



Strengthening Rural Maternity Care in Pennsylvania

Written testimony | Pennsylvania Section, American College of Obstetricians and Gynecologists

Center for Rural Pennsylvania | Public Hearing on Women's Health | October 20, 2026

Members of the Center for Rural Pennsylvania:

Thank you for the opportunity to provide testimony on women's health in rural Pennsylvania. The Pennsylvania Section of the American College of Obstetricians and Gynecologists (PA ACOG) urges the Commonwealth to treat rural maternity care as essential health infrastructure. Safe care depends on a sustainable workforce, functioning delivery facilities, and reliable connections to higher levels of care throughout pregnancy and the postpartum period.

These are systems-level challenges that require systems-level change. Recruiting a clinician will not restore access if the hospital cannot support a delivery team. Preserving a delivery unit will not ensure safety if emergency transport and referral systems are unreliable. Pennsylvania needs a coordinated strategy that strengthens each part of the system.

The Pennsylvania access and workforce gap

As of January 2026, the Center identified 75 hospitals providing labor and delivery services, including 25 in rural counties. Twenty-three counties had no hospital offering these services; all were rural, representing 48% of Pennsylvania's rural counties. [1]

The Center's May 2025 workforce analysis found 3.6 practicing OB/GYNs per 10,000 females ages 15–44 in rural counties, compared with 8.4 in urban counties, using 2022 clinician data. Nine rural counties had no practicing OB/GYN. Rural OB/GYN numbers declined 10% between 2019 and 2022; urban numbers increased less than 1%. [2]

March of Dimes' August 2026 update classifies 10.4% of Pennsylvania counties as maternity care deserts and another 16.4% as having low or moderate access. A maternity care desert has neither a hospital or birth center offering obstetric care nor an obstetric clinician. This is a narrower measure than the absence of a hospital delivery unit. [3]

The Commonwealth's February 2026 Rural Health Transformation Plan reports 38 labor and delivery unit closures since 2005. This is a statewide closure count, not a count limited to rural hospitals. [4,5]

Closures affect whole regions and the full continuum of care

Pennsylvania Health Access Network documented the April 2025 closure of UPMC Cole's maternity unit and a seven-county north-central region without hospital maternity services. The Center's January 2026 update adds Warren County: eight contiguous counties, approximately 35,000 women ages 15–44, and roughly 6,000 square miles without local labor and delivery services. [1,6]

For families, losing local delivery services means arranging longer trips, time away from work, child care, and transportation for repeated visits, as well as childbirth. For communities, it places additional demands on emergency departments, EMS, and receiving hospitals. The Center's updated analysis describes these pressures and their implications for prenatal and postpartum care. [1]

The 2026 Pennsylvania Maternal Mortality Review Annual Report, which examines deaths occurring in 2022, found that 47 of 53 pregnancy-related deaths (89%) were preventable. Nearly half (49%) occurred 43 days to one year after pregnancy ended, and mental health conditions accounted for 49% of pregnancy-related deaths. The report also cites an access analysis showing that 47.6% of rural women lived more than 30 minutes from a birthing hospital, compared with 11.9% of urban women. [7]

An effective rural obstetric system must therefore support early and ongoing prenatal care, safe delivery, postpartum follow-up, and timely access to mental health and substance use treatment. Access cannot be measured solely by whether a hospital has a delivery unit.

Recruitment and retention require support for the entire team

Rural obstetric care requires OB/GYNs, appropriately trained family physicians, certified nurse-midwives, pediatric/neonatal clinicians, nurses, anesthesia professionals, and dependable surgical and emergency support. Recruitment incentives should be paired with workable call schedules, backup coverage, competitive compensation, continuing education, and professional connections to referral centers. Doulas and community health workers can strengthen navigation and support alongside the clinical workforce.

PA ACOG recommends addressing payment, staffing, and professional support together. A small delivery volume does not eliminate the need for around-the-clock readiness. ACOG's guidance on rural and low-volume obstetric settings emphasizes that supporting these

providers is a shared responsibility of communities, government, payers, and health facilities. [8]

Regional networks should strengthen local access

ACOG and the Society for Maternal-Fetal Medicine's Levels of Maternal Care framework supports coordinated, risk-appropriate care. [9] Pennsylvania should use this approach to connect local clinicians and facilities with referral centers, establish clear consultation and transfer pathways, and return patients to local care when appropriate. Regionalization should preserve safe local capacity while ensuring that patients can reach specialized care promptly.

Five policy priorities for the Commonwealth

1. Pay for rural maternity readiness and protect essential services.

A rural maternity payment and stabilization strategy developed by the Department of Human Services and the Department of Health could account for the cost of maintaining safe, round-the-clock staffing and emergency capacity. Appropriate Medicaid payment improvements, together with targeted support for essential low-volume services, would help sustain this capacity, with funding linked to staffing, quality, and access standards. For communities facing a planned closure, timely public notice, a regional access assessment, and a funded transition plan would support continuity of care. Such planning would address receiving-hospital capacity, prenatal and postpartum services, and EMS readiness.

2. Build and retain a rural maternity workforce.

Pennsylvania's existing Primary Care Loan Repayment Program, which already includes OB/GYNs and certified nurse-midwives, provides a foundation for dedicated rural maternity awards and retention incentives. [10] Additional investment in rural OB/GYN rotations, family medicine obstetric training, midwifery and nursing placements, and preceptor support could strengthen the workforce pipeline. Shared call and backup coverage, mentorship, and protected continuing education would complement recruitment efforts and support retention. Attention to professional liability costs and barriers would further inform this strategy. Evaluating both recruitment and continued rural practice after service commitments end would help assess its long-term impact.

3. Establish accountable regional referral and transfer networks.

Funded regional agreements among delivery hospitals, referral centers, local clinics, emergency departments, and EMS could create a more dependable system for consultation and transfer. These agreements would identify facility capabilities, establish a

single access point for urgent consultation and transfer coordination, define escalation procedures, and support reliable transport and information exchange. Cross-state partnerships would be particularly valuable where patients routinely seek care across Pennsylvania's borders. Funding for recurrent team simulation, along with review of transfer delays and unplanned deliveries outside obstetric units, would support ongoing improvement.

4. Keep prenatal and postpartum care accessible locally.

Investment in local clinics, mobile services, and shared-care arrangements linked to delivery hospitals could make prenatal and postpartum care more accessible. Reimbursement for telehealth consultation and clinically appropriate remote monitoring, including fetal non-stress tests and blood pressure monitoring with a clear response pathway, would extend the reach of these services. Access to blood pressure monitors has consistently been a recommendation of the state's Maternal Mortality Review Commission to reduce maternal mortality and morbidity. House Bill 1234 and House Bill 1088, which address coverage for blood pressure monitoring, are currently pending in the state Senate. Remote blood pressure monitoring is a low-cost tool that can save lives and prevent costly hospital readmissions. Funding for transportation, navigation, and behavioral health connections would support access through the postpartum year, alongside continued in-person care for examinations, diagnostics, and urgent evaluation. Pennsylvania's Rural Health Transformation Plan already proposes maternal health hubs, remote monitoring, and workforce development, creating an opportunity to strengthen existing local services and establish sustainable financing. [4]

5. Measure access and make rural maternity investment accountable.

A regularly updated county and regional maternity-access inventory maintained by the Department of Health and the Center could provide a clearer picture of service availability. This inventory would capture active delivery services, clinicians who provide obstetric care, staffing and call capacity, appointment availability, travel times, and service closures. Distinguishing licensed clinician counts from clinicians accepting patients and attending deliveries would make these measures more useful. Reporting access and quality measures by rurality and other relevant characteristics, with privacy safeguards, would help target investment and assess whether patients can obtain timely care.

Pennsylvania's rural families deserve a dependable system of care. The Commonwealth can make progress by financing readiness, supporting the workforce, connecting regional partners, maintaining local prenatal and postpartum services, and holding the system

accountable for access. PA ACOG welcomes the opportunity to work with policymakers, rural clinicians, hospitals, and communities to advance these priorities.

References

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9. ACOG and Society for Maternal-Fetal Medicine. Levels of Maternal Care. Obstetric Care Consensus No. 9. 2019. [Source](#)
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