

Strengthening Maternity Care in Pennsylvania

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The case for sustained investment

Chair and members of the Committee:

Thank you for the opportunity to submit testimony regarding the future of maternity care in Pennsylvania. My name is Christina MacDowell, DNP, CNM. I serve as Chief Operating Officer and a Certified Nurse-Midwife at Wayne Memorial Community Health Centers (WMCHC), a Federally Qualified Health Center serving rural northeastern Pennsylvania.

I respectfully urge the General Assembly to establish sustained investment in rural and underserved maternity care, with explicit recognition of the capacity of FQHCs to organize comprehensive services, develop collaborative maternity teams, and preserve access across the lifespan. Funding should support both communities experiencing gaps in care and established programs demonstrating strong performance. Proven success should be a reason to invest before essential services become vulnerable.

The word midwife means “with woman.” That commitment has defined my career, including the privilege of serving women in the Pennsylvania community where I grew up. My perspective combines direct clinical care with executive responsibility for the workforce, partnerships, and financial resources that make that care possible. From both vantage points, the conclusion is clear: excellence requires a dependable system behind it.

Maternity access is essential community infrastructure

Pennsylvania’s 2025 Maternal Mortality Review Annual Report, examining deaths occurring in 2021, found that 41 of the 42 pregnancy-related deaths reviewed, or 98 percent, were classified as preventable. This designation means reviewers identified at least some chance that reasonable changes in patient, family, provider, facility, system, or community factors could have averted the death. It does not assign responsibility to a single individual or guarantee that a particular intervention would have prevented every death. It identifies substantial opportunities for improvement.[1]

The same report cites access data showing that 47.6 percent of rural women lived more than 30 minutes from a birthing hospital, compared with 11.9 percent of urban women.[1] Travel burden affects routine appointments and becomes particularly consequential during urgent evaluation, labor, or an obstetric emergency.

Service availability also depends on clinical coverage, adequate staffing, referral capacity, transportation, and a functioning receiving hospital. Preserving access requires investment in those connected responsibilities. A rural community with fewer births still requires a prepared maternity team, and the costs of readiness continue between patient encounters.

Pennsylvania should therefore recognize maternity services as essential community infrastructure. Reimbursement for individual visits and deliveries must be complemented by support for the staffing, preparedness, and coordination required to keep services dependable.

The WMCHC model and reported outcomes

At WMCHC, we have built maternity infrastructure around the needs of our community. Our continuum connects prenatal care, ultrasound, behavioral health, nutrition, delivery, postpartum services, lactation, primary care, and pediatrics. Certified Nurse-Midwives, family physicians, OB/GYN physicians, nurses, and support professionals work together, with maternal-fetal medicine expertise when needed. We serve women regardless of their ability to pay.

Our reported program outcomes include a primary cesarean section rate of approximately 7 percent, first-trimester entry into prenatal care of approximately 90 percent, and a low birth weight rate of approximately 8 percent. Very low birth weight babies are exceptionally rare in our program. These figures are program measures supplied for this testimony; they should be interpreted within the patient population served and should not be treated as risk-adjusted comparisons with other institutions.

These results support a compelling case for sustaining the clinical and operational capacity behind them. They also warrant continued measurement, review, and improvement. Public investment should help successful programs preserve their performance and share their experience, while maintaining appropriate attention to case mix, reporting definitions, and clinical complexity.

The relationships behind our care are equally important. We know our patients' names, their children's names, and the sports their children play. We understand the responsibilities they carry and the barriers that can interrupt care. When an appointment is missed, a team member notices. When a patient reports that something feels wrong, someone listens. When she needs help, she has a trusted place to turn.

Our relationship begins before pregnancy and continues as families grow and women's needs change throughout their lives. That continuity depends on the whole team: scheduling staff, nurses, clinicians, care coordinators, and the professionals supporting behavioral health, nutrition, and lactation. Their daily work converts access into a reliable patient experience. This is community health at its best.

Recognizing the distinctive capacity of FQHCs

FQHCs offer Pennsylvania an established platform for strengthening maternity care. They bring community relationships, integrated clinical services, care coordination, and a commitment to patients facing financial and geographic barriers. Investment can build on existing capacity while helping organizations address the additional requirements of maternity services.

An important component of that platform is the Federal Tort Claims Act (FTCA) Health Center Program. Eligible Health Center Program award recipients and subrecipients that receive federal deeming, together with eligible covered individuals, may receive federal medical malpractice liability protections for qualifying services within the scope of deemed employment and the approved scope of project. FQHC designation alone does not confer this protection on every organization or service. HRSA identifies reducing or eliminating malpractice premium expenditures for covered services as a purpose of the program, making more resources available for patient care.[2]

Pennsylvania should recognize this existing federal investment when developing its maternity strategy. Properly structured maternity services through eligible, deemed health centers can use an established liability framework alongside state investment in workforce, clinical capacity, and coordination. This offers a

practical opportunity to strengthen recruitment and sustainability without requiring the Commonwealth to create an entirely new protection mechanism.

HRSA's policy manual recognizes that covered clinicians may follow health center patients into local hospitals to maintain continuity of care when the services are within the health center's approved scope of project and the individual's scope of employment. It also addresses qualifying obstetrical supervision during delivery. These provisions are directly relevant to coordinated prenatal and hospital maternity models.[3]

Coverage must be evaluated for the actual arrangement. A health center's deeming does not automatically extend protection to a partner hospital, its independent personnel, every contracted clinician, or every patient seen on hospital call. Teaching, resident supervision, services to non-health-center patients, and proposed birth center operations require careful review of applicable federal requirements. Separate coverage remains necessary for activities and participants outside FTCA protections.[3]

I recommend that Pennsylvania fund technical assistance to help participating FQHCs and partners align proposed maternity services with HRSA scope requirements, eligible employment or contracting arrangements, credentialing, hospital agreements, and appropriate supplemental coverage. Where federal clarification or a particularized coverage determination is needed, the Commonwealth should support that process rather than assume that a partnership is covered.

This opportunity must remain anchored in patient safety. Annual deeming requires evidence of credentialing, quality assurance, and risk management. HRSA's requirements address ongoing risk assessment and staff training, including obstetrical procedures.[4] State investment should reinforce that infrastructure through simulation, emergency drills, reliable escalation, and coordinated review of maternal and newborn outcomes.

Leveraging FTCA means making effective use of a federal resource within its established requirements. It does not fund the staffing, equipment, or hospital readiness needed to deliver care. Those responsibilities require a complementary state commitment.

Building a sustainable maternity workforce and regional system

Pennsylvania should invest in collaborative teams that include Certified Nurse-Midwives, appropriately trained family physicians practicing obstetrics, OB/GYN physicians, nurses, and specialty support. Clinical responsibilities must reflect competence, credentialing, applicable law, patient risk, and the capabilities of the care setting.

Midwifery is maternity care. Supporting midwifery education, rural clinical placements, preceptors, and retention can help communities develop a lasting workforce. Family medicine obstetric training and advanced training pathways can similarly strengthen continuity for women and families. Investment should support dependable clinical coverage and working conditions that allow clinicians to remain in rural practice.

Regional networks must preserve access to hospitals capable of operative delivery and managing complications. Pennsylvania should also support appropriately integrated birth centers for selected low-risk patients, with ongoing risk assessment, qualified staff, emergency readiness, physician and hospital collaboration, and dependable transfer pathways. Authorization alone will not establish a sustainable service; planning, capital, operating support, and reimbursement must be addressed.

FQHCs can help anchor these networks through local prenatal and postpartum services and continuing relationships with patients. The goal is a coordinated system in which changing risk leads promptly to the appropriate level of care, with clear responsibility for consultation, communication, and transfer.

Funding success and protecting the financial foundation

Programs delivering strong results can become less visible when funding is concentrated on responding to closures or correcting failure. Successful performance does not eliminate the costs of maintaining access. It should strengthen the case for preserving a proven community resource.

Pennsylvania should create funding pathways that recognize demonstrated outcomes alongside community need, travel burden, service availability, workforce vulnerability, and the cost of sustaining essential services. Grant criteria should accommodate both service preservation and responsible expansion. Multiyear support would allow organizations to recruit, retain, and plan with greater confidence.

The 340B Drug Pricing Program is also part of the financial infrastructure supporting safety-net services. For our organization, protecting the resources that help maintain care is integral to maternity sustainability. Direct investment and protection of existing resources should proceed together.

HRSA's revised 340B Rebate Model Pilot allows approved manufacturers to implement rebates for selected drugs, with listed approved plans scheduled to begin January 1, 2027. The model changes the timing and administration of obtaining the 340B price for affected transactions; it does not replace upfront discounts for all drugs.[5] The potential cash-flow and administrative effects deserve attention when assessing safety-net capacity.

I ask Pennsylvania to evaluate available state protections and advocate federally for reliable, timely access to 340B benefits. Policies affecting safety-net financing should be assessed for their consequences for staffing, community services, and patient access. Preserving these resources complements the use of FTCA protections and sustained state funding.

Recommended legislative action

I respectfully recommend that the General Assembly pursue the following priorities:

1. Establish dedicated, multiyear funding for rural and underserved maternity infrastructure, including clinical readiness, workforce stability, prenatal and postpartum access, and care coordination.
2. Explicitly recognize FQHCs as eligible partners in maternity preservation and expansion initiatives, with funding criteria that value strong performance alongside documented community need.
3. Support responsible use of FTCA protections through technical assistance, federal scope and coverage review, and well-defined hospital and regional partnership arrangements.
4. Finance midwifery education, family medicine obstetric training, rural preceptorships, loan repayment, and retention strategies tied to community service and safe clinical practice.
5. Preserve rural hospital maternity capacity and support appropriately integrated birth centers and regional networks with practiced emergency and transfer arrangements.
6. Protect safety-net financial resources, including 340B, while requiring meaningful reporting on access, quality, workforce retention, and the use of public funds.

Accountability should be built into these investments. Performance measures should use clear definitions and reporting periods and include timely prenatal access, postpartum follow-up, maternal and newborn outcomes, patient experience, workforce stability, and preparedness. Measures should account for clinical risk and avoid discouraging programs from serving patients with complex needs.

Closing statement

WMCHC has built something worth preserving and worth learning from. Our reported outcomes and our longstanding relationships demonstrate the value of a community maternity team. We welcome the opportunity to share that experience and to demonstrate how investment sustains access and quality.

I have held women's hands through labor and cared for families through moments of uncertainty and joy. I have seen the reassurance that comes when a patient knows her clinician, the team communicates, and someone answers the phone who knows her name. That trust takes years to build. It deserves a future.

I ask the Commonwealth to invest while these teams are in place, while their community relationships are strong, and while their doors remain open. Preserve excellence, develop the workforce, and use the federal and state resources available to build a dependable maternity system for Pennsylvania's future.

Every mother deserves access. Every baby deserves a safe beginning. Every community deserves a maternity system it can depend on.

Thank you for the opportunity to submit this testimony and for your commitment to Pennsylvania's mothers, babies, and families.

References

[1] Pennsylvania Department of Health. 2025 Pennsylvania Maternal Mortality Review Annual Report, deaths occurring in 2021, pp. 24 and 35. <https://www.pa.gov/content/dam/copapwp-pagov/en/health/documents/topics/documents/programs/2025%20MMR%20Report.pdf>

[2] HRSA Bureau of Primary Health Care. What is the Federal Tort Claims Act. <https://bphc.hrsa.gov/compliance/ftca/what-ftca>

[3] HRSA. Federal Tort Claims Act Health Center Policy Manual, sections C.5.1 through C.5.3. <https://bphc.hrsa.gov/sites/default/files/bphc/compliance/ftcahc-policy-manual.pdf>

[4] HRSA. Health Center Program Compliance Manual, Chapter 21, Federal Tort Claims Act Deeming Requirements. <https://bphc.hrsa.gov/compliance/compliance-manual/chapter21>

[5] HRSA. 340B Rebate Model Pilot Program, reviewed October 2026. <https://www.hrsa.gov/opa/340b-model-pilot-program>

WMCHC outcome figures and descriptions of local services and experience are supplied by Christina MacDowell for this testimony.