

Written Testimony – Center for Rural Pennsylvania Public Hearing

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To: The Board of Directors, Center for Rural Pennsylvania

Introduction

Chair and Members of the Board, thank you for the opportunity to speak with you about maternity care in rural Pennsylvania. My name is Emily McGahey. I am a certified nurse-midwife and the Clinical Director of The Midwife Center in Pittsburgh, one of only four licensed freestanding birth centers in the Commonwealth.

I want to leave you with one idea: rural Pennsylvania already has a proven, cost-effective way to expand maternity and primary care, and it is midwifery. What it needs is the system around it — hospital partners, fair payment, and policy that lets midwives work to the full extent of their training.

I know rural families want this care, because many of them already drive up to two hours to reach us.

Midwifery 101: who midwives are

A midwife is a licensed clinician, not just a support person at a birth. Certified nurse-midwives (CNMs) and certified midwives (CMs) are advanced practice providers. They hold a master's or doctoral degree, pass a national board exam from the American Midwifery Certification Board, and are licensed by the state. They care for people from the teen years through menopause and beyond.

The word “midwife” covers several credentials, and the differences matter for policy. Doulas are often confused with midwives, so I include them here too.

Role	Training and credential	What they do	Status in Pennsylvania
Certified nurse-midwife (CNM)	Registered nurse plus a graduate midwifery degree; AMCB board certification	Prenatal, birth, and postpartum care; gynecology; primary care; prescribing; newborn care to 28 days	Licensed; works in hospitals, birth centers, clinics, and homes
Certified midwife (CM)	Same graduate education and AMCB exam as a CNM, without a nursing degree first	The same scope as a CNM	Licensed under Act 14, signed May 2026; regulations are being written now
Certified professional midwife (CPM)	Credentialed by the North American Registry of Midwives; trained for community birth	Out-of-hospital pregnancy and birth care	No licensure pathway currently; practice mostly in patients' homes
Doula	Non-clinical training; no license required	Emotional, physical, and informational support before, during, and after birth	Not a clinician; does not deliver babies, diagnose, or prescribe

Doulas and midwives are teammates, not substitutes. A doula supports the family; a midwife is responsible for the clinical care of mother and baby. Rural families benefit from both, but only a licensed clinician can fill a maternity care desert.

What women want does not change with the zip code

A mother in Potter County wants the same things as a mother in Pittsburgh. She wants to be listened to. She wants to be safe. She wants care she can afford, from someone who knows her, close enough to home that she can actually get there.

The research bears this out. Postpartum mental health, substance use, safety at home, and the social conditions that shape health are concerns for rural and urban women alike. Maternity care deserts are not only a rural problem either: 35% of U.S. counties, rural and urban, have no hospital or birth center offering obstetric care and no obstetric provider.

What changes with geography is how far she must travel for care, and the risk that comes with that distance:

- Rural women face nearly twice the risk of maternal death that urban women do.
- One in four rural hospitals stopped offering obstetric services between 2010 and 2022.
- Nearly 40% of rural communities are more than 30 minutes from the nearest hospital maternity unit.
- Infant mortality roughly doubles in counties that lose hospital obstetric services.
- Rural women are more likely to be uninsured before pregnancy (15.4% vs. 12.1%) and after it (12.7% vs. 9.8%).
- More than half of surveyed rural hospitals report no nurse-midwifery care in their communities.

Medicaid is the thread that ties rural maternity care together. It pays for 47% of rural births, compared with 41% nationally. One in three hospitals that provide inpatient maternity care to Medicaid enrollees is rural, and these hospitals are typically more than 40 minutes from the next in-state option. Federal Medicaid financing changes enacted in 2025 are expected to add pressure on these units. When one closes, a rural mother's drive gets longer, but her needs stay the same.

Let me tell you about one of our families. She lives in New Castle, in Lawrence County, one of the 48 counties this Center classifies as rural. Her family had moved from out West and had no relatives nearby. The hospital near her home could not accommodate her family's needs: if she went into labor in the evening, her husband would have had to drop her off and leave to care for their six-year-old son. Her mother could not come either; her mother's husband passed away the week before the baby was born.

Late in her pregnancy, she transferred her care to The Midwife Center, more than an hour from home. With a doula on her team, her husband and son could both be with her. Early labor brought her to us, then stopped after about 14 hours, so together we decided she should go home. Halfway there, labor came back hard. As her husband drove her back, our midwife stayed on the phone with

her the entire way, coaching her through every contraction. Our staff met her at the door with a wheelchair. She was fully dilated and ready to push.

In her words: “There is no way a hospital would have been on the phone with me the entire time, ready and waiting with a wheelchair.” And: “It was farther away than the hospital and I feel like more places like that should exist so women can have more control over their birth experience.”

Her story holds every theme of this testimony: a rural family, a long drive, needs the nearest system could not meet, wrap around midwifery care, and a safety plan that held up mile by mile.

Maternity care deserts and the distance rural families travel

About 1 in 10 Pennsylvania counties is a maternity care desert, and those deserts sit mostly in rural areas. A desert is a county with no hospital offering obstetric care, no birth center, and no obstetric provider at all.

The wider gaps are larger still:

- **25%** of Pennsylvania counties lack the full range of maternity care, affecting about 200,000 families a year.
- **12.4%** of Pennsylvania women have no birthing facility within 30 minutes of home, compared with 9.7% nationally.
- **15.6%** of Pennsylvania birthing people receive inadequate prenatal care.
- More than 100 hospital obstetric units have closed nationwide since 2022, and rural units close first.

Distance is not only an inconvenience. Families who live farther from a birthing hospital have worse outcomes for both mothers and babies.

We see this every day at The Midwife Center. Every week, women travel to our Pittsburgh center from Erie, Altoona, Johnstown, Fayette County, Lawrence County, West Virginia, and Ohio. They drive past closer options because they want midwifery care, and in many of their home communities care simply does not exist.

Midwives are primary care providers, not only birth attendants

Most people picture a midwife at a birth. In practice, birth is a small share of what we do. A midwife can be a rural woman's main health care provider for her whole life. At The Midwife Center, our midwives:

- Manage thyroid disease, high blood pressure, and high cholesterol
- Provide annual exams, cancer screening, and preventive care
- Provide full gynecologic care, contraception, and IUD and implant placement
- Test for and treat sexually transmitted infections
- Prescribe medications and order labs and ultrasounds
- Care for newborns through their first 28 days

Midwives also work across settings. About 98% of midwife-attended births happen in hospitals, and midwives attend more than 30% of births in rural hospitals. A midwife workforce strengthens the hospitals rural communities already have; it does not compete with them.

This matters because the obstetric physician workforce is shrinking. Federal projections show OB-GYN supply falling 7% by 2030 while demand rises 4%. Midwives can take on low- and moderate-risk care so physicians can focus on high-risk pregnancies and surgery.

Midwives are also cost-effective primary care. One midwife can manage a woman's annual exams, chronic conditions, gynecology, pregnancy, and her newborn's first weeks — care that would otherwise be split among several providers and settings. Midwifery education also costs less and takes less years than medical school, so new midwives are ready to fill rural gaps.

Better outcomes at lower cost

In the birth center model, the true exemplar of the midwifery model in the United States, better outcomes and lower costs go together. The strongest evidence comes from the federal CMS Strong Start initiative. It followed about 46,000 Medicaid recipients across 47 birth centers in 22 states, including ours.

Women who received prenatal care in the birth center model had better outcomes no matter where they eventually gave birth, including in a hospital. They had lower rates of preterm birth, low birthweight, and cesarean birth, across racial and ethnic groups. Savings came to about \$2,000 per mother–baby pair for each episode of care.

National birth center data show the same pattern:

- A cesarean rate of about 9–10%, roughly one-third of the 32% national rate
- 93% spontaneous vaginal birth among women admitted in labor
- 90–96% breastfeeding at discharge, regardless of insurance
- Emergency transfers to a hospital under 2%

Those savings are real money for Pennsylvania payers. Every cesarean and every preterm birth we help prevent avoids hospital, surgical, and NICU costs. Preterm birth alone costs the U.S. health system an estimated \$26 billion a year. One estimate looked at a year of births covered by Pennsylvania Medicaid managed care organizations (MCOs). If every Pennsylvania family receiving Medicaid started care in a freestanding birth center, the savings from safely avoided cesarean births alone would be \$36,833,000. At The Midwife Center, our care saves insurers millions of dollars every year.

A community-based model built for rural families

Community-based midwifery care is built around the whole person and the place she lives. That is why it fits rural Pennsylvania. I will use our care model at The Midwife Center as an example.

A safety plan for every family who travels. When a patient lives up to two hours away, we build an individual safety plan with her. It covers which hospital is closest, when to leave for labor, how weather affects the drive, and what to do in an emergency. Distance is planned for, not ignored.

A full picture at intake. We screen every patient for financial, physical, mental, and spiritual safety. Community health workers on our staff connect families to food, housing, transportation, and behavioral health support. In rural areas these needs are often what decide whether a mother keeps her appointments.

Time with each patient. Our shortest visit is 20 minutes, and many are longer. That time is how we catch concerns like depression, substance use, and high blood pressure early. But much of it is not reimbursed. Insurers pay for a brief visit, and the rest of the care is absorbed by the center. This unpaid time is a structural gap, and it is one reason birth centers struggle to survive.

Integration with hospitals is non-negotiable

A birth center cannot succeed on its own. It is safe because it is part of a system. That means hospital partners who are willing to consult and collaborate with our midwives, accept transfers smoothly, and run transfer drills with us so that everyone knows their role before an emergency happens.

The national record shows what integration makes possible: zero maternal deaths across more than 26,000 birth center admissions, and emergency transfers under 2%.

For rural Pennsylvania, the lesson is clear. Placing a birth center in a maternity care desert is not enough. Rural communities need willing hospital teammates — obstetricians, emergency departments, and transport services that see midwives as partners. Without them, a new birth center is set up to fail.

Recommendations

Pennsylvania has made real progress. Act 14 of 2026 will license certified midwives. The state's \$193.3 million Rural Health Transformation award includes a Maternal Health Initiative to reopen labor and delivery units and expand birth centers. These recommendations would help that investment succeed.

1. **Build integration into rural maternity funding.** Make hospital consultation, transfer agreements, and joint drills a condition of Rural Health Transformation maternity grants. Support hospitals that partner with midwives and birth centers and hold those who don't accountable.
2. **Pay the model what it is worth.**
 - Pay birth centers fairly. Today they are paid a fraction of hospital rates for care of similar risk.
 - Add a newborn facility fee, so newborn monitoring and treatment are paid for.
 - Pay for visit time, community health worker services, and care coordination.
 - Explore bundled, episode-based payment for birth center care.
3. **Make Medicaid contracts work.** Require managed care plans to contract with licensed birth centers and midwives on fair terms, and enforce it.
4. **Remove policy barriers.** Finish Act 14 regulations quickly which will modernize collaborative agreement requirements, allow midwives to prescribe medication for opioid use disorder

and help hospitals and birth centers prepare to integrate certified midwives into their teams, expanding the pool of available midwifery candidates.

5. **Grow the rural workforce.** Fund scholarships, loan forgiveness, and incentives for midwives who practice in rural areas and birth centers.
6. **Address liability costs.** Explore options such as a risk pool, since rising malpractice premiums threaten small birth centers.

Closing

Rural families are not asking for something new. They are asking for what every family wants: safe, respectful care close to home. Midwives can provide it at lower cost and with strong outcomes. The families driving two hours to reach us show the demand is already there.

With the right partners, fair payment, and sensible policy, we can bring that care closer to them. Thank you for your time and your commitment to rural Pennsylvania.

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