



Mobile maternity care as infrastructure

A structural solution for the 35 percent of U.S. counties without obstetric care.

KEY TAKEAWAYS

- Medicaid financed 41 percent of U.S. births in 2023 and 47 percent of births in nonmetropolitan areas, making maternity care deserts an important issue for state health and fiscal leaders.
- Mobile maternal health programs extend in-person prenatal and postpartum care into counties without obstetric providers using Medicaid billing and contracting tools states already operate. These programs would function as access extenders connected to regional delivery systems, not as replacements for hospital labor and delivery capacity.
- The strongest model is hybrid and regional: a mobile clinic delivering in-person prenatal and postpartum care, telehealth supporting monitoring and specialty consultation between visits, and a defined connection to the hospital that manages labor, delivery, and complications beyond the clinic's scope.

The issue

35%

of U.S. counties have no birthing facility and no obstetric clinician

2.3M

reproductive-age women live in maternity care deserts

150K

babies born to desert-county residents in 2022

38 min

travel to the nearest birthing hospital, vs. ~16 min nationally



Maternity care access in the United States is contracting. The March of Dimes 2024 publication, *Nowhere to Go*, reported that 35 percent of U.S. counties have no birthing facility and no obstetric clinician. Approximately 2.3 million reproductive-age women live in these maternity care deserts, and roughly 150,000 babies were born to residents of these counties in 2022. Nearly two-thirds of the deserts are rural, and residents travel up to 38 minutes to reach the nearest birthing hospital, against a national average of about 16 minutes.¹

The problem is geographic, and it is growing. The states with the highest share of desert counties sit in the Midwest and Southeast, where in several states half or more of all counties have no obstetric care.¹ These same counties carry a disproportionate share of Medicaid-financed births: Medicaid financed 41 percent of U.S. births in 2023 and 47 percent of births in nonmetropolitan areas.² For state Medicaid programs, that concentration makes maternity care deserts a major access issue. Unmanaged hypertension, diabetes, infection, or behavioral health needs contribute to higher-cost emergency, delivery, or neonatal care.

Women living in deserts receive less prenatal care and face roughly a 13 percent higher risk of preterm birth.¹ The populations most affected, including American Indian and Alaska Native women, are also the populations with the highest pregnancy-related mortality.³ Postpartum mental health conditions, substance use disorder, and intimate partner violence account for a substantial share of pregnancy-related deaths,⁴ and each requires screening and a referral pathway that distance routinely interrupts.

Beyond the geographic disparities, there are racial and ethnic ones as well. According to CDC data, American Indian and Alaska Native and Black women experience the highest rates of pregnancy-related death,³ and the counties with the least access overlap with the communities where many of these women live. Effective response depends on culturally appropriate care and, for tribal communities, coordination with tribal health systems and the Indian Health Service, whose facilities and governance shape where and how care is delivered.

The coverage-capacity gap

While optional, nearly every state Medicaid program has extended postpartum coverage to a full 12 months (only Arkansas has not).⁵ The clinical argument for extended coverage is strong. Most pregnancy-related deaths occur after delivery rather than at delivery, across the year that follows birth, and federal maternal mortality review data find that more than 80 percent of these deaths are preventable.⁴

Coverage, however, does not ensure access to care when local delivery capacity is limited. In a maternity care desert, an enrollee can have a full year of postpartum coverage and still not have an obstetric clinician within reach. This creates an operational challenge for states: how to translate coverage into prenatal, postpartum, screening, and monitoring services. Mobile maternal health programs address part of this gap by bringing in-person care into the county and connecting patients to the nearest delivering hospital, while labor and delivery remain hospital-based.

Why no single approach closes the gap

No single fix resolves a maternity care desert, and the strongest response combines several approaches within a regional delivery system.

Bricks-and-mortar obstetric units

Reopening or establishing new bricks-and-mortar obstetric units may be one response, but it is often difficult to sustain on its own. Hospital obstetric units close in rural areas because volume is low, reimbursement is insufficient, and workforce is limited. The March of Dimes report counted 107 obstetric unit closures in 2021 and 2022, roughly one in every 25 units.¹ In many communities, reopening or rebuilding an obstetric unit would require addressing the same low-volume, reimbursement, and workforce pressures that contributed to closure.

Telehealth

Telehealth is an important, but incomplete, strategy. Remote blood pressure monitoring, connected scales and glucose meters, asynchronous record review, and tele-consultation with maternal-fetal medicine (MFM) specialists extend care into counties that have none. Telehealth cannot perform the hands-on components of maternity care on its own: laboratory draws, imaging, physical examination, and vaccines. It works as a layer on top of in-person capacity rather than a substitute for it.

Non-emergency medical transportation

Non-emergency Medical Transportation (NEMT) can help patients reach distant care, but does not reduce the distance patients must travel. While a mandatory Medicaid benefit, NEMT alone is insufficient to eliminate transportation barriers. The program suffers from persistent operational problems, including complicated scheduling, inconsistent availability, and physical inaccessibility. These shortcomings help explain why uptake remains low: fewer than 5 percent of Medicaid enrollees used the service in fiscal year 2018, according to the Medicaid and CHIP Payment and Access Commission (MACPAC).⁶

Each approach addresses part of the access problem, but none by itself supplies the in-person components of maternity care in the county where the patient lives. Mobile maternal health programs can supply some in-person services that telehealth and transportation benefits cannot. The strongest model is likely hybrid and regional: a mobile clinic delivering in-person prenatal and postpartum care, telehealth supporting monitoring and specialty consultation between visits, and a defined connection to the hospital that manages labor, delivery, and complications beyond the clinic's scope.

What mobile maternal healthcare delivers

A mobile clinic brings the in-person components of prenatal and postpartum care into the county where the patient lives, then coordinates the delivery itself with the nearest hospital or birth center. Labor and delivery, surgical obstetrics, blood bank access, neonatal resuscitation, and emergency cesarean capacity remain at the partnering hospital. The mobile clinic functions as an access extender and risk-identification site. It can identify conditions that require monitoring or escalation and route patients to a higher level of care when needed. Rigorous closed-loop referral processes confirm that the patient reaches the delivering facility, that records are transferred, and that postpartum follow-up is completed.

Typical service mix

Routine prenatal visits, blood pressure measurement, urine protein testing, gestational diabetes screening, labs, ultrasound, vaccines, behavioral health screening, postpartum and lactation support, and contraception counseling. Community health workers (CHWs) and doulas provide navigation and help with social drivers of health, and a closed-loop referral connects each patient to the delivering hospital and, for higher-risk pregnancies, to maternal-fetal medicine.

Staffing configuration

Staffing is based on services and community needs. A common configuration pairs a certified nurse midwife (CNM), or a nurse practitioner with obstetric training, with a medical assistant, community health worker, or doula, and an obstetrician available through a collaborating arrangement and tele-consultation. Some programs also employ physicians, registered nurses, sonographers, or behavioral health specialists.

Mobile maternal health programs can also fit within financing tools states already operate. Services may be billed through existing Medicaid infrastructure rather than requiring new procedure codes or provider types, although state-specific billing and licensure rules will determine implementation.

Clinics can be deployed through ownership, leasing, or full-service turnkey arrangements, allowing rural providers or states to add capacity without building a permanent facility. A mobile clinic can also serve more than one desert county on a rotating schedule, which may better match capacity to demand.

A mobile clinic in a maternity care desert manages low- and moderate-risk pregnancies and screens continuously for the conditions that require a higher level of care. Risk stratification at intake and at each visit determines who can be managed locally and who must be referred. Written escalation protocols govern the conditions that cannot wait: severe hypertension and signs of preeclampsia, decreased fetal movement, bleeding, abnormal ultrasound findings, and acute presentations of substance use disorder, intimate partner violence, or suicidal ideation.

Implementation mechanism

States can act through mechanisms already within their authority:

Direct managed care payments. Use state directed payments to managed care plans under 42 CFR 438.6(c), the authority that lets a state direct how its plans pay providers, to fund maternity care delivered by mobile clinics.

Bill through existing infrastructure. Bill through existing Medicaid infrastructure, using Place of Service code 15 for mobile clinics and operating mobile sites under a federally qualified health center's scope of project and prospective payment rate where a health center is the sponsor.

Enable leasing and turnkey models. Structure funding opportunities to allow for leasing or turnkey service arrangements, so providers can match capacity to local birth volume without upfront capital expense.

Draw on transformation funding. Draw on available funding to stand up capacity, including the Rural Health Transformation Program,⁷ alongside the Medicaid payment mechanisms above.

Each mechanism requires state-specific design. Provider enrollment, scope of practice, collaborating obstetrician or certified nurse midwife arrangements, ultrasound and laboratory billing, malpractice coverage, and state licensure all vary, and Place of Service code 15 does not by itself settle how

every service is billed. Where a federally qualified health center sponsors the clinic, adding mobile maternity services may require a change to its scope of project. The 12-month postpartum coverage extension adopted by nearly every state provides a coverage window for follow-up through the postpartum year.

Measuring outcomes

Mobile maternal healthcare should be monitored and measured using established metrics for maternity care. Process measures include first-trimester entry into prenatal care, adequacy of prenatal care, gestational diabetes screening and follow-up, blood pressure control, aspirin prophylaxis where indicated, postpartum visit completion, and depression screening with connection to treatment. Outcome measures include preterm birth, low birthweight, severe maternal morbidity, emergency department use, and avoidable transfers. One measure is specific to this model: closed-loop delivery coordination, or the share of patients whose delivery, records transfer, and postpartum return are confirmed. Tying payment or contract expectations to these measures would give states a way to assess whether mobile capacity is improving access and outcomes compared with the status quo of no local obstetric access.

TECHNICAL ASSISTANCE

Mission Mobile Medical provides implementation support for state Medicaid programs and maternal health agencies integrating mobile healthcare into maternal and rural access strategies. Our team includes policy analysts, operational experts, and financial modelers with direct experience in mobile clinic deployment, Medicaid payment design, and rural program operations.

SOURCES

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CONTACT

Mollie Williams

VP of Evidence & Insight and Director of National Policy, Mission Mobile Medical

mollie.williams@missionmobilemed.com