties have a single obstetric clinician

Source: Maternity Care Access in Texas, March of Dimes, 2026.

Family Physicians per 100,000 Population in Texas Rural Counties, 2025

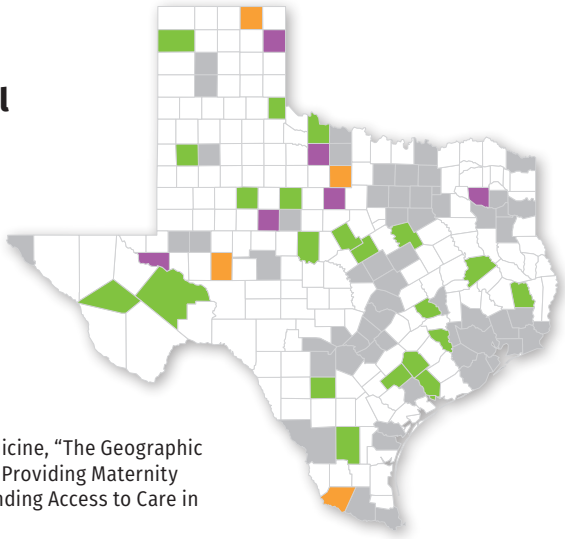
- Rural county (no FPs)
- Rural county (> 0 - 35.9)
- Rural county (36 - 57)
- Rural county (> 57)
- Urban county



Source: WWAMI Rural Health Research Center, University of Washington, 2026

Distribution of Family Physicians Providing Maternity Care in Rural Counties, 2024

- FP with hospital
- FP only
- Hospital only
- Nonrural county



Source: The Annals of Family Medicine, "The Geographic Distribution of Family Physicians Providing Maternity Care and Opportunities for Expanding Access to Care in Rural Areas," July 2025.

But fatalism is not in rural Texans' vocabulary. That is why the Rural Maternal Health Assembly gathered in 2024 to formulate a blueprint to halt — if not reverse — the decline in rural maternal health. At its initial convening, Assembly participants judged the system to be teetering "perilously close to a crisis,"[11] requiring swift action by lawmakers to avert further loss of rural hospital labor and delivery services and preventive maternal healthcare.

The Assembly's plan, the Rural Texas Maternal Health Rescue Plan,[12] outlined 12 priority recommendations, grouped by urgency, that if implemented would stabilize and improve rural maternal healthcare access and birth outcomes. And lawmakers heard the warning, adopting several Rescue Plan recommendations either wholly or in part to help stabilize availability of rural maternal health care.

Of particular importance, lawmakers passed House Bill 18, the Rural Health Stabilization and Innovation Act. The legislation, coupled with $150 million in enhanced biennial funding,[13] addressed one of the Rescue Plan's highest priorities, strengthening rural hospital financial health. Lawmakers also enacted other bills to codify recommendations within the report. [see sidebar, page 6]

Yet, as important as these investments are, the state's rural maternal health system remains precarious. In 2025, two additional rural Texas hospitals suspended their labor and delivery services. That is why the Assembly reconvened in 2026 to articulate what additional policy levers lawmakers should pull to protect rural maternal health access.

What emerged from the work is this: **launch a Healthy Rural Texas Pregnancy Moonshot, wherein the state supports a multi-year, coordinated, aspirational, visible, and funded public strategy** designed to:

- Safeguard and extend rural maternal health to all rural women, and
- Measurably improve rural maternal health outcomes within five years.

Rural communities pride themselves on their ability to tackle difficult problems. And rural maternal health is no different. However, rural maternal health is akin to rural broadband, utilities, and water infrastructure. **The law of small numbers means that market forces alone are insufficient to ensure the preservation of essential rural maternal healthcare.**

Lawmakers intuitively understand this, having already generously underwritten vital rural hospital services, such as labor and delivery, to ensure their continued availability. Yet, positive birth outcomes depend not only where a woman delivers, but also on the timeliness and quality of maternal healthcare provided well before and after her baby arrives.

Forthcoming Rural Texas Strong grants [see Appendix 1] may help improve access. Funding will be used to expand rural health workforce, upgrade healthcare equipment, and support technological innovations. However, eligible grantees are not required to allocate dollars to maternal health initiatives. Moreover, in a state as large as Texas, $1.4 billion over five years, spread across 202 rural counties, will only go so far. Thus, more investments will be needed to develop and sustain Texas' rural maternal healthcare system.

For the forthcoming 90th Texas Legislative Session, the Assembly acknowledges the state budget will be tight, with agencies already instructed to identify savings within their 2028-29 biennial budgets.[14] As a result, lawmakers will be bombarded with a surfeit of funding proposals resulting in difficult decisions about where to allocate limited resources. **However, rural maternal health is not something that can wait. Once these services are gone, they rarely come back.** And many of the interventions needed to keep them are low-cost and high-reward, meaning they will save money while saving lives.

By pursuing a coordinated strategy, the Rural Maternal Health Moonshot, Texas will help ensure the heart of the state — its rural communities — remain attractive places to live, work, and visit.

Major Rural Maternal Health Victories in the 89th Texas Legislature

- Improving the financial stability of rural hospitals at risk of closure through Medicaid inpatient hospital rate modernization.
- Providing grant funding to support rural hospital financial viability and innovation.
- Boosting rural hospital labor and delivery and obstetrical service "add on" payments.
- Sustaining incubator dollars for federally qualified health centers to help expand capacity and delivery system innovation.
- Making lactation consultation services a Medicaid benefit.
- Funding to expand availability of mobile rural preventive health clinics to more underserved communities.
- New funding to support existing and new postgraduate family medicine-obstetrical care training programs.
- Increase in funding for the Texas A&M University Rural and Community Health Institute Program to assist rural communities improve rural maternal health safety, access, and quality.

From Rescue to Moonshot — 12 Priorities

CODE RED PRIORITIES

1. Improve the timeliness and availability of rural maternal health by modernizing Medicaid maternal health delivery models and payments for rural maternal health professionals.
2. Boost the rural maternal health workforce by expanding training pipelines and incentive programs for both clinical and nonclinical health professionals committed to rural practice.
3. Sustain state investments to bolster rural maternity hospital care services and to cultivate community health centers' maternal health capacity and innovation.
4. Launch Project Healthy Rural Texas Pregnancies, a multi-pronged, cross-sector campaign and resource center to increase access to and coordination of critical preventive maternal health services.

CRITICAL PRIORITIES

5. Robustly fund the state's women's health programs to sustain women's preventive health services.
6. Bring maternal healthcare services to where rural women live and work by expanding the use of alternative care settings, such as mobile, pop-up, and virtual clinics, as well as patient navigation.
7. Ensure excellence in rural maternal healthcare quality by growing innovative educational and training partnerships to deliver safe, high-quality maternity care.
8. Pioneer formation of rural maternal health utilities to ensure counties with the highest rurality can offer women access to critical preventive maternal health services.

ESSENTIAL PRIORITIES

9. Enhance chronic disease prevention, management, and treatment before and between pregnancies to reduce chronic disease-related complications during pregnancy.
10. Improve health outcomes and well-being of rural mothers and babies by alleviating nonclinical barriers to care.
11. Establish and fund innovative, cost-effective partnerships between primary care and dentistry to increase the use of preconception preventive oral care to reduce oral health-related complications during pregnancy.
12. Extend existing Medicaid doula coverage to cover additional nonclinical, evidence-based prenatal and postpartum services for doulas who complete state-approved certification or who demonstrate core competencies.

Rural Texas Maternal Health Rescue Plan 2026

From Rescue to Moonshot

POLICY DETAILS

CODE RED PRIORITIES

1. Improve availability and timeliness of rural maternal healthcare.

- **Update Medicaid payment rates for women's and maternal health clinicians practicing in rural communities.**
- **Establish a menu of standardized rural maternal health value-based care options to increase participation among rural practices.**
- **Reduce paperwork and administrative barriers that deter health professionals' Medicaid participation.**
- **Increase healthcare coverage among rural women to improve the use of preventive and maternal health services while also improving rural practice viability.**

Rural healthcare practitioners are foundational to the economic prosperity of any rural area, providing jobs and undergirding rural communities' tax bases. These practitioners include family physicians, obstetricians, and advanced practice professionals like certified nurse midwives, advanced practice registered nurses, and physician assistants. Like any business, practices cannot operate if they cannot pay their staff and keep the lights on. Yet, the state's largest payer for maternal health services, Medicaid, pays woefully low rates for health professional services, well below the cost of providing not only obstetrical care but also the primary care services women need before and after pregnancy.[15]

Statewide, Medicaid covers 53% of all births.[16] In rural counties, that figure ranges from 60% to 92%. Medicaid fee-for-service payments for professional maternal health services have not been substantially updated in two decades.

In 2025, lawmakers enacted multiple funding measures to bolster rural hospitals' financial stability and to support rural inpatient maternity care. However, the fourth priority from the Rural Texas Maternal Health Rescue Plan[17] — ensuring viability of rural health professionals — remains an unfulfilled goal. **Without greater investments in the people that provide women's and maternal healthcare, it will be impossible to sustain progress Texas has made in rural maternal health.** The bottom line is that facilities cannot operate without clinicians, including physicians, nurses, and allied health professionals.

Over the next five years, the Rural Texas Strong (RTS) grant [see Appendix 1] will bring $1.4 billion in new federal funding ($281 million per year) to transform rural healthcare delivery.[18] A portion of the grant funding will be used to help communities recruit and retain healthcare workers. As important as these dollars will be to build a rural healthcare workforce for the future, without addressing underlying Medicaid payment inadequacies, it will be difficult for communities to compete for rural maternal care clinicians. Medicaid is the predominant source of maternity healthcare coverage for rural women, but it is also the lowest payer. Even with enhanced signing bonuses and other financial incentives that RTS will support, those dollars cannot replace sufficient payments to cover the costs of providing care.

For physicians and advanced practice professionals, increasing payments for office-based care will boost the availability of both prenatal and postpartum care, promoting early detection and management of chronic diseases that contribute to pregnancy-related complications. Higher Medicaid payments are also an essential component of retaining and recruiting more rural healthcare clinicians.[19]

However, modernizing payments is not just about the amount Medicaid pays, but also about how it pays. Texas Medicaid has been at the forefront of redesigning healthcare delivery, adopting its original value-based care payment framework more than a decade ago. Value-based care models reward healthcare systems and healthcare professionals for better health outcomes by paying for the quality of care rather than its quantity, while also improving cost effectiveness by promoting the right care at the right time in the right place.

Yet, in rural areas, value-based care requires substantial upfront costs to establish data collection and reporting capabilities, create analytical systems, redesign workflows, reimagine care delivery, adopt a team-based approach, enhance care coordination, and revise how practices engage and communicate with patients.

Recommendation 1A. Redesign Medicaid rural maternal health payments.

- Establish up-to-date Medicaid health professional payments for clinicians — physicians and advanced practice professionals who provide women's preventive, primary, or specialty care services before, during, and after pregnancy.
- Boost access to care and rural practice viability by establishing monthly sustainability payments to ensure stable cash flow and add-on payments to reward practices that provide prenatal and postpartum care.
- Establish a stakeholder process to advise HHSC on a long-range Rural Maternal Health Payment Modernization Plan to reimagine how Medicaid pays rural maternal health clinicians, with recommendations due to the Legislature by September 1, 2028.

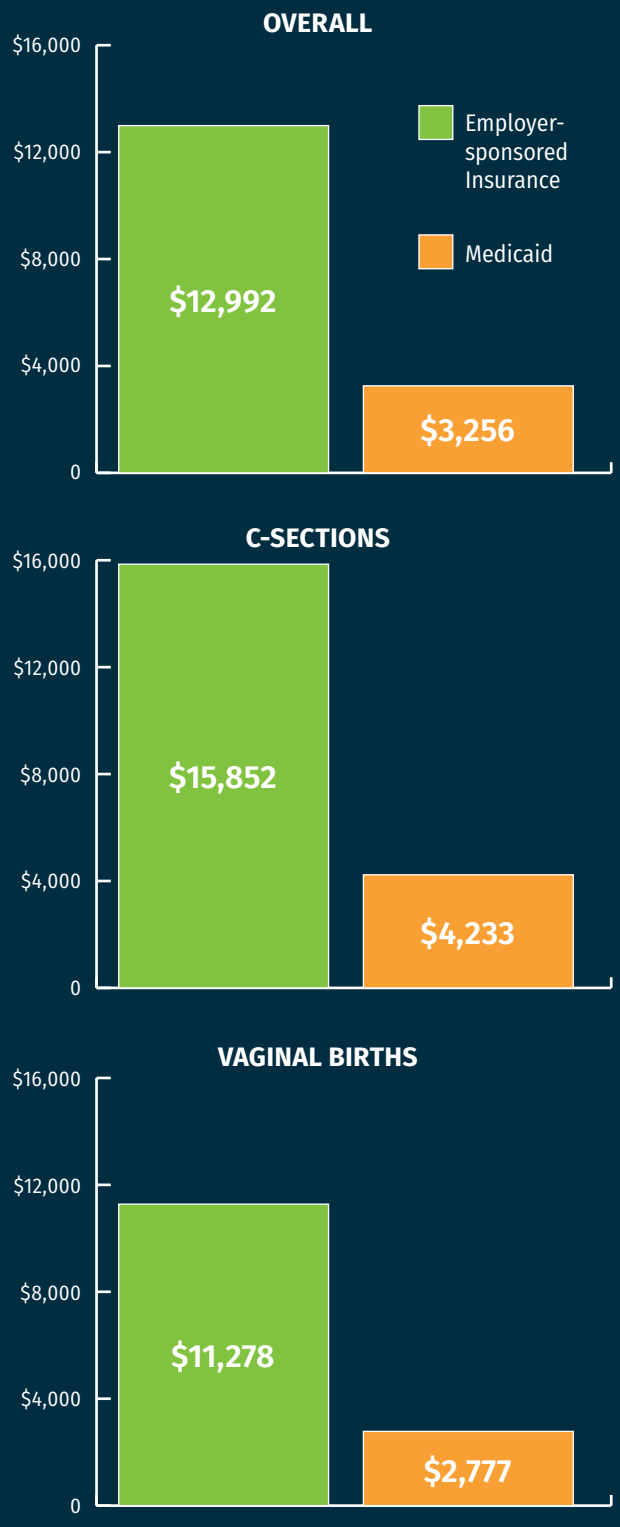
Recommendation 1B. Develop standardized rural maternal health value-based payment models in which practices can choose to participate.

Rationale: Being able to administer the same value-based payment strategy across the entirety of a rural practice's Medicaid business would increase adoption of Medicaid value-based payment strategies in rural areas — a win for clinicians, patients, and the state. Clinicians would gain from having a more sustainable payment strategy, patients from better health outcomes, and Texas Medicaid from broader adoption of more effective, efficient patient care delivery.

Recommendation 1C. Minimize costly Medicaid red tape and administrative hassles.

Rationale: The money and time spent on unnecessary administrative costs detract from the financial viability of rural practices. Common costs include lengthy delays in Medicaid enrollment and health plan credentialing, which means practices are not getting

Average Payments for Births in Texas, Employer-Sponsored Insurance versus Medicaid



Source: Health Care Cost Institute, Average Payments for Childbirth Among the Commercially Insured and Fee-for-Service Medicaid, 2022.

Estimates of Productivity Lost Due to Preterm Births in Texas

Annual Preterm Birth-related Disability	**$20,939,339**
Annual Preterm Birth-related Absenteeism	**$51,852,154**
Total Annual Preterm Birth-related Workplace Productivity Loss	**$72,791,492**

Source: Heartland Forward, "The Economic Case for Investing in Maternal Health," 2024.

paid, and burdensome prior authorizations. Due to the number of rural women who benefit from pregnancy-related Medicaid, maternal health professionals must be able to quickly and easily enroll in Medicaid and complete Medicaid managed care organization (MCO) credentialing. However, the system providers use to complete enrollment, the Provider Enrollment and Management System (PEMS), can be slow and cumbersome. And until practices complete Medicaid enrollment, MCOs cannot finalize credentialing. If practices see patients regardless, there is no retroactive payment for these services.

Prior authorizations, when judiciously applied, are a necessary component of a modern healthcare delivery system, helping to avoid potentially harmful prescription drug interactions and ensuring appropriate healthcare utilization and program integrity. However, judicious is the operative word. Nationally, Medicaid managed care plans deny 14% of prior authorizations, not including denials related to prescription drugs. When appealed, 47% get reversed. By comparison, Medicare Advantage plans deny 12% of PA requests; ACA Marketplace plans, 18%. Excessive use of prior authorizations results in delayed or no care. It also raises overhead costs, further weakening the financial viability of rural practices.[20]

Lawmakers have expressed understandable concern about whether reducing PA will increase overutilization of services or even encourage fraud, waste, and abuse. However, with the advent of artificial intelligence, applying transparent, fast, clinically accurate algorithms could eliminate the need for many prior authorizations, while still ensuring appropriate utilization of services and mitigating the risk of fraud, waste, and abuse.

Rural Texans appreciate a good challenge, and resolving the administrative, clinical, and payment barriers that deter more clinicians and facilities from providing rural maternal health services is definitely one. And the RMHA provides the forum to do it, bringing together multidisciplinary stakeholders, including state agencies, to timely identify solutions.

Thus, the Assembly asks that HHSC collaborate with the RMHA to undertake a joint endeavor that will seek solutions to vexing issues identified by RMHA participants, including:

- Improve the functionality, accuracy, and timeliness of Medicaid provider enrollment and credentialing experiences;
- Examine and expedite transparent and accountable technological strategies to reduce Medicaid managed care prior authorizations for services provided to women before, during, and after pregnancy, including those related to vendor drug program compliance;
- Review the Medicaid and Healthy Texas Women's preferred drug lists to ensure coverage of medications clinicians need to appropriately manage women before, during and after pregnancy, including making it easier to provide prenatal vitamins and iron supplements; and
- Implement technological support to help rural practices more easily incorporate prenatal and postpartum virtual care into their practices.

Recommendation 1D. Reduce the burden of uncompensated care by increasing the number of rural Texas women with meaningful healthcare coverage.

Rationale: Being uninsured has deleterious effects not only on the health and financial security of patients, but also the financial stability of rural practices. Twenty-five percent of rural Texas women ages 18 to 64 lack health insurance, despite a record number of rural Texans enrolling in the ACA Marketplace from 2020-25.[21] However, discontinuation of federal enhanced

Average Commercial Rate for Delivery Services by Texas Region

	C-section delivery	Vaginal delivery
Metro	$10,842	$7,765
Urban	$8,171 (-18%)	$5,931 (-20%)
Rural	$6,710 (-38%)	$4,755 (-39%)

Source: Texas A&M Health, Rural and Community Health Institute

Note: The variation in costs shown in charts on pages 9 and 11 is due to different denominators. The chart on page 9 includes only employer-sponsored commercial plans, while this chart includes data from the entire commercial health insurance market, including the ACA.

premium tax credits at the end of 2025 will make matters worse. Already, 150,000 fewer Texans now have ACA coverage compared to the prior year, marking the first enrollment drop in six years. That number will only climb. Medicaid provides coverage to women while pregnant and in the 12 months postpartum, but before pregnancy and between pregnancies, healthcare coverage also matters.

Through Texas's women's health programs, uninsured women can get basic preventive healthcare. These services are vital. However, they are not comprehensive, meaning women may have no coverage for needed specialty care to diagnose and manage acute or chronic conditions that contribute to poor health and birth outcomes.

That is why improving the availability of robust healthcare coverage across a woman's reproductive lifespan leads to healthier pregnancies and babies. At a minimum, Texas must enact robust outreach and education efforts to inform rural women about their health insurance options and to make it easier to obtain coverage by simplifying the enrollment and referral processes.

- Increase funding for the Community Partner Program (CPP) by providing grants to community-based organizations to deliver enhanced outreach, education, and enrollment in Medicaid, the Healthcare Marketplace, or other available, meaningful coverage options, enhancing healthcare access for rural women.
- Expand the use of out-stationed eligibility workers to connect eligible rural women to Medicaid and other public services.
- Reform Texas' presumptive eligibility policies to encourage more hospitals and community health centers to participate.
- Provide state funding to help uninsured rural women who are eligible for ACA Marketplace to purchase coverage.
- Collaborate with mobile health units and communities to provide onsite enrollment assistance in conjunction with community events.

2. Boost the rural maternal health workforce by expanding training pipelines and incentive programs for both clinical and nonclinical professionals, with targeted additional resources to programs committed to placing and supporting graduates in rural communities.

A sustainable and well-supported rural maternal healthcare workforce is essential for delivering high-quality care to rural women throughout their reproductive life spans. This task requires thinking creatively and thoughtfully about how to attract and retain not only obstetrical and primary care health professionals, but also allied health and trained nonclinical professionals, such as community health workers and health educators, whose services complement and extend clinical capacity.

State policymakers have long recognized the importance of subsidizing the state's rural healthcare workforce to ensure rural residents have access to critical services. This is evidenced by ongoing support for state-backed loan repayment programs for physicians, nurses, and mental health professionals; rural preceptorships for medical students; and new dollars to expand the family medicine-obstetrics postgraduate training program to boost access to rural obstetrical care.

Over the next five years, rural Texas will benefit not only from state funding to grow the rural health workforce but also from new dollars from the Rural Texas Strong Grant Initiative 4: The Next Generation of Small-Town Doctor and Team. [see Appendix 1] Through the grant, facilities, community clinics, and other eligible entities that win awards will collectively receive $322 million to ensure the next generation of small-town doctors are surrounded

> "Rural OB nurses and physicians are incredibly resourceful, but resourcefulness should never be the healthcare system's plan. Mothers and babies deserve safe maternity care close to home, and rural clinicians deserve the support to provide it."
>
> — Mandy Pugh, MSN, CNM, C-EFM, RNC-OB
> Association of Women's Health, Obstetric and Neonatal Nurses, Rural Representative

by sufficient advanced practice professionals and allied health professionals to give rural residents access to all levels of care in their communities.

According to the state's approved grant application, local communities seeking funds can use them to:[22]

- Develop career paths for local high school students;
- Provide scholarships for recent high school graduates;
- Offer relocation or signing bonuses for early, mid, or late career professionals; and
- Create a new residency training program, fellowship, or combined program, including partnerships with academic institutions or an existing teaching hospital.

Over five years, each county will be eligible for up to $725,000 for Initiative 4. These dollars most certainly will amplify rural workforce development already underway thanks to Texas' own workforce development projects. Nevertheless, given the depth of rural Texas' healthcare professional deficit, more dollars will be needed. There is no stipulation that eligible grant recipients spend a portion of the funding on maternal health.

The rising cost of clinical education and the payment differential for rural maternal health professionals mean practitioners considering rural practice already face serious financial hurdles before they even set foot in a rural community. New limits on federal loans for graduate healthcare training programs will make it worse by increasing the cost of pursuing degrees in medicine, advanced nursing, social work, physician assistant programs, dentistry, and other professions. Meanwhile, Medicaid covers 60% to 90% of rural maternity care costs yet pays the lowest rates.[23] [24] This one-two punch means any community-level recruitment package must make a rural practice worthwhile.

Advancements in artificial intelligence (AI) will potentially alleviate some workforce issues. In fact, Rural Texas Strong dollars will be available to promote technological innovation to streamline healthcare delivery and administration. Yet, maternal health is inherently hands-on.

Additionally, all 50 states will be recipients of the Rural Transformation Grants. This means that Texas will be competing against every state in the country to increase rural healthcare capacity amid a projected nationwide shortage of primary care and obstetrical care clinicians, among others.

The Assembly urges lawmakers to amplify the benefits of the RTS dollars by:

- Increasing investments in training for clinicians who provide preventive, primary care, or maternal health services to rural women, including mental healthcare;
- Augmenting rural training availability and incentive programs, including scholarships for allied health and nonclinical health professionals whose skills help extend the capacity of physicians and advanced practice professionals who provide maternal healthcare;
- Enhancing loan forgiveness for maternal health clinicians who serve remote and frontier communities; and
- Expanding or establishing rural apprenticeships for medical assistants and other allied health professionals by providing stipends to supervising maternal health clinicians or programs.

Recommendation 2A: Increase investments in Texas-grown rural health professional loan repayment, training, and incentive programs as part of a comprehensive strategy to compete against other states to successfully recruit more practitioners to rural communities.

Specifically, the RMHA recommends that lawmakers:

- Enhance funding for all health professional loan repayment programs to offset reductions in federal loan repayment dollars;
- Preserve $5 million in new biennial funding to increase family medicine obstetrical physician postgraduate training opportunities in Texas;
- Increase funding for nurse faculty loan repayment to ensure sufficient nurse educators are available to train the next generation of rural nurses; and
- Reinstate loan repayment for dentists who practice in underserved or rural areas.

Recommendation 2B. Expand the number of rural rotations available for medical students to gain firsthand experience in rural practice, including rural maternal healthcare.

These rotations should include direct patient care, community health involvement, and clinical shadowing to inspire more professionals to pursue careers in rural maternal health.

Recommendation 2C. Develop and fund a network of rural training opportunities for certified nurse midwives and advanced practice registered nurses, who often have limited opportunities to train in rural areas.

Funding should support women's and maternal care rural preceptorships during training and post-graduate fellowships. Texas could learn from Iowa, where a facility, the Mary Greeley Medical Center, solved its shortage of faculty by asking its nurses to become educators and preceptors, providing supplemental payments to compensate them for their time.

Recommendation 2D. Increase loan repayment funding for nurses pursuing advanced training to offset reductions in federal student aid.

The U.S. Department of Education capped federal graduate student loans for nurses seeking a master's or PhD, changes that may reduce the number of advanced practice nurses, educators, and nurse leaders. The change will particularly curtail the ability to cultivate nurse faculty, who train bedside nurses, certified nurse midwives, and others to provide women's health and maternity care. Without sufficient faculty, the shortage of bedside nurses available to practice in labor and delivery units or obstetrical care practices will grow.

Recommendation 2E. Extend rural Texas' perinatal capacity by expanding the availability of both allied health and community health workers.

- Augment the availability of community health workers via loan repayment, enhanced rural training sites, apprenticeships, and incentive programs for rural maternal care specific activities.
- Support the use of community-based doulas to provide nonclinical perinatal support services to rural women by funding scholarships for state-approved rural doula training or certification.
- Provide training and funding to support the delivery of perinatal care by appropriately supervised emergency medical technicians.
- Increase the availability of medical assistants by expanding training pathways for rural high school students, such as on-the-job apprenticeships within community centers or medical practices.

Rationale: To extend perinatal care to more rural women, Texas must extend the capacity of clinicians — rural physicians and advanced practice professionals (APPs), which include certified nurse midwives, advanced practice registered nurses, and physician assistants. Training and deploying teams of allied health professionals like medical assistants, licensed vocational nurses, emergency medical technicians, and nonclinical health professionals like community health workers and community doulas could help address health disparities and improve rural maternity care capacity. These professionals help augment the capacity of physicians and APPs, providing services such as patient education, care coordination, and case management. Rural Texas Strong grants are intended to help rural communities attract and retain members of the healthcare team, but additional funding will be needed to meet demand.

Texas Medicaid recognizes community health workers as a provider type, defined as nonclinical professionals who help connect people with healthcare and social services.[25] Low payment rates discourage their broader use by community centers, organizations, and hospitals, where they are most commonly used.

Medical assistants, or MAs, are allied health professionals whose skills help expand the capacity of physicians and APPs. MAs provide both clinical and administrative tasks, such as scheduling appointments, taking vital signs, and administering medications. Texas offers both accredited and certificate training MA programs, but rural students seeking MA training often lack the resources to attend distant training schools. Online training paired with paid apprenticeships could expedite training and increase clinical capacity, while offering better paying jobs to recent high school graduates.

Likewise, emergency medical professionals, acting under physician supervision, are increasingly being used in rural areas to provide home visits to high-risk pregnant and postpartum women, following additional training on maternal healthcare. This reduces the need for transport to a hospital when care at home can be safely provided. For example, Project Swaddle,[26] established in Indiana in 2018, trains community paramedics to provide nonemergency transportation, as well as virtual and in-person "check-ins" for high-risk pregnant and postpartum women who have been referred to the program by a physician, case manager, or the Women, Infants, and Children (WIC) program. Participants receive regular visits from the paramedic, who updates the patient's obstetrical care professional and connects women to local social services to address nonmedical drivers of health.

Rural Texas will need more obstetrical care clinicians, and none of the health professionals discussed above can substitute for them. However, by increasing the supply of any and all of the above, Texas could help extend the capacity of existing clinicians, allowing them to see more patients.

Recommendation 2F. Provide incentives for physician anesthesiology residents and fellows and nurse anesthesia students pursuing a Certified Registered Nurse Anesthetist degree to practice rurally through funded electives in rural settings.

3. Continue state investments to bolster access to maternity care in rural hospitals and to cultivate community health center infrastructure and innovation.

Rural hospitals, rural health clinics, and community health centers are the backbone of rural maternal health. They need help to survive.

A decade ago, 60% of rural hospitals provided maternity care. Today, the inverse is true. Also, community health centers (CHC) provide essential preventive care, but many rural and frontier centers struggle to provide the full array of women's preventive care, including prenatal care.

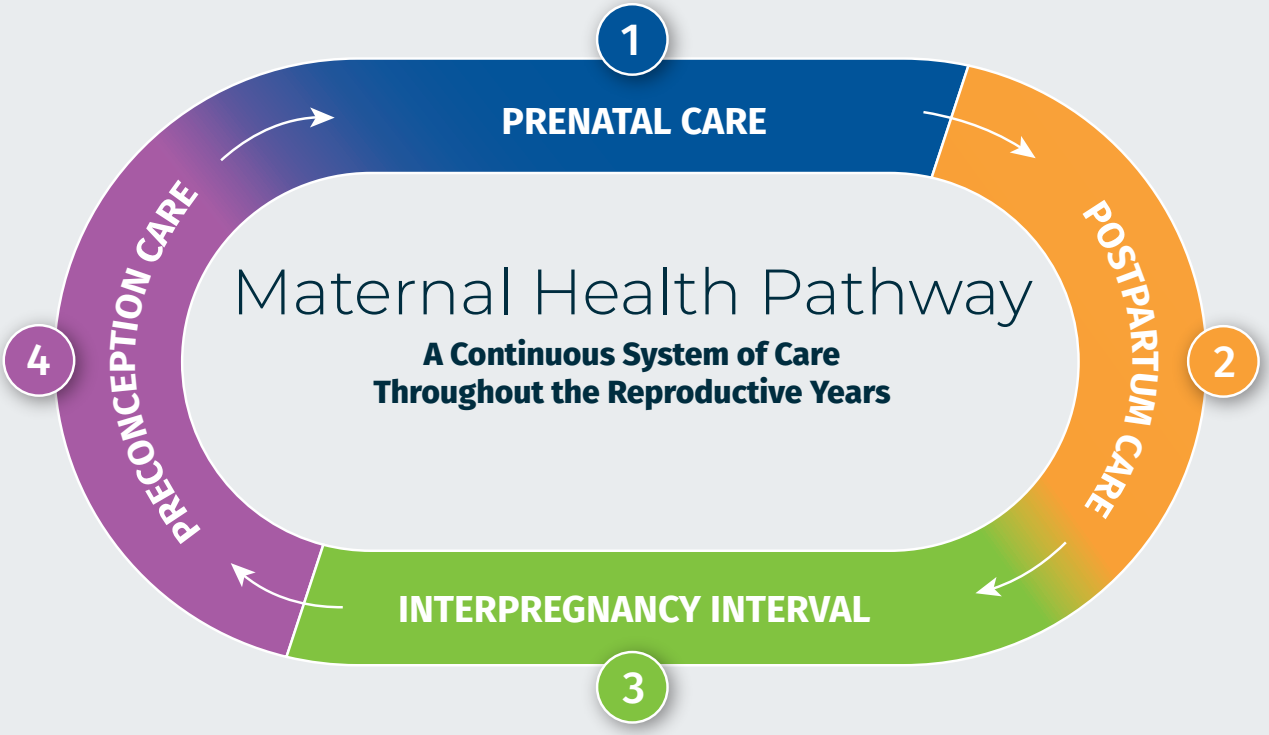
Recognizing the importance of these providers, lawmakers have invested new resources over the past several years to improve access to both rural hospitals and CHCs, also known as federally qualified health centers, or FQHCs.

In 2025, lawmakers augmented the state's FQHC incubator program, doubling its appropriation from $20 million in 2023 to $40 million, with the goal of increasing availability of community centers in rural and underserved areas. Over the past several years, these dollars have funded at least 11 centers to improve maternal health, of which seven projects serve rural communities.[27] Providers use funds to expand center capacity, hire more maternity care health professionals, and purchase crucial equipment, such as ultrasound machines.

Likewise, to bolster the financial resources of the state's rural hospitals, lawmakers allocated $150 million to improve these facilities' long-range fiscal situation by establishing cost-based Medicaid payments, Medicaid maternity care, and related "add-on" dollars and state-funded grants to foster hospital stabilization and innovation.[28] Collectively, these changes fulfilled the 2025 Assembly's Code Red recommendations about rural inpatient maternity care services.

Continued funding for both FQHCs and rural hospital maternity care services will be critical to improving rural women's access to maternal health services.

Recommendation 3A. Maintain incubator funding for federally qualified health centers.



Recommendation 3B. Preserve rural hospital cost-based reimbursement and Medicaid add-on funding for maternity care.

Recommendation 3C. Maintain state-based rural hospital sustainability and innovation grant dollars to help these facilities hire and retain the staff required for obstetrical care physicians and certified nurse midwives to safely provide labor and delivery services, including registered nurses, sonographers, anesthesia personnel, and respiratory therapists.

Recommendation 3D. Require state regulated public and private health plans to establish commensurate maternity care payment rates for rural and urban hospitals and clinicians.

Today, commercial health plans pay as much as 40% less to a rural hospital for the same maternity care services provided in an urban one, though the cost of delivering these services in a rural setting is often more expensive.

4. Launch Project Healthy Rural Texas Pregnancies, a dedicated campaign and bureau to help rural communities develop innovative, pragmatic, cost-effective, and cross-sector strategies to increase access to and coordination of rural women's preventive healthcare before, during, and after pregnancy.

Texas has long led efforts to improve maternal and newborn healthcare quality, establishing expert advisory panels as well as the Perinatal Quality Collaborative[29] to assist the state identify and address systemic factors contributing to poor maternal or neonatal health outcomes. The Assembly strongly supports each of these efforts. [see Appendix 2]

At the same time, there are few resources to help communities adapt the way in which local maternal healthcare services are organized, delivered, and coordinated locally and regionally, factors that also optimize health outcomes and lower costs.

Economic analyses show that when expectant mothers must seek care outside their home counties, the associated costs of time away from work, transportation, and lodging, if needed, exceeds $6 billion nationally.[30]

Rural communities need dedicated support establishing multi-pronged, cross-sector strategies to increase access to and use of critical preventive health services for rural women.

For example, preventive healthcare before, during, and after pregnancy is essential to better birth outcomes. Yet rural women struggle to obtain any or all such services.[31]

Preconception is the best time to identify and manage conditions that undermine the health of a future pregnancy. Once pregnant, prenatal care is the cornerstone of promoting healthy pregnancies and reducing complications for mother and baby,[32] including rates of maternal and neonatal deaths.[33] For it to be most effective, prenatal care should be close to home and begun during the first trimester, when clinicians will assess and manage risk factors that contribute to poor maternal and neonatal health outcomes, such as screening for diabetes or high blood pressure, while also providing important health education and counseling.

According to an independent analysis of Medicaid managed care compliance with prenatal care timeliness standards, statewide only 57.4% of women with low-risk pregnancies received a prenatal care appointment within 14 days, and only 18.5% for high-risk, indicating significant problems with network adequacy.[34] Importantly, the review stated, "low compliance may reflect both limited appointment availability and fragmented referral and care coordination processes particularly for members requiring maternal-fetal medicine and subspecialty oversight."[35]

Other factors for late or no prenatal care include lagging Medicaid application processing for pregnancy-related Medicaid applications, declining Medicaid participation among rural clinicians, transportation challenges, and misunderstandings or misinformation among women about the necessity of early and ongoing prenatal care.

When rural women do get prenatal care, it is often late — the second or even third trimester, increasing the likelihood of poor birth outcomes. When prenatal care begins late, it abbreviates opportunities for clinical management for conditions like gestational diabetes, hypertension, or infections. Preterm birth rates are three times higher among women without prenatal care. When babies arrive early, there is a heavy health and economic toll on mothers, babies, and families.[36] Babies born to mothers without prenatal care are five times more likely to die.[37]

Late or no prenatal care also means that at the time of delivery, clinicians have limited knowledge about underlying health risks, raising the odds a C-section will be performed to minimize potential complications.[38] Like any major surgery, C-sections pose not only greater risks of complications but also higher costs, averaging 1.8 times more than vaginal deliveries ($28,998 versus $15,712).[39]

However, by reimagining how rural prenatal care is scheduled, coordinated, and delivered within a county or region, communities can help minimize gaps in care and connect women to prenatal care sooner.

Postpartum care usage among rural women is low for the same reasons: inadequate health plan networks, confusion about benefits or eligibility, lack of care coordination and service navigation, and gaps in coverage, among others.

Moreover, rural women must travel far from home to get perinatal care, creating burdens for them and a strain on neighboring health systems, while also increasing the odds of poor outcomes for both mothers and babies.

Addressing Priority 4 is closely tied to Priority 1 — increasing Medicaid payments for healthcare clinicians. Low reimbursement rates make it harder to recruit and retain rural primary and obstetrical care clinicians. And of those who do stay, many limit their Medicaid participation if they participate at all.

Beyond financial issues, there are clinical and care delivery mechanisms that if deployed, would boost use of prenatal and postpartum care. These include making prenatal care delivery more functional and flexible, expanding the use of and payment for rural-designed group prenatal care, providing community-based or regional patient navigation services, and implementing a system of early detection and triage to ensure women with known pregnancy-related risk factors initiate prenatal care as early as possible.

With grant funding, rural communities could leverage their local and regional healthcare and community relationships to build coordinated systems of care, including home visiting, virtual care, and mechanisms to minimize non-medical barriers to care, such as lack of transportation.

Recommendation 4A. Establish a Healthy Rural Pregnancy Bureau to assist communities in designing and deploying innovative, pragmatic, cross-sector strategies to improve the delivery and coordination of rural women's and maternal preventive health.

The bureau should be charged with collaborating with rural communities to:

- Evaluate, develop, and deploy innovative, pragmatic, and cost-effective strategies to boost use of prenatal care;
- Devise coordinated county-based or regional maternal care pathways to link and coordinate services before, during, and after pregnancy;
- Increase rural maternal health efficiency and ensure effective use of resources to improve maternal care;
- Pilot innovative strategies with local WIC offices, retail chains, grocery stores, community centers, and health plans to make it easier for women to obtain proof of pregnancy and health history (health screening, blood pressure check, height, weight) without waiting for a first prenatal care appointment. Women with specified risk factors would be triaged quickly to prenatal care; and
- Assist rural communities prepare grant proposals for which funding would foster implementation of perinatal care improvement initiatives tailored to unique county or regional needs.

Recommendation 4B. Establish a Rural Maternal Health Community Grant Program to support communities implementing initiatives devised in collaboration with the bureau.

Recommendation 4C. Revise Medicaid and health plan clinical policies to simplify use of and promote virtual care for prenatal visits to align with American College of Obstetricians and Gynecologists' guidance, as well as to increase the use of remote patient monitoring for higher risk women and authorizing it for a broader array of rural practice types.

As part of this effort, Texas Medicaid durable medical equipment policies must be amended to support ready availability and use of devices such as blood pressure cuffs, home ultrasounds, and glucose monitors to



When Distance Becomes an Emergency

A 17-year-old pregnant woman from Jasper County went into premature labor and decided to travel by car to Lufkin, where she planned to deliver because labor and delivery services were no longer available in her home community. Approximately 35 miles out of Lufkin, in a remote stretch of the Angelina National Forest with limited cellular service, the family's vehicle broke down.

Emergency medical services and local firefighters responded after receiving the call. The baby was delivered in the ambulance but did not survive. According to local officials, it is unlikely the baby would have survived even if delivered closer to home. It simply arrived too soon.

While this tragedy may not have been preventable, the circumstances illustrate the challenges rural families face when essential maternity services are located many miles away. Long travel distances, unreliable transportation, and limited access to emergency care can compound already high-risk pregnancies, adding obstacles at the moments when timely care matters most.

> "Texas's rural maternity care network is withering on the vine. Far too many women cannot obtain even the most basic of services before and after pregnancy, much less during it. If young women and their families do not trust that they can safely start a family in small-town Texas, how can those towns survive?"
>
> — Douglas Curran, MD
> Chief Medical Officer, East Texas Community Clinic

safely monitor pregnancies remotely. Even for high-risk women, remote home ultrasounds and other devices have been shown to be safe and effective.[40]

Recommendation 4D. Prioritize the timely processing of pregnancy-related Medicaid applications to avoid delays in women obtaining early prenatal care.

Recommendation 4E. Undertake a rural outreach campaign to inform women about the importance of care throughout the maternal health pathway (pre-pregnancy, pregnancy, postpartum, and interpregnancy care), including outreach and marketing initiatives to educate rural women and clinicians about the availability of women's preventive healthcare.

Recommendation 4F. Decrease maternal health complications due to anemia following hemorrhage by making prenatal iron supplements more readily available from women's obstetrical care clinicians.

Recommendation 4G. Improve timely diagnosis and treatment of perinatal behavioral health conditions among rural women.

- Improve reimbursement for evidence-based perinatal behavioral health services delivered in obstetrical and primary care settings, including repeated depression and anxiety screening, behavioral health integration, collaborative psychiatric consultation, care coordination, and tele-behavioral health services.
- Expand opportunities for perinatal mental health training among obstetrical clinicians, primary care providers, nurses, community health workers, and nonclinical support staff to promote early identification and intervention.
- Simplify and standardize referral protocols for rural women who require outpatient or inpatient behavioral health services, including clear pathways following consultation with the Texas Perinatal Psychiatric Access Network (PeriPAN).
- Support multidisciplinary care models that facilitate screening, patient navigation, warm handoffs, and longitudinal follow-up for women with perinatal mental health and substance use disorders.

Rationale: Perinatal mental health conditions affect approximately one in five mothers and are among the leading causes of maternal morbidity.[41] Obstetrical and primary care practices are often the first point of contact for women seeking help, particularly in rural communities. While Medicaid currently reimburses postpartum depression screening, reimbursement policies could be strengthened to better support repeated screening throughout the perinatal period, behavioral health integration, clinician consultation time, care coordination, and tele-behavioral health services. Expanding reimbursement for these evidence-based services would improve timely identification and treatment while reducing barriers to care.

Additionally, PeriPAN provides an important mechanism for obstetrical clinicians to obtain

psychiatric consultation while allowing patients to remain close to home. However, clinicians experience uncompensated consultation time and challenges navigating referrals to outpatient and inpatient behavioral health services. Standardized referral pathways, enhanced reimbursement, and expanded workforce training would improve continuity of care and ensure rural women receive timely, coordinated, and comprehensive behavioral health services.

Recommendation 4H. Increase incentives for implementation of traditional or hybrid group prenatal care, allowing practices to provide both in-person and virtual services to better meet the needs of rural women.

Recommendation 4I. Provide funding to support the establishment of regional patient navigation services to improve care for pregnant and postpartum women, improve transitions between obstetric and primary care, connect women to behavioral health services, and specialty care to address chronic diseases, particularly in the postpartum year.

CRITICAL PRIORITIES

5. Provide robust funding to sustain Texas's women's health programs.

Texas women can get women's preventive health services via the Healthy Texas Women (HTW) program or the Family Planning Program (FPP), both of which provide critical preventive and basic primary care services, such as well-woman exams, contraceptive coverage, and cancer screenings. Additionally, women diagnosed with breast or cervical cancer are eligible for full Medicaid coverage during their cancer treatment. Regular use of preventive healthcare throughout a woman's reproductive lifespan is the linchpin of better birth outcomes.

Recommendation 5A. Continue robust funding for Texas' women's health programs: Healthy Texas Women, Family Planning Program, and the Breast and Cervical Cancer Treatment Program.

Recommendation 5B. Simplify access to long-acting reversible contraceptives (LARC), the most effective form of contraception, particularly immediately following delivery for women who want them.

LARCs help women and families better time and space pregnancies, a key element of better birth outcomes. Many rural women who wish to obtain LARCs struggle to do so, particularly before leaving the hospital following delivery. Women face limited availability of local services because rural obstetrical care practices have stopped providing women's preventive health services due to payment and administrative hassles.[42] Expansion of mobile preventive health clinics, as discussed in Priority 6, will help, but addressing payment barriers is also key.

6. Bring maternal healthcare services to where rural women live and work by expanding the use of alternative care settings, such as mobile, pop-up, at-home prenatal visits, and virtual services, and increasing the use of patient navigation.

In 2025, the Legislature allocated $20 million to extend mobile women's preventive health clinics to additional rural communities, doubling its previous investment due to overwhelming interest. Today, these "clinics on wheels" operate across rural Texas. However, the vastness of rural Texas, combined with the paucity of women's health services, means many communities still hope to benefit from these clinics. Already, rural women are less likely to have a doctor's visit in their pre-pregnancy year or postpartum. Mobile clinics are only one innovative strategy to reach more rural women.

Others are scheduled pop-up or drive-through clinics, located at grocery stores, schools, fire stations, and other conveniently located sites, where maternal health teams provide either targeted or comprehensive preventive health services. During the pandemic, several hospitals pioneered drive-through prenatal care appointments, an invention of necessity that, if revived, could ensure more rural women can easily access services in their community.

By boosting funding to expand mobile health clinics, as well as alternative options, such as pop-up or drive

through centers, and allowing reimbursement for home-based prenatal care, Texas can help more rural women obtain these important services.

Patient navigators can also help by connecting expectant women with obstetrical care clinicians. Likewise, navigators can help tired, new mothers schedule postpartum care for themselves and their newborns, coordinate transportation, refer them to needed parenting support or mental health resources, and provide basic education on potential warning signs of maternal or newborn complications. Studies show patient navigators can promote patient self-efficacy, enhance access to care, and sustain engagement with care, including making health visits more productive.[43] Additionally, patient navigators help facilitate referrals to services to address non-medical needs, including food pantries and childcare.

Assembly members noted that many hospital systems, faith-based organizations, and community entities have attempted to provide low-tech navigation systems by creating websites with resources women could access. Still, the systems are difficult to keep current and typically do not provide a vital in-person connection. When drawn from the community, studies show navigators can improve use of and compliance with medically necessary care and mitigate barriers to it.[44] Establishing regional or local patient navigators, drawn from the communities they serve, would be much more useful.

Recommendation 6A. Increase funding to support deployment of innovative alternative care settings for women's preventive health services, including mobile health units, pop-up clinics, virtual care clinics, and hybrid models.

Recommendation 6B. Develop, in conjunction with maternal and emergency medical clinicians, protocols and payment mechanisms to allow rural community emergency medical professionals, operating under physician delegation and supervision, to provide limited prenatal and postpartum care.

7. Ensure rural maternal healthcare excellence by fostering innovative educational and training partnerships to support local delivery of safe, high-quality maternity care.

Texas' statewide Perinatal Quality Improvement Network (PQIN) seeks to improve maternity and child health. The framework has evolved over time, but today it consists of multiple components that work collaboratively to improve the quality and safety of maternal and neonatal health. Entities within the PQIN include the Maternal Mortality and Morbidity Review Committee (MMMRC), the Texas Alliance for Innovation in Maternal Health (TexasAIM), and the Texas Collaborative for Healthy Mothers and Babies (TCHMB), among others. The Perinatal Advisory Council (PAC) advises the state on the criteria it should use to designate neonatal and maternal levels of care.

The individual and combined work of the PQIN and PAC have resulted in implementation of many important patient safety and clinical improvement initiatives, such as developing maternal and neonatal level-of-care designations to distinguish hospitals based on the types of maternal care they are capable of providing routinely; inpatient hospital safety "bundles" to help improve early intervention for common maternal health emergencies, such as hemorrhage; and assessment of factors that contribute to maternal deaths and severe complications to help design life-saving interventions. Rural women have higher rates of pregnancy-related mortality[45] as well as complications. In fact, when adjusted for population, nationally there are 4,378 cases of severe maternal morbidity and mortality among rural mothers who would not have experienced morbidity or mortality had they been living in urban areas.[46]

Assembly members strongly support Texas's perinatal improvement efforts, while also acknowledging that implementation presents unique challenges for rural communities, which may lack the financial, technical, workforce, or continuing education capacity to do so. Innovative partnerships funded by lawmakers have helped rural facilities and clinicians achieve the goals of PQIN without the costs of hiring more staff or traveling to urban areas.

Given the low volume of maternal health services in small rural communities, obstetrical nurses and physicians must have opportunities to hone and

maintain clinical skills through continuing education and simulations. Such approaches help ensure that clinicians are well-prepared to manage maternal health in settings with limited resources and low volumes of maternal care.

Recommendation 7A. Provide funding to strengthen and sustain Texas's perinatal quality collaborative, the Maternal Mortality and Morbidity Review Committee, and the Perinatal Advisory Council, and task each with ensuring their data collection and reporting, and operational requirements consider the unique challenges of rural healthcare facilities.

Recommendation 7B. In collaboration with the state's Perinatal Quality Collaborative, establish a statewide center for rural maternal health excellence to provide hospitals, clinicians, and clinics with a centralized resource for evidence-informed rural maternal health quality improvement strategies.

Recommendation 7C. Extend additional funding to existing programs that provide obstetric emergency simulation training to rural emergency departments and low-volume labor and delivery units.

Such training improves facility and clinician readiness when pregnant patients experience rare, high-acuity events, such as postpartum hemorrhage, severe hypertension, shoulder dystocia, and maternal cardiac arrest.

Recommendation 7D. In collaboration with Texas's Perinatal Care Collaborative, provide funding for regional or statewide rural perinatal nursing "boot camps" (or similar collaborative educational approaches) to help entry-level rural labor and delivery nurses gain clinical skills and for current nurses to refresh their skills. The recommendation is based upon boot camps conducted by the Oklahoma Perinatal Nurses Forum, which is a component of the Oklahoma Perinatal Quality Improvement Collaborative.

Recommendation 7E. Provide funding to develop targeted training for rural non-obstetrical and nonclinical professionals to help improve identification of maternal early warning signs and risk factors, focusing on primary care clinicians, emergency medical professionals, social workers, and others who do not frequently encounter such events.

Rationale: Given that rural health systems have fewer resources and higher staff turnover, it will be important to develop training tailored to their specific needs. Training should also be developed for nonclinical professionals, such as community health workers, doulas, and peer support specialists, who regularly work with pregnant women and would benefit from enhanced training in recognizing potential pregnancy-related complications.

Recommendation 7F. Establish a rural TexasAIM cohort to provide initial and ongoing input and analysis on implementation of maternal health safety bundles in rural facilities and incorporate simulation-based readiness assessments and multidisciplinary drills as complementary strategies to support implementation of maternal safety bundles in rural hospitals.

8. Pioneer the formation of a rural maternal health "utility," in partnership with regional councils of government and counties, to ensure women living in the high rurality counties retain access to the most critical preventive maternal health services.

"Utility" refers to the usefulness or practical value of something — services that are essential for daily living.[47] Texans know that wherever they travel within the state, they can get water and electricity. Broadband is increasingly considered a utility as well. That is because Texas knows these services are critical to infrastructure. Likewise, through the state trauma system, Texas subsidizes rural trauma hospital services to ensure rural residents and visitors have access to regional, life-preserving services in the event of traumatic accidents or illnesses.

Vital maternal health services should be the same, meaning women and families should feel safe knowing that even if the community cannot sustain full obstetrical care, they will have, at a minimum, access to preventive care before, during, and after pregnancy. To ensure access to these services, Texas should evaluate the creation of county-based or regional rural maternal health utilities, in which the state or state-local partnerships provide resources to sustain these critical services, much like it does with broadband, water, and electricity. A healthcare utility is a "nonprofit organization or service model designed to deliver essential healthcare products and services at the lowest sustainable cost, with the goal of making them accessible to everyone at a low price."[48]

ESSENTIAL PRIORITIES

9. Improve chronic disease prevention, management, and treatment before and between pregnancies to reduce chronic disease-related complications during pregnancy.

Healthy pregnancies do not begin at conception, but in the months and years before. Once a woman gets pregnant, previously unmanaged chronic conditions lead to expensive and difficult-to-treat maternal care. Conditions such as diabetes and hypertension can result in serious pregnancy-related complications and birth defects, even if the mother received early prenatal care. For example, according to the state's panel of maternal health experts, 25% of all mothers who experienced pre-pregnancy obesity also experienced maternal hypertension and diabetes, both of which can seriously harm mother and baby.[49]

Babies born to women with pre-gestational diabetes have higher rates of congenital birth defects and prematurity. At the same time, women with high blood pressure and hypertension before pregnancy also experience more adverse birth outcomes, including perinatal death. For women ineligible for Medicaid or comprehensive healthcare coverage, Healthy Texas Women is an important source of preventive and primary care, including prescriptions for the treatment of diabetes and hypertension. However, if HTW enrollees need to see a specialist to manage their condition better, specialty care is not a covered benefit. Furthermore, HTW does not cover nutritional counseling or FDA-approved obesity management medications.

HTW will soon be incorporated into Medicaid managed care, providing an opportunity for health plans to establish value-added services to address the specialty care needs of HTW enrollees who choose their plans.

Recommendation 9A. Enhance access to specialty care services for pre-pregnancy medical diagnoses or conditions that elevate risks of poor birth outcomes via the HTW Plus program by promoting Medicaid MCO wraparound services.

Recommendation 9B. Establish a system of regional remote specialty consultative services to provide rural obstetrical care clinicians 24/7 access to clinician-to-clinician consultations to improve management of complex patients or OB emergencies.

This organization would be similar to PeriPAN and the Arkansas ANGELS[50] program, which provides virtual conferences between rural clinicians and maternal-fetal medicine specialists and real-time ultrasound readings for complex pregnancies. During the postpartum period, rural obstetrical care clinicians also need the ability to quickly consult with other specialists, such as cardiologists.

10. Improve the well-being and health outcomes of rural mothers and babies by streamlining and harmonizing efforts to alleviate nonclinical barriers to care, including the extension of Texas's perinatal home visiting programs to more communities.

Timely access to medical care is key to good health, but many other factors, including access to nutritious foods, economic opportunities, and transportation, play an even more important role. These factors, known as nonmedical drivers of health (NMDOH), account for as much as 80% of a person's well-being and health outcomes, which can undermine the effectiveness of medical interventions when left unaddressed. Many NMDOH are more common in rural

areas, where women and families often struggle to obtain healthy foods, find reliable transportation, obtain safe, affordable childcare, or secure their economic future due to a lack of local jobs.[51]

For example, pregnant women taking insulin for the treatment of diabetes will nevertheless often experience more complications if they also lack access to nutritious foods needed to manage their blood sugar. Without access to reliable transportation or childcare, busy rural moms may reluctantly need to postpone or skip needed care with potential downstream effects to their health as well as increasing overall costs.

Over the past two legislative sessions, lawmakers took important steps to address NMDOH among pregnant women, enabling standardized voluntary screening for these factors and for Medicaid MCOs to improve access to nutritious, medically appropriate foods for high-risk pregnant women.

Given the magnitude of these challenges in rural Texas and the uncoordinated approach to successful NMDOH initiatives, Texas should mirror the efforts of other states. At least half of states have enacted a policy framework to address NMDOH, focusing on approaches that integrate screening, referral, and intervention into clinical practice and better coordinate screenings to reduce duplication.

Recommendation 10A. Implement a cohesive, integrated strategy to address clinical and nonclinical drivers of health for rural mothers, including better aligning NMDOH screening by health plans, centers, and practices to avoid duplication, which may deter women from responding at all.

Recommendation 10B. Extend Texas's innovative rural perinatal home visiting programs or something similar to reach more expectant rural mothers and their families with clinical and nonclinical service arrays, depending upon the need.

Rationale: Texas has long embraced home visiting programs, such as the Nurse Family Partnership (NFP) and the Texas Home Visiting (THV) program, to help promote positive child outcomes by addressing the health and welfare of new parents and families. While the programs vary in their approaches, evidence shows they can help young families thrive by teaching parents-to-be how to care for themselves and their children's physical, mental, and emotional well-being. NFP deploys trained nurses to serve as trusted advisors and resources, engaging young mothers during early pregnancy and remaining involved with a family through the child's second birthday. THV, on the other hand, relies on trained nonclinical volunteers who serve as mentors to at-risk parents. Regardless of the model, the goal is to improve pregnancy outcomes, child health and development, and families' economic self-sufficiency.

Similarly, Parents as Teachers (PAT)[52] is an award-winning program for providing in-home visitation services. PAT is currently testing a hybrid in-person/virtual model to reach more families in Texas. Among its goals are to improve parent understanding of early childhood development, promote early identification of pediatric developmental delays, improve school readiness, and prevent child abuse.

In other states, communities recruit and train local volunteers, such as retirees, to serve as "aunties" or "grannies" to new mothers, acting as mentors who provide parenting education, help schedule healthcare visits, provide crisis referrals, and so forth. Vermont, for example, established Postpartum Angels,[53] which matches families with trained volunteer home visitors who conduct up to 12 weekly home visits after the birth or adoption of a baby.

In addition to interventions provided by NFP or THV, perinatal home visiting programs can also provide a clinical bridge for high-risk pregnant or postpartum women, bringing services to them between scheduled in-person visits, thereby limiting the need for travel.

While implementing home visiting programs in rural areas is more challenging due to the long distances home visitors must travel, exploring more unconventional interventions can help Texas efficiently deliver these services to rural women.

"Research shows that when maternal care services close in a rural community, they practically never come back. Pregnant moms in maternal care deserts have poorer outcomes, leading to increased morbidity and mortality. That is why the work of the Rural Texas Maternal Health Assembly is so important."

— Kia Parsi, MD
Executive Director, Texas A&M Rural and Community Health Institute

11. Reduce the incidence of maternal health complications by improving access to preventive oral healthcare before and after pregnancy.

Evidence shows that sound oral health before and during pregnancy also helps improve birth outcomes, including potentially reducing the rate of preterm births. According to the Department of State Health Services:

> *Hormonal, physical, and dietary changes leave pregnant women at higher risk of caries (tooth decay) and periodontal (gum) disease. Poor prenatal oral health is associated with pre-term births and low birth weight. After delivery, caries-causing bacteria are transmitted from mother to baby through common activities such as kissing and sharing spoons.*

Prenatal appointments provide an opportune time to evaluate a pregnant woman's oral health, identify potential problems, and make referrals to dentists. Texas Medicaid currently pays for emergency dental care during pregnancy. While most Medicaid MCOs offer a value-added preventive dental care benefit during pregnancy, dental care is not a covered benefit. Rising rates of late or no prenatal care mean that oral health interventions during pregnancy, while women have coverage for preventive care, might not happen.

Before pregnancy, HTW includes no preventive oral health services. Improving oral health before pregnancy is key to better birth outcomes, including establishing innovative primary care-oral health partnerships to help primary care clinicians incorporate oral health screenings and education into practice and vice versa, along with referrals to dentists for treatment.

Recommendation 11A. Improve the timeliness of preventive oral healthcare for pregnant women by:

- **Ensuring Medicaid MCOs and Dental MCOs maintain an adequate network of participating dentists.**
- **Improving outreach and education to inform obstetrical care clinicians of dental benefits available for pregnant women and postpartum women**

For Medicaid enrollees under age 19, including pregnant enrollees, Texas Medicaid covers comprehensive preventive and restorative dental services via dental managed care organizations known as Dental MCOs. For pregnant Medicaid enrollees over age 19, Texas Medicaid does not cover dental care. However, as a value-added benefit, Medicaid MCOs include limited preventive dental and related services as a covered benefit.

Many obstetrical care clinicians lack awareness of dental benefits for their pregnant or postpartum Medicaid patients. Those that did not know expressed frustration trying to find in-network dentists accepting new pregnant or postpartum patients. As described above, improving timeliness of preventive oral health during and after pregnancy can improve birth outcomes and lower pregnancy-related Medicaid costs by reducing complications related to poor oral health.

Recommendation 11B. Establish and fund innovative oral and maternal health collaborations, such as those articulated in the Practice Guidance for Texas Prenatal and Dental Providers,[54] emphasizing oral health education and preventive care before and between pregnancies.

Recommendation 11C. Improve continuing education opportunities for dentists and oral health clinicians regarding opportunities to improve screening of pregnant patients for potential early warning signs or complications, such as hypertension.

Recommendation 11D. Incorporate dental healthcare screening and prevention services into women's health mobile and pop-up clinics.

Recommendation 11E. Encourage Medicaid MCOs to provide preventive dental care as a value-added benefit to women enrolled in HTW.

12. Extend existing Medicaid doula coverage to encompass additional nonclinical, evidence-based prenatal and postpartum care services.

Rationale: Doulas are nonclinical professionals, providing pregnant and postpartum women with "physical, emotional, and informational support across the perinatal experience."[55] In 2023, lawmakers authorized doulas as a Medicaid provider type but limited their services to case management for high-risk pregnant women. However, 26 states now cover a wider array of doula perinatal services, such as support during labor and delivery.[56] Research shows doula services are consistently associated with lower rates of maternal anxiety, depression, and social isolation,[57] any of which can disrupt healthy parent-baby bonding critical to healthy early childhood development. Moreover, doula care is linked to higher rates of postpartum visits and breastfeeding.[58]

Extending doula care to additional defined, evidence-based, non-clinical services, such as childbirth and parenting education, labor coaching, and breastfeeding support could improve rural maternal health capacity and outcomes.

Doulas providing perinatal care (as opposed to providing only case management) should be required to complete state-approved training relating to perinatal care or demonstrate core competencies through other state-approved means.



Appendix 1

Rural Texas Strong

A Major Federal Investment in Rural Healthcare

On July 4, 2025, President Trump signed into law H.R. 1, known as the One Big Beautiful Bill Act. The bill fundamentally changed the administration, coverage, and financing of Medicaid, the Affordable Care Act, and Medicare. Over the next 10 years, the bill will reduce Medicaid funding nationwide by nearly $1 trillion, primarily due to changes to Medicaid in states that adopted Medicaid expansion for eligible working-age adults.

To address concerns about the potential deleterious impact of the bill on rural healthcare, Congress added a provision establishing a new five-year Rural Transformation Grant program to be administered by the Centers for Medicare and Medicaid Services (CMS).

From 2026 to 2030, $50 billion will be allocated. $25 billion will be split evenly among all states with an approved application. The other $25 billion will be distributed based on specified criteria, including a state's rurality and adoption of strategies to fulfill CMS's five priority policy goals for the grant, which include implementing initiatives to:

- Improve disease prevention, chronic disease management, behavioral health, and prenatal care;
- Increase access to services;
- Boost and sustain the rural healthcare workforce;
- Promote innovation in care delivery to improve health outcomes and improve care coordination; and
- Support tech innovation to improve cybersecurity and healthcare efficiency.

Congress specified that entities eligible to receive funding include rural hospitals, federally qualified health centers, rural health clinics, and behavioral health clinics, among others.

After conducting statewide public hearings, Texas identified six key areas on which it would focus its grant, dubbed Rural Texas Strong.

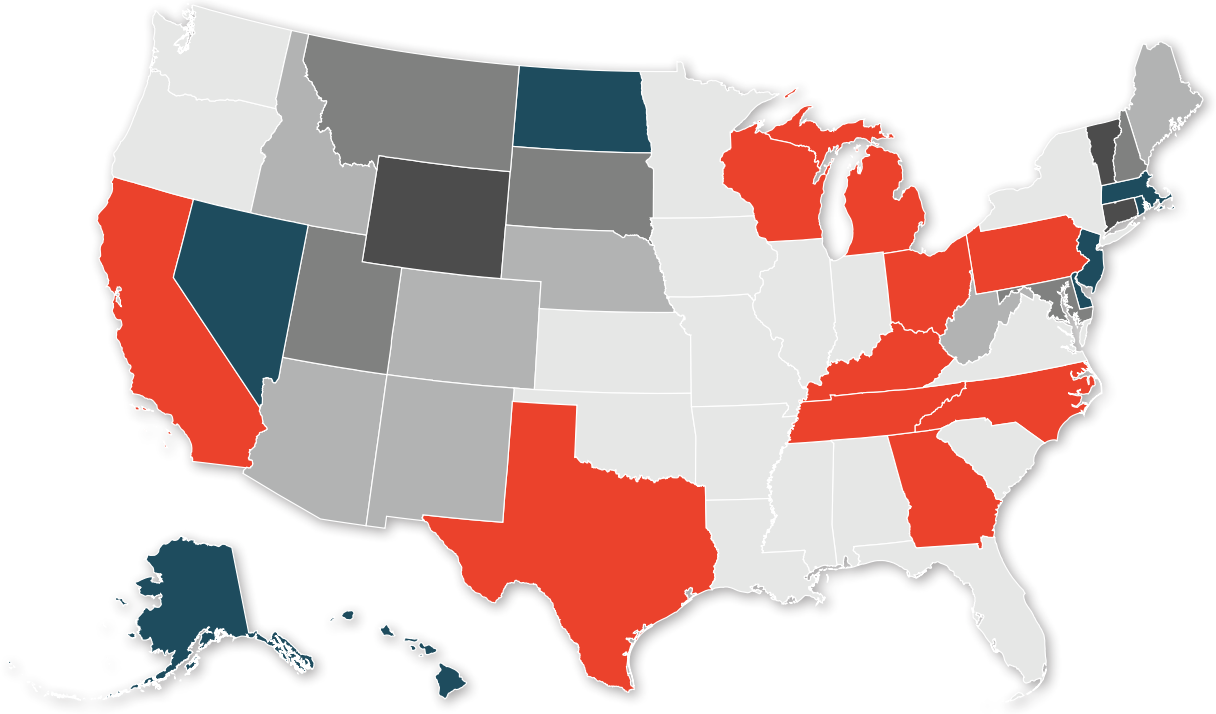
1. **Make Rural Texans Healthy Again** by improving preventive healthcare and nutrition
2. **Rural Texas Patients in the Driver's Seat,** increasing use of patient navigation tools and portals, as well as access to integrated care networks.
3. **Lone Star Advanced AI and Telehealth,** leveraging technology to reduce workload on rural clinicians and facilities while also increasing access to remote specialty care.
4. **The Next Generation of a Small-Town Doctor and Team,** fostering recruitment and retention of rural primary care doctors and mental health professionals while also increasing rural training pipelines for rural students pursuing allied health and other health-related professions.
5. **Unified Infrastructure and Rural Cyber Protection,** reinforcing rural hospitals' security and privacy systems to prevent costly breaches; and
6. **Infrastructure and Capital Investments for Rural Texas,** modernizing outdated facilities and equipment to promote high-quality care and better patient experiences.

On December 31, 2025, CMS approved Texas's application, awarding the state $1.4 billion over five years, the highest award made. Annually, the grant equates to $281 million or more. If a state fails to comply with its grant requirements, unspent funds will be returned to CMS for distribution to other states.

Notably, while Texas' total grant award is enormous, when compared to the state's high rurality and rural health challenges, the award averages only $66 per rural resident. Comparatively, New Jersey's award equals $1,069 per rural resident.

This is not to minimize the award. Rather, highlighting per capita investment shows that federal dollars alone will be insufficient to ensure that Texas can preserve healthcare access, making a rural way of life for millions of Texans possible now and forever.

First-year Rural Health Fund Awards Range From Less Than $100 Per Rural Resident in 10 States to More Than $500 in Eight States



Award per rural resident from $10 billion available through the rural health fund in the first year:

< $100 | $100-$200 | $200-300 | $300-400 | $400-500 | > $500

Source: KFF analysis of rural health fund awards from the HHS Tracking Accountability in Government Grants System.

Rural Texas Strong and Maternal Health

As designed by Congress, the Rural Transformation Grants aim to improve the sustainability and accessibility of healthcare in rural communities for the entire population, meaning everyone from newborns to grandparents. Thus, rural maternal health is not the focus. However, investments that will strengthen the state's rural health system will also indirectly benefit rural mothers, families, and communities.

While Texas's grant application to CMS noted that pregnant and postpartum populations will be high-priority populations, the state did not stipulate that eligible grant recipients spend a portion of the dollars on them.

Among Texas's six initiatives, three have the greatest correlation to rural maternal health: 1, 3, and 4.

- Strengthen chronic disease prevention, helping improve maternal and newborn health outcomes.
- Increase availability of maternity specialty care using telemedicine, improving timely interventions and healthcare quality; and
- Boosting access to locally based primary and obstetrical care clinicians, reducing the need to travel far from home for these services.

To date, HHSC has announced an estimated $116.25 million will be awarded to eligible rural hospitals for Initiative 1, $56.25 million competitively, while HHSC has solicited competitive applications for Initiative 4. As of this writing, it is not known whether any local entity will apply the funds to improve maternal health.

By augmenting new federal Rural Texas Strong dollars with state dollars, Texas will have the greatest impact on mutual efforts to safeguard rural maternal health for current and future generations.

Appendix 2

Texas Initiatives to Improve Perinatal Quality, Safety and Health Outcomes

Rural pregnant women are at greater risk of experiencing severe pregnancy-related complications or worse, death, than their urban peers.[59] The majority of such tragedies are preventable, which is why it is vital that Texas assess the underlying clinical, community and individual root causes that lead to them as well as to identify strategies to address them. Texas does this through a variety of state-supported initiatives and expert panels, each of which help inform state policy makers, clinicians, hospitals, and community leaders on ways to make the care of pregnant women, wherever they live, better, safer and more effective.

Texas Collaborative for Healthy Mothers and Babies (TCHMB)

Texas's Perinatal Quality Collaborative (PQC), bringing together stakeholders from across the state to improve the quality of care for mothers and babies using data to promote evidence-based decision-making and improve healthcare systems and maternal and infant health outcomes.

TexasAIM

Supports Texas birthing hospitals with technical assistance and collaborative learning to make quality improvement changes that lead to improved outcomes for mothers, including ending preventable maternal death and severe maternal morbidity.

Maternal Mortality and Morbidity Review Committee (MMMRC)

A multidisciplinary committee created by the state to review pregnancy-related deaths, identify factors contributing to them, and advise lawmakers on ways in which Texas can reduce rates of preventable maternal deaths and complications.

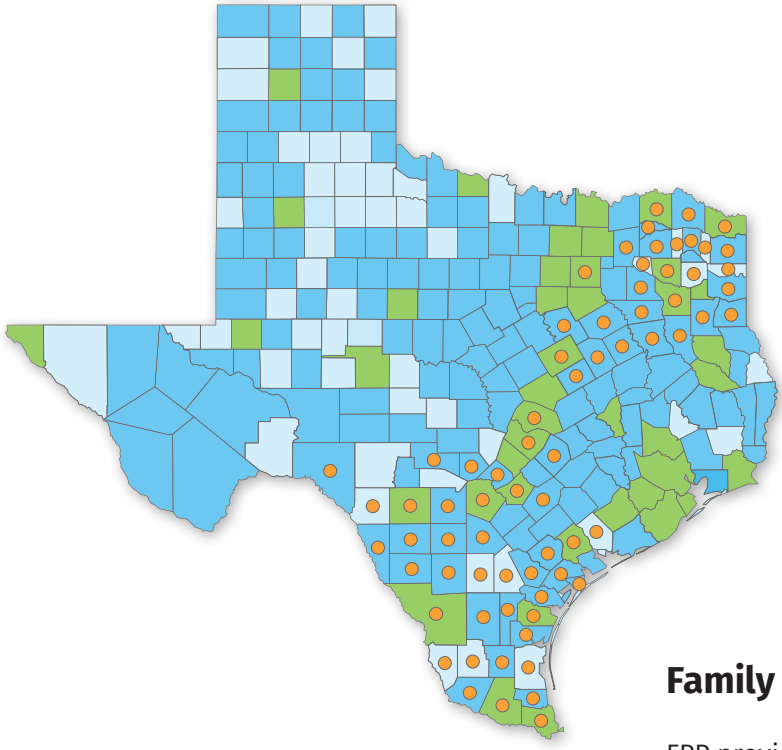
Perinatal Advisory Council

Develops and recommends criteria for hospital designation levels of care capabilities for neonatal and maternal services. Members include physicians, nurses, and hospital administrators with expertise in obstetrical and/or neonatal care drawn from rural and urban communities.

Sources: Texas Perinatal Quality Collaborative (PQC); Department of State Health Services; Texas Health and Human Services

Appendix 3

Healthy Texas Women, Family Planning Program, and Breast and Cervical Cancer Services



Healthy Texas Women Provider Count

- 0
- 1 to 4
- 5 or more

Mobile Units

- Mobile unit available

Source: Healthy Texas Women, https://www.healthytexaswomen.org/healthcare-programs

Healthy Texas Women (HTW)

HTW offers eligible women ages 19 to 44 access to preventive health care services before and between pregnancies. Services include annual well woman exams and contraceptive counseling and services, which allow women to select a birth control method best suited to them and to thus better time and space pregnancies. HTW also provides screenings for cancer and chronic diseases, such as diabetes. Through HTW, participating women have access to services that will help them become healthier in the years and months before pregnancy so as to improve birth outcomes if and when they start a family later.

Family Planning Program (FPP)

FPP provides free or low-cost preventive health care to eligible Texas women and men up to age 64. Among the services it offers are access to birth control and screenings for chronic diseases, such as hypertension and diabetes. Like HTW, FPP helps women better time and space their pregnancies as well as start any future pregnancy on a healthier footing.

Breast and Cervical Cancer Services (BCCS)

BCCS provides breast and cervical cancer screening and diagnostic services, such as mammography and pap smears, to eligible women between 18 and 64 years of age.

Appendix 4

Community Health Centers: Keystones in Texas' Rural Maternal Health System

Primary care delivery is at the heart of all federally qualified health centers (FQHC). Each center's patients receive care from interdisciplinary care teams whose mission is to provide high quality, accessible, and "whole person" services. This means teams:

- Promote wellness and prevention to keep patients' bodies and minds healthy,
- Diagnose and treat them when they are sick, and
- Address nonclinical factors that may undermine good health, such as a lack of access to healthy foods.

Today, 81 independent FQHCs serve Texas, 40 of which offer patient care at 150 clinical sites dotted throughout 84 rural counties.[60] Over the past several years, FQHCs' rural maternal footprint has increased, thanks to state funding to incubate new FQHCs and expand service sites at existing ones.

Community health centers (CHCs) play a pivotal role in rural women's health, providing vital services throughout their lives, but particularly during their reproductive years. Given their importance, the Rural Maternal Health Assembly conducted informal listening sessions with clinical and administrative leaders whose centers serve people living within Texas' 202 rural counties. The purpose:

- Gain broader insight into the unique challenges FQHCs face delivering perinatal care, and
- Discern whether there are unique regulatory or legislative reforms that would best help clinics overcome them.

The conversations included half a dozen leaders, whose input supplemented insights previously gleaned from FQHC directors serving within the Assembly itself. The Assembly also solicited input from FQHC outreach and eligibility workers to learn more about barriers rural women encounter trying to obtain health care coverage or services.

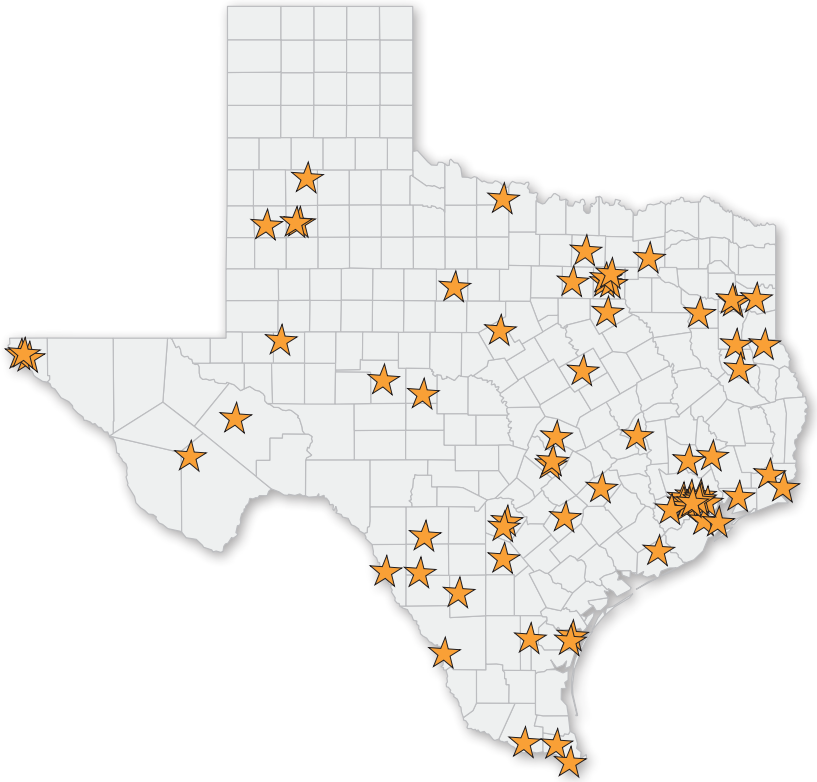
The Role of FQHCs in Rural Maternal Health

CHCs are critical to the health of rural women and the health of the maternal health system, acting as keystones that provide services on which the entirety of the state's system depends. Preventive care is central to women's health. In fact, these services are the foundation of healthy pregnancies, which start in the years before conception, not when pregnancy is confirmed. **Preventive and primary care before and between pregnancies is the most optimal time to prevent, diagnose, and address underlying health conditions or behaviors, like smoking, which could contribute to pregnancy-related complications later.**

Women's preventive health services commonly offered by rural CHCs include:

- Annual women's preventive health exams, where women receive screenings for cancer and chronic diseases, such as diabetes;
- Preconception health education, such as tobacco cessation and healthy nutrition resources;
- Contraceptive counseling and services to help time and space pregnancies;
- Pregnancy testing;

Locations of 81 independent FQHCs serving Texas, offering care at more than 700 clinical site across 131 counties



According to the National Association of Community Health Center, there are **723 health center delivery sites** in Texas.

The federally funded health center organizations in Texas **leverage $279,568,372 in federal investments to serve 1,788,356 patients,** 34% of whom are uninsured and 34% of whom are covered by Medicaid.

- Chronic disease management and treatment; and
- Postpartum care, including lactation consulting, perinatal depression screenings and treatment, and diagnosis and management of current or new health conditions that may arise in the year after delivery.

Many rural clinics also provide maternity care, though the extent of services varies, ranging from prenatal care through postpartum or prenatal care only.

Beyond traditional women's health and maternity care, CHCs also offer dental and behavioral health services, which contribute to better birth outcomes for mothers and babies while helping to reduce health care costs. For example, preventive dental care before and during pregnancy helps lower the rate of preterm births — babies being born too soon — and gestational diabetes.[61] Meanwhile, early detection and management of perinatal depression, anxiety, or other mood disorders improve bonding between mothers and babies, which in turn promotes healthy early childhood development.

In addition to clinical services, rural CHCs provide the following.

- They serve as critical training sites for primary care physicians, family medicine-obstetricians, dentists, advanced practice professionals, community health workers, medical assistants, nurses, and other allied health professionals, helping to expand the local maternal health care workforce.
- They support local economic development by:
  - Ensuring rural women can obtain essential healthcare services close to home, thereby keeping those dollars within the community;
  - Developing a skilled healthcare workforce, whose purchasing power within the community improves the local tax base; and
  - Retaining and attracting employers, who want their own employees to have access to crucial care close to home and work.

- They provide vital community services for any woman who walks into a center, such as pregnancy testing, eligibility and enrollment services, health education and nutrition courses, and screening for nonmedical drivers of health. For uninsured women, CHCs offer a sliding fee schedule to address patients' concerns about affordability.
- They avert rural women from traveling to urban communities unnecessarily for routine maternal health care, thereby reducing potential overcrowding, longer waiting times, and strained resources in neighboring communities.
- They facilitate innovative maternal health alliances within and across communities to help foster more effective and efficient use of clinical and social service resources.

The State of Perinatal Services Among Rural CHCs

Despite the benefits FQHCs bring to rural communities, compounding economic and demographic challenges make it difficult for centers to sustain some or all maternal health services. Like other rural health care facilities, CHCs face:

- Protracted and worsening workforce shortages for both clinical and non-clinical staff,
- Inadequate payments from public and private health insurers,
- Perplexing and time-hogging administrative hassles, including cumbersome provider enrollment and health plan credentialing processes that increase costs and detract from direct patient care,
- Rising numbers of uninsured and underinsured women,
- Delays approving Medicaid coverage for pregnant women due to the backlog of Medicaid applications,
- Declining patient census for women needing perinatal services,
- Lack of infrastructure to promote regional coordination and transitions of care,
- Antiquated hospital medical staff credentialing policies that deny hospital maternity care privileges to family physicians with advanced obstetrics training.
- Insufficient Medicaid managed care specialty physician and behavioral health networks, and
- Limited resources to address underlying nonclinical barriers to care, such as access to healthy foods.

Multiple CHCs interviewed for the project said the culmination of these factors has resulted in their own centers or centers within their region limiting or suspending some or all perinatal services. Some offer prenatal care only, referring women to neighboring centers or hospitals during the last trimester.

A smaller group of CHCs has limited or halted maternal health services. Persistent workforce shortages are among the most vexing problems, with searches to recruit new obstetrical care physicians or certified nurse midwives often exceeding 12 months or more.

Beyond obstetrical care clinicians, centers struggle to recruit and retain every other profession too, from primary care clinicians to certified nurse midwives to community health workers, among others. As a result, workforce issues quickly become circular. Without nurses and allied health professionals, doctors will not accept a recruitment offer, and vice versa.

Moreover, with frequent staff turnover and shortages, clinics struggle to:

- Integrate dental and mental health services into perinatal service lines,
- Promote patient-to-clinician continuity of care, and
- Fulfill timely postpartum appointments.

Of course, the closure of rural hospital maternity care units also imperils rural CHC perinatal care because they lack a place to refer patients for labor and delivery.

Improving Sustainability Through Partnerships and Innovation

Given persistent staffing shortages, rural CHCs are testing new strategies to improve access to perinatal care. One approach is to share staff among other regional CHCs or even private practices. Another involves CHCs partnering with private practices, wherein most low-risk pregnancies are referred to the CHC while the private practicing obstetrical care physicians manage high-risk patients to avoid the need for referrals to urban centers.

Without enough clinicians, other centers are amping up perinatal cross training, ensuring every primary

care clinician has the skills to initiate prenatal care rather than waiting for a designated prenatal care appointment to become available.

Virtual care, including artificial intelligence (AI) patient platforms, is another way that FQHCs are striving to mitigate workforce shortages and improve patient outcomes. Virtual care on its own or paired with other technological innovations, can:

- Extend the capacity and range of clinical teams,
- Allow expeditious communication between patients and clinicians between regular appointments, and
- Improve the feasibility of hybrid group prenatal and postpartum education, with one clinical team able to treat more women on the same day.

In East Texas, a CHC is evaluating hybrid group prenatal care across several rural and remote sites. They are the first center in the state to test this approach.

However, virtual care is not a solution by itself. Many rural women still lack reliable broadband, which is critical to deploying virtual care and other patient-focused apps. The lack of privacy at home while attending a virtual exam is another.

For CHC clinicians, it can also be challenging to incorporate virtual care into busy workflows. Virtual care requires additional time to train patients about how to reliably use the technology. Moreover, if a rural clinician wants to incorporate virtual care into practice, they also need the ability to remotely check patient vital signs, like blood pressure and glucose levels, and they have to monitor the fetus. However, Remote Patient Monitoring (RPM) remains limited for women enrolled in pregnancy-related Texas Medicaid.

Lawmakers passed House Bill 2727 in 2023 to increase use of RPM. The bill designated FQHCs as an approved user of the technology in addition to broadening the number of diagnoses for which RPM can be used, including high risk pregnancies. However, the bill specified Medicaid must complete a cost-benefit analysis of RPM before implementing it, a review that as of yet has not been completed.

Arkansas and California, among other states, already allow RPM for pregnant women. Rather than wait, several CHCs, in collaboration with Medicaid managed care organizations, have begun testing platforms that incorporate RPM, including an AI component.

Improving Local Collaboration to Boost Birth Outcomes

For rural women, obtaining needed women's and maternal health services often requires cobbling together care across several communities; getting prenatal care in one and delivering in another, either because the local community lacks a maternity care hospital or because the patients require a higher level of care. Ensuring rural pregnant women receive the right care at the right time and in the right place necessitates a high degree of collaboration among clinicians and facilities.

All too often, such coordination does not happen because there is not a hub or central entity to provide it. The lack of coordination shows up in worsening birth outcomes, including rising C-section rates, preterm births, and low birth weight babies, or worse, maternal or neonatal deaths.

However, in East Texas, a nascent, informal, 35-county coalition hopes to improve coordination. Maternal health leaders have brought together rural CHCs, hospitals, academic health centers, and social service organizations to compile a list of resources and to discuss strategies to promote more efficient, coordinated, safe, and cost-effective perinatal care. Without funding, however, the coalition has paused its efforts.

Rural CHCs: Tenaciously Adapting

Rural CHCs not only benefit the health of mothers and babies, but also the health of the communities they serve. Yet, all is not rosy for them. Over the past several years, many have had layoffs, frozen new hiring, reduced center locations, or even discontinued services. Like a cracked keystone in a wall, instability among rural CHCs ripples across the entire rural maternal health system — and the economy — making the whole enterprise weaker.

While rural CHCs are not immune from the sociodemographic and economic challenges disrupting rural health care delivery, their adaptability and resourcefulness make them ideal partners in solving the state's rural maternal health crisis. In particular, because community-based boards govern CHCs, they are well suited to fostering community-led strategies to design, deploy, and test innovative maternal health care delivery models. For example, if lawmakers were to implement recommendations 4A and 4B, which together are designed to accelerate and foster

innovative regional maternal health networks, then rural centers, working in collaboration with urban sister sites, private practicing clinicians, and rural hospitals, could develop and organize care delivery and workforce solutions that will help expand rural availability of key preventive pre-pregnancy, prenatal and postpartum health care, while facilitating seamless out-of-community maternal health care as needed.

Nascent initiatives already exist in Texas, yet without funding, they are difficult to launch and sustain.

Over the next biennium, Texas can stabilize and strengthen rural CHCs, and in turn the entirety of the system on which rural mothers and babies depend, by implementing the Rural Maternal Health Moonshot and maintaining existing FQHC incubator dollars.

Appendix 5

Supporters, Contributors and Informational Resources

Rural Texas Maternal Health Rescue Plan Supporters

Baylor Scott & White Health

Consortium of Texas Certified Nurse-Midwives, affiliate of the American College of Nurse-Midwives

DHR Health

East Texas Community Clinic

Global Family Practice, LLC

Huntsville Memorial Hospital

JPS Health

Lakeland Medical Associates

March of Dimes

Medina Healthcare System

Program of Excellence for Mothers, Children, and Families at the Texas A&M College of Nursing

Rolling Plains Memorial Hospital

Society for Maternal-Fetal Medicine

Texans Care for Children

Texas A&M College of Nursing

Texas A&M Family Medicine Residency Program

Texas Association of Charitable Clinics

Texas Association of Community Health Plans

Texas Dental Association

Texas Hospital Association

Texas Nurse Practitioners

Texas Pediatric Society

Texas Rural Health Association

Texas Tech University Health Sciences Center

Texas Society of Anesthesiologists

Texas Women's Healthcare Coalition

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State Agency Informational Resources

Health and Human Services Commission

Department of State Health Services

The conveners invited all entities with a known interest in improving rural maternal health. Several were unable to participate, others declined.

Special appreciation to these Assembly conveners and position paper authors.

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Special thanks to the T.L.L. Temple Foundation for generously funding the Assembly's work.

Assembly Conveners

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A&M Rural and Community Health Institute

TACHC
TEXAS ASSOCIATION OF COMMUNITY HEALTH CENTERS

TEXAS HEALTH INSTITUTE

TORCH
Texas Organization of Rural & Community Hospitals

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HUNTSVILLE MEMORIAL HOSPITAL

JPS Health Network
Fort Worth, Texas

Global Family Practice
Advanced Rural-Global Medicine & Surgery

MEDINA HEALTHCARE SYSTEM
In Partnership with Methodist HEALTHCARE | SAN ANTONIO

Lakeland Medical Associates

MARCH OF DIMES

Society for Maternal-Fetal Medicine

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College of Nursing
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Our Family,
Rolling Plains Memorial Hospital

TACHP | Texas Association of Community Health Plans

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Family Medicine Residency Program

TDA | Texas Dental Association

TNP Texas Nurse Practitioners

Texas Pediatric Society
The Texas Chapter of the American Academy of Pediatrics
Incorporated in Texas

TXACC Texas Association of Charitable Clinics

Texas Hospital Association

Texas Tech University Health Sciences Center™

TSA
Texas Society of Anesthesiologists

Texas Rural Health Association

UTA

UNT Health Fort Worth
University of North Texas College of Osteopathic Medicine

Texas Women's Healthcare Coalition

Waco Family Medicine Institute

University of North Texas Health Science Center

Contributor

HealthPOINT

State Agency Informational Resources

DSHS

Texas Health and Human Services

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