# MAKING PROGRAMS LAST:

## SUSTAINABILITY STRATEGIES FOR RURAL MATERNAL HEALTH NETWORKS

This issue brief was developed with information as of May 2026

The Health Resources and Services Administration (HRSA) provides start-up funding to help rural maternal health networks implement innovative approaches to enhance and expand maternal and obstetrics (OB) care in their rural communities.

HRSA funds rural maternal health networks through two programs: the Rural Maternity and Obstetrics Management Strategies (RMOMS) program and the Delta Maternal Care Coordination (Delta MCC) program. Official network partners include obstetric hospitals, prenatal and postpartum care providers, support service agencies, and state Medicaid programs.

Networks use the federal funding offered through the HRSA Federal Office of Rural Health Policy to plan, build, and implement their approaches while also finding ways to sustain the new services in the long term.

Rural communities face multiple challenges in sustaining maternal health care. Hospitals and clinics providing these services have low patient volume and high fixed costs, difficulties attracting and retaining skilled maternal health professionals, and limited reimbursement for prenatal and postpartum care.[1] Rural areas also often have higher rates of maternal mortality and risk factors contributing to poor outcomes, such as chronic illness and substance use.[2, 3, 4]

HRSA supports sustainability planning by offering **tools developed in partnership with the Georgia Health Policy Center (GHPC)**, which provides evidence-based research, program development, and policy guidance to improve health status at the community level. These tools help networks evaluate their positioning across areas like leadership, collaboration, and resource diversification.

This issue brief complements these tools by describing the strategies networks in the RMOMS Fiscal Year (FY) 2019, 2021, and 2022 Cohorts[a] used or planned to use to sustain

[a] As of May 2026, the RMOMS program included six cohorts: 2019, 2021, 2022, 2023, 2024, and 2025. The Delta MCC program included one cohort (2024). This issue brief includes information from the RMOMS 2019, 2021, and 2022 Cohorts using data as of their program end dates. See Appendix A for a list of the networks.

their initiatives beyond their formal RMOMS funding periods. The issue brief also shares networks' recommendations to other rural health providers working to sustain maternal health services in challenging fiscal environments.

**RMOMS FY 2019, 2021, and 2022 Network Initiatives**

- **Clinical and support services:** HRSA funding enabled networks to expand access to maternal care through new clinical services, such as new prenatal care clinics and technologies like ultrasound machines. Networks also implemented social supports, such as doula care and patient navigation.
- **Telehealth expansion:** Telehealth initiatives were a cornerstone of network innovation. All RMOMS 2019, 2021, and 2022 networks implemented or expanded virtual services to reach participants in remote rural areas.
- **Capacity Building and Patient Engagement:** Beyond direct services, HRSA funding supported provider capacity building and patient engagement initiatives that were critical to long-term system improvements.

See Appendix A for details.

## SUSTAINABILITY STRATEGIES

HRSA funded networks to implement innovative initiatives to improve maternal health care and to develop plans for how to sustain these activities when funding ended. During in-depth interviews,[b] network staff described three primary sustainability strategies they leveraged to continue their programs after federal funding ended:

- Securing insurance reimbursement,
- Absorbing program costs into operating budgets, and
- Identifying new grant opportunities as a short-term measure.

Each approach comes with benefits and drawbacks that networks balanced to produce the best chance of long-term sustainability. Frequently, they combined approaches to create a pathway to sustainability for effective initiatives. Table 1 below indicates primary and secondary funding streams used by networks to sustain their initiatives. Primary approaches were typically more common than secondary approaches because, when available, they offered greater stability. New grant opportunities are classified as a secondary approach because funding is typically time-limited and therefore only offers a temporary solution.

[b] Interviews were conducted toward the end of each program year with staff from the network lead organization and partner organizations, including program leadership, clinicians, patient navigators, and data managers. Interviewers used a standardized protocol with structured questions related to sustainability strategies to guide the conversations. Interviews were recorded, transcribed, and summarized in analytical tables, which enabled researchers to identify common themes and illustrative examples across networks.

**Table 1: Strategies and Most Feasible Funding Sources**

| Initiative | Insurance Reimbursement | Absorb Costs into Operating Budgets | New Grant Opportunities |
|---|---|---|---|
| New Clinical Care | ● | ○ | ○ |
| Telehealth | ● | | ○ |
| Remote Patient Monitoring (RPM) | ● | ○ | ○ |
| Patient Navigation | ○ | ● | ○ |
| Provider Training | | ● | ○ |
| Patient Education and Support | | ● | ○ |

● = *Primary approach;* ○ = *Secondary approach*

## Securing Insurance Reimbursement

Networks indicated that, in most cases, insurance reimbursement was the most stable method for sustaining services. Reimbursement eligibility allows providers to recoup at least part of the cost necessary to provide the service. HRSA-funded health centers and Rural Health Clinics (RHCs) may also be able to cover costs by leveraging the enhanced payments they receive from the federal government for serving as safety net providers (e.g., Section 330 grant funding).[5, 6]

However, securing insurance reimbursement is not always possible, and payers can be slow to cover new service lines. In addition, service utilization can impact whether insurance reimbursement covers the full cost of care given high fixed costs for certain initiatives, such as new telehealth models. Finally, the complexity of billing codes and evolving payment policies require networks to engage regularly with state-level partners, payers, and hospital and clinic billing departments to stay informed, share local needs, adapt to changes, and optimize reimbursement.

### Services Commonly Covered by Insurance

If a service is already reimbursable through Medicaid and private insurance, the path to sustainability is relatively straightforward. However, reimbursement varies by insurance program and state and may change over time. Networks emphasized the importance of understanding reimbursement policies at the outset of a program to ensure award funds were used strategically to fill gaps that were not covered through other sources. Throughout the grant period, they closely monitored changes in insurance reimbursement policies to identify new opportunities for reimbursement and maximize available funding.

Many of the RMOMS program **clinical initiatives** were primarily reimbursable through insurance:

- **New clinical care:** The networks that launched new clinical services relied on insurance reimbursement to sustain them. West Virginia (WV)-RMOMS funding enabled multiple rural clinics to hire nurse practitioners and certified nurse midwives to

provide prenatal care. While this care was reimbursable by insurance, HRSA funding supplemented provider salaries while the clinics built up their patient panels.

- **Telehealth:** Telehealth is also largely reimbursable through insurance. The Maine RMOMS virtual nutrition therapy program, the Maine RMOMS virtual perinatal behavioral health platform, and the maternal fetal medicine (MFM) telehealth services adopted by both the Bootheel Perinatal Network (BPN) and RMOM-Southeast Missouri Partnership (SMP) were billable to insurance providers. For the two MFM initiatives, reimbursement covered the technology in addition to the time of the nurse, sonographer, and MFM provider. In RMOM-SMP's program, payments were split between the organization that provided the sonographers and the health system where the MFM provider practiced.
- **RPM:** RPM is reimbursable by insurance in many states, making it relatively straightforward for RMOM-SMP, RMOMS South Dakota (SD), and Maine RMOMS to maintain their RPM programs. However, when RMOMS 2019 funding was ending, Medicaid in New Mexico did not reimburse for RPM, creating funding uncertainty for the Rural OB Access and Maternal Services (ROAMS) network's home monitoring kits for blood pressure and blood sugar. The Arkansas Medicaid program only covered RPM for patients with insulin-dependent diabetes, but in 2025, the Arkansas legislature expanded coverage to women with gestational diabetes as well, improving the sustainability of the Arkansas (AR) MOMS RPM program.

For services that were already reimbursable by insurance, HRSA funding helped support:

- The purchase of equipment, such as telehealth and sonography machines
- Training staff on new processes
- Covering provider salaries while they built up patient panels
- The optimization of billing and coding

Insurance reimbursement for **support services,** such as patient navigation and doula care, is less common. However, some insurance programs are expanding benefits, giving networks a stronger sustainability pathway for those services. For example, the 2025 Arkansas legislation also expanded Medicaid coverage to community health workers (CHWs). There is also an upward trend in state Medicaid coverage of doula services; 26 states had this benefit in April 2026, up from 14 states in 2024.[7] Understanding the changing insurance reimbursement landscape is a key component of any sustainability strategy.

### Medicaid as a Sustainability Partner

Medicaid is a crucial sustainability partner for rural maternal health networks as the program covers about half of births in rural areas.[8] Therefore, networks worked with their state Medicaid agencies (official network partners) through a variety of avenues:

- **Sharing local needs:** With insider knowledge on challenges faced by rural patients and providers, networks were uniquely positioned to share experiences with Medicaid partners and help inform reimbursement policy. The New Mexico Medicaid program, a ROAMS partner, made two major changes in reimbursement policy to promote maternal health service access and sustainability because of its collaboration with ROAMS. Lactation consultation can now be billed as a clinical service, increasing reimbursement, and women enrolled in "pregnancy Medicaid" gained access to Medicaid transportation services.
- **Demonstrating cost savings:** Similarly, networks often had access to data on service utilization and outcomes that could be used to inform reimbursement policy. ROAMS shared information with the New Mexico Hospital Association demonstrating the financial loss on each Medicaid-covered delivery at eight rural New Mexico hospitals, which ultimately informed the statewide effort to raise Medicaid reimbursement rates. RMOMS SD assessed the cost savings from its OB Hub, through which maternal health specialists virtually monitored women in labor at rural hospitals.
- **Gaining clarity on reimbursement requirements:** Close collaboration with Medicaid also enabled networks to build programs around reimbursement requirements. Maine RMOMS coordinated with Medicaid on reimbursement for virtual behavioral health services, the first program of its kind in Maine. RMOMS SD intended to align its RPM program with Medicaid reimbursement standards. While phone calls between patients and case managers were eligible for reimbursement, text messages were not, posing a problem for the program, which often relied on text communication.
- **Leveraging additional services offered through managed care plans:** Finally, Medicaid managed care plans often offer direct services that can support the work of RMOMS-funded patient navigators. BPN, for example, worked closely with the Medicaid managed care plans in Missouri to connect women to transportation services, free delivered meals, and breast pumps.

### Other Reimbursement Considerations

Even with insurance reimbursement, sustainability can be a challenge. Patient volume can impact whether insurance reimbursement covers the full cost of care. Low population density, combined with high fixed costs,[9] can make it difficult for rural providers to maintain staffing, specialized services, or multiple service sites. As a result, some networks recommended concentrating services in higher-utilization locations or adjusting service models to remain viable once external funding ends.

Billing codes can also be complex. Networks and maternal health experts noted the importance of engaging with hospital and clinic payment offices and supporting any needed enhancements related to billing and coding to ensure full and appropriate reimbursement.

When the Arkansas Medicaid program unbundled its maternal health payments, AR MOMS worked with its IT staff to ensure clinicians were coding correctly and all prenatal services were captured and billed accordingly.

## Absorbing Costs into Operating Budgets

Even when services qualify for some insurance reimbursement, networks may need to find ways to absorb unreimbursed costs into their operating budgets. RMOMS funding allowed networks to test various approaches and demonstrate value to partners to encourage ongoing support. Partners were more willing to cover costs if services were perceived as:

- Highly impactful,
- Low cost,
- Partially reimbursable,
- Eligible for future reimbursement, or
- Appropriate for cost-sharing across multiple partners

**Highly impactful.** Some non-clinical services are not entirely reimbursable, but networks saw them as widely beneficial, prompting several networks to include them in their operating budgets. For example, Families First in Minnesota committed to continuing group prenatal care classes, with each host site taking on associated costs. Staff noted that the demonstrated success of the classes motivated sites to continue them even without outside funding. Care coordination was also perceived as impactful and valuable to maintain regardless of availability of external funds. To ensure continuity, Families First planned to integrate high-risk care coordination and navigator roles into ongoing operations. RMOM-SMP and WV-RMOMS similarly intended to absorb the cost of care coordination within each clinical partner's operating budget.

> "Sanford knows that [care coordination] is work we have to do regardless…it just kind of goes into the operational responsibilities…my directors would be responsible for continuing those conversations, continuing that work."
>
> – Families First

**Low cost.** Relatively low-cost services, such as patient and provider education, were also being maintained through internal support. Texas (TX)-RMOMS was able to maintain patient education programs by establishing a partnership with a nonprofit organization late in the performance period. This organization took on these programs, which aligned well with its overall mission.

**Partially reimbursable.** Programs may also qualify for partial reimbursement, making networks willing to bridge funding gaps with internal funds to leverage this reimbursement. For example, state Medicaid programs may reimburse some costs associated with RPM programs if certain criteria are met, but cost of the equipment used to monitor patients may not be reimbursable. RMOM-SMP and RMOMS SD both purchased blood pressure cuffs

and glucometers using their HRSA funding. To replenish equipment, the networks planned to use their own operating budgets. Additionally, if the programs do not generate sufficient insurance reimbursements to sustain them, the costs may need to be absorbed by the network. For example, if a patient uploads 12 blood pressure readings a month instead of the 16 minimum Medicaid requires for reimbursement, the monthly costs associated with that patient are not reimbursable in South Dakota. RMOMS SD and TX-RMOMS noted that, although some aspects of care coordination were reimbursable, funding levels fell short of covering the true cost of sustaining these roles. These networks planned to cover the difference internally.

**Expected reimbursement.** Networks may also be willing to cover the entire cost of services temporarily while they wait for insurance reimbursement to come through. Maternal Health Connection in Montana planned to sustain its doula program through its operating budget because the network hoped to eventually receive some reimbursement through insurance once approved.

**Sharable across partners.** Finally, program costs may be too steep for a single provider to shoulder alone, making sustainability more likely when they can be shared across partners. At the end of RMOMS 2019 funding, BPN planned to maintain its online referral platform by splitting costs across two partners.

## Identifying New Grant Opportunities as a Short-Term Measure

> "We use grant funds to help prove out a new delivery model… we will sustain it… but some pieces may get trimmed down if we don't have another funding source."
> – RMOMS SD

In addition to seeking reimbursement and absorbing costs into operating budgets, RMOMS networks within the 2019, 2021, and 2022 Cohorts planned to seek other grants to cover the full cost of highly impactful programs. For example, ROAMS in New Mexico relied on grants from several foundations and a special state Medicaid investment fund to support its RPM program, which was not reimbursable through Medicaid, and maintain additional ROAMS services after RMOMS funding ended. In South Dakota, RMOMS SD's telehealth OB Hub connected providers to specialists through provider-to-provider consultations, which were not reimbursable under insurance rules. Network staff emphasized the Hub's role in improving outcomes and preventing complications, so they planned to pursue funding from additional grants in addition to leveraging the lead hospital's operating budget to maintain the hub's scale and reach.

Several networks indicated that their RMOMS initiatives aligned well with other grants or funding streams, making additional grant funding straightforward. For example, funding for WV-RMOMS' Lamaze and lactation training already came from a state program that addressed substance use during pregnancy. Similarly, BPN successfully leveraged federal

grants to cover costs of its care coordination program and referral platform. Maine RMOMS planned to transition some provider training programs to complementary grants.

The first three networks funded through RMOMS successfully accessed grant funding to continue their efforts. They were able to make the case for continued support by showcasing activities and outcomes in grant applications and through presentations at state and national conferences. This work involved leveraging external evaluation findings on increases in prenatal care access in addition to networks' own analyses on social support provided and miles saved through telehealth.

**Program Highlight**

In 2024, University Health (UH) in Texas secured two federal grants to enhance maternal and infant health outcomes across South Texas. In a press release, UH stated that "both programs will build on the success of another federally funded maternal health program, TX-RMOMS." The new funding will support the hiring of new staff, including nurses, patient navigators, and licensed mental health providers, and expand services in MFM and mental health.

## NON-FINANCIAL STRATEGIES TO SUPPORT SUSTAINABILITY

Networks also strengthened sustainability by building workforce capacity and making programs more cost-effective.

### Build Workforce Capacity

Networks reported that staff recruitment challenges and low utilization of maternal health services made it essential to build the capacity of existing staff and encourage them to expand the scope of their responsibilities.

- **Build Existing Staff Capacity:** Existing clinical and support staff can take a more active role in maternal health service provision through additional training and support. ROAMS' tele-OB model enabled a nurse practitioner at a rural clinic to learn how to provide basic prenatal care with the support of the delivery hospital. TX-RMOMS trained sonographers in rural clinics to conduct more advanced ultrasounds as part of its MFM telehealth initiative. Staff across multiple networks received key training and certifications with HRSA funding to serve as doulas, CHWs, lactation consultants, dieticians, and licensed clinical social workers. Families First helped hospital obstetric providers receive Indian Health Services (IHS) credentialing. These formal certifications supported sustainability by allowing staff to meet requirements and bill insurance for their time.

RMOM-SMP's patient navigator was previously a clinic receptionist. She "excels" at her new role since she was already familiar with the patients and the referral partners in the area.

- **Provide Opportunities for Staff to "Wear Multiple Hats":** Health care systems that struggle with low prenatal patient volume can also broaden staff responsibilities for those trained in maternal health care. For example, a new prenatal care provider with WV-RMOMS also served children and older adults. Her large and diverse patient panel helped cover costs so she could continue providing prenatal care, despite the comparatively small size of the maternal health patient population. WV-RMOMS also invited existing staff that served as medical assistants and patient navigators to participate in lactation consultation trainings. Maine RMOMS laid the groundwork for a future Family Medicine in Obstetrics fellowship to train more family medicine physicians to perform Cesarean sections, which could help family medicine providers with larger and more sustainable patient panels safely provide all components of prenatal and delivery care.

## Streamline Implementation

Rural maternal health networks also emphasized that maintaining initiatives should not only generate patient benefits but also introduce system efficiencies.

- **Address Technology and Workflow Inefficiencies:** New workflows and technologies should be as seamless as possible or address existing inefficiencies to promote their long-term use.
- **Choose Proven Technology with Ongoing Support:** RMOMS networks found that proven technologies with robust technical support promoted sustainability. Smooth initial adoption and effective training and technical assistance made staff feel more capable of continuing with activities, such as RPM and automated referrals, post HRSA funding.
- **Adopt a Continuous Quality Improvement Approach:** The continual assessment of how programs are working, either through quantitative data analysis or feedback from patients and staff, helped networks identify opportunities for improvement. The RMOMS SD team regularly revised RPM care algorithms and monitoring parameters based on input from clinicians and patient experiences.

## Make the Most of Funding

To make dollars go further in challenging fiscal environments, networks analyzed data to inform decisions and collaborate across multiple partners.

- **Track Utilization and Payer Mix of New Services to Make Informed Decisions:** AR MOMS carefully monitored utilization of its new maternal health clinics to determine which clinics could be sustained through insurance reimbursement after the end of RMOMS. Discussions on patient payer mix and preference for care also informed network decisions to target patient outreach to increase demand for services. By pro-

moting clinics in areas with local employers, AR MOMS also hoped to increase the number of patients who were privately insured.

- **Roll Out Programs Strategically:** To avoid overwhelming staff and ensure manageable uptake, Maine RMOMS typically rolled out new initiatives at pilot sites, which helped engage partners in program design and initial roll-out while ensuring time for monitoring before future scale-up. This phased strategy supported sustainability by scaling with capacity and reimbursement progress.

> To support decision-making, networks can apply the "What, Why, Who, How" framework developed by GHPC and outlined in **The Dynamics of Sustainability.** This HRSA sponsored resource helps organizations reflect on the relevance of services, alignment with community needs, internal leadership, and the practicality of sustaining services through local support.

- **Identify Opportunities for Collaboration:** An advantage of the network approach is that multiple partners can share program benefits and responsibilities. Spreading resources and efforts across different partners can offset program costs. Maternal Health Connection shared costs associated with staffing, training, or administrative functions with the local county health agency. RMOM-SMP partners shared the expenses for the telehealth program; the rural clinic covered the cost of the sonographers, and the tertiary hospitals covered the cost of the MFM provider.

## CONCLUSIONS

Rural maternal health networks receiving RMOMS program funding were committed to maintaining services and programs that demonstrated improved maternal health care access and outcomes. This commitment showed in the adoption of sustainability strategies that ranged from securing Medicaid reimbursement to accessing new grant funds. The RMOMS networks in the 2019, 2021, and 2022 Cohorts offered promising practices within uncertain fiscal, workforce, and policy environments, indicating that programs can be maintained with careful analysis, planning, and coordination across network partners.

## APPENDIX A: OVERVIEW OF RURAL MATERNAL HEALTH NETWORK INITIATIVES

HRSA provides start-up funding for staff and equipment to support a range of maternal health care initiatives, including telehealth, patient navigation, and new clinical and support service lines. The funding also helps build provider capacity and enhance patient engagement.

**Initiatives Launched by Rural Maternal Health Networks**

| Network | New Clinical Care | Telehealth | Remote Patient Monitoring (RPM) | Patient Navigation | Provider Training | Patient Education |
|---|---|---|---|---|---|---|
| **2019 Cohort (September 2019 – August 2023)** | | | | | | |
| Bootheel Perinatal Network (BPN) (MO) | | ● | ● | ● | ● | |
| Rural OB Access & Maternal Services (ROAMS) (NM) | | ● | ● | ● | | ● |
| Texas (TX)-RMOMS | | ● | ● | ● | ● | ● |
| **2021 Cohort (September 2021 – August 2025)** | | | | | | |
| Families First (MN) | ● | ● | ● | ● | | |
| RMOM-Southeast Missouri Partnership (SMP) (MO) | | ● | ● | ● | | |
| West Virginia (WV)-RMOMS | ● | | ● | ● | ● | ● |
| **2022 Cohort (September 2022 – August 2026)** | | | | | | |
| RMOMS South Dakota (SD) | | ● | ● | ● | | |
| Maternal Health Connection (MT) | ● | ● | ● | ● | ● | ● |
| Maine RMOMS | | ● | | | ● | ● |
| Arkansas (AR) MOMS | ● | | ● | ● | | ● |

**Clinical and Support Services**

HRSA funding enables networks to expand access to maternal care through new clinical services, such as new prenatal care clinics and access to essential technologies like ultrasound machines. For example, AR MOMS launched bi-weekly maternal health clinics at existing primary care-only locations, increasing access to prenatal care in underserved areas. Nurse practitioners, certified nurse midwives, and other providers have also been hired to address provider shortages. Alongside these clinical enhancements, networks implemented a variety of support services. These include patient navigation to connect participants with health and social services, nutrition counseling, and screenings to identify behavioral and mental health needs. HRSA funding supported hiring new types of staff, like CHWs, often to establish proof of concept and demonstrate their value in improving patient outcomes.

**Telehealth Expansion**

Telehealth has been a cornerstone of network innovation. All RMOMS 2019, 2021, and 2022 networks implemented or expanded virtual services to reach patients in remote rural areas. In partnership with a virtual provider platform, Maine RMOMS began offering mental health services to pregnant women. BPN and RMOM-SMP implemented MFM telehealth to connect patients with out-of-area providers, and all but one network adopted RPM to monitor patients with hypertension and diabetes. RMOMS SD piloted a telehealth OB hub: this centralized virtual support model connects rural providers and patients with MFM specialists and nurse case managers to monitor risk, provide clinical guidance, and ensure timely referrals to appropriate delivery sites. HRSA funding to purchase telehealth equipment and train providers helped make these initiatives possible.

**Capacity Building and Patient Engagement**

Beyond direct services, HRSA funding supports provider capacity building and patient engagement initiatives critical to long-term system improvements. Several networks used funds to invest in workforce development tools, such as training mannequins, ALSO certification, and virtual learning platforms like the Extension for Community Healthcare Outcomes (ECHO) model. These tools help prepare clinical teams to manage complex maternal health needs – even in rural hospitals with low delivery volumes. Patient engagement was also a key focus, with Families First offering group prenatal care to foster community and improve maternal outcomes.

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