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Leonard Davis Institute of Health Economics

Optimizing Health Care for the Maternal-Infant Dyad

An Evidence-Based, Policy-Oriented Summary

Prepared for Senator Maria Collett, 12th Senate District, Pennsylvania • March 2026

This brief summarizes the peer-reviewed research of the Scott Lorch–led health services research group, whose work spans health care access, delivery, utilization, and policy for the maternal-infant dyad. The overarching finding is clear: **Pennsylvania must prioritize policies that remove barriers, increase access, and ensure financial sustainability** for (1) the health care systems that serve birthing people and infants, (2) the perinatal workforce, and (3) public benefits proven to improve maternal and infant outcomes. After summarizing policy recommendations for the short, medium, and long term, the following two sections focus on health care and the final section on broader drivers of health, community conditions, structural racism, housing, and the environment, which are equally consequential (section 3).

Policy Recommendations

Pennsylvania can improve maternal–infant health by stabilizing access to obstetric and postpartum care and increasing integration of community-based supports. Near-term priorities include protecting hospital capacity, sustaining comprehensive postpartum coverage, and advancing policies that promote culturally responsive care. Over time, the state should consider opportunities to support and expand the perinatal workforce, reform reimbursement and oversight structures, and leverage policy to address social drivers of health. Long-term investments in coordinated regional systems and sustainable financing mechanisms will be essential to ensure equitable, high-quality care for mothers and infants across the state.

Short term

- Identify hospitals at high risk of closure for targeted state support
- Learn from successful doula-integration programs across the state
- Partner with community-based organizations to overcome barriers to doula engagement
- Educate and train health care staff on immigrant rights and culturally congruent care.
- Continue Pennsylvania's 12-month postpartum Medicaid extension
- Maintain coverage for Medicaid services
- Support the PA MOMNIBUS 2.0 legislative package

Medium term

- Strengthen hospital reimbursement policies that protect obstetric service availability
- Enhance oversight of hospital acquisitions and closures
- Improve doula credentialing and oversight to support professionalization
- Remove barriers to credentialing and certification for mental health providers
- Support innovative staffing models and expanded scope for certified nurse-midwives, nurse practitioners, and physician assistants
- Expand access to evidence-based remote patient monitoring and telehealth with appropriate reimbursement
- Ensure contraception coverage to prevent short interpregnancy intervals
- Advance inclusionary zoning

- Update Pennsylvania's Qualified Allocation Plan for affordable-housing development to prioritize pregnant people and families with young infants.
- Consider postpartum carve-outs through 12 months to shield this high-risk population

Long term

- Formalize regionalized perinatal care
- Create workforce-pipeline incentives for doulas
- Develop innovative care-delivery and treatment models for postpartum individuals
- Improve reimbursement for multidisciplinary care that includes mental health services
- Pursue legislation to mitigate malpractice-insurance costs
- Strengthen private-insurance regulation
- Advance a state-based tax to fund paid family leave

1. Improving Access to Perinatal Care

1.1 Childbirth Unit Closures, Risk-Appropriate Care, and Rural Health

Access to hospital-based childbirth care continues to decline. Between 2010 and 2022, 238 rural and 299 urban hospitals nationwide lost childbirth services (Kozhimannil 2024). Pennsylvania has been one of the hardest-hit states, losing 31 hospitals with childbirth services—a 27.7% decline—with 46.2% of rural hospitals losing these services in that period (Kozhimannil 2024; Kozhimannil 2025). Closures are most frequent among small, rural hospitals facing high fixed costs, lower volume, and a greater share of Medicaid patients whose reimbursement rates fall below the cost of care.

The goal of risk-appropriate care is to match patient and infant clinical needs with hospital capabilities (Lorch 2012). For complex cases, higher-level subspecialty care—typically in urban centers—improves outcomes, yet among rural residents who need the highest level of care, only about one quarter receive it, with distance being the primary barrier (Osei-Poku 2024; Handley 2025).

Adverse outcomes are disproportionately concentrated in rural communities, which experience higher rates of maternal morbidity and both term and preterm infant mortality (Kozhimannil 2019; Ehrenthal 2020; Bourque 2025). When childbirth units close, travel time to the nearest hospital with services increases by an average of 29 miles, and rates of emergency department birth and preterm birth rise (Hung 2016; Kozhimannil 2018). In the postpartum year, rural birth parents are less likely to see an obstetrician-gynecologist and more likely to rely on acute care (Handley 2025a).

Policy Recommendations

Identify hospitals at high risk of closure for targeted state support. Strengthen hospital reimbursement policies that protect obstetric service availability, particularly in rural settings. Formalize regionalized care through transfer networks and reimbursement for maternal and neonatal transport before birth. Support innovative staffing models and expanded scope for certified nurse-midwives, nurse practitioners, and physician assistants. Pursue legislation to mitigate malpractice-insurance costs.

1.2 Maternal Mental Health

Maternal mental health conditions—including perinatal anxiety and depression—affect one in five birthing people and are the leading cause of pregnancy-related death, with nearly all such deaths preventable. Black, Latina, and Indigenous birthing people experience significantly higher rates of

conditions such as postpartum depression, and only a minority of birthing people are screened or offered treatment (Policy Center for Maternal Mental Health 2025). Governor Shapiro has called for universal postpartum depression screening and faster mental health referrals, signaling state-level momentum on this issue.

Policy Recommendations

Remove barriers to credentialing and certification for mental health providers. Develop innovative care-delivery and treatment models for postpartum individuals, given that screening is improving. Improve reimbursement for multidisciplinary care so that mental health services can be provided alongside gynecologic and pediatric care.

1.3 Advancing Postpartum Support with Innovative Models of Care

Doula support across the care continuum: Research demonstrates that Medicaid enrollees with doulas had a 47% lower risk of cesarean delivery, a 29% lower risk of preterm birth, and were 46% more likely to attend a postpartum visit (Ogunwole 2022; Falconi 2024). Despite proposed legislation, Pennsylvania has not yet enacted Medicaid coverage for doula care. In a first-of-its-kind randomized trial, Burris and colleagues tested doula-coordinated postpartum care at the NICU bedside for mothers of hospitalized infants—a high-risk population reluctant to leave their babies. Mothers in the intervention group received care 20 days earlier and had more complete visits (Burris 2025).

Remote monitoring for hypertensive disorders: Hypertensive disorders are a leading cause of maternal morbidity and mortality. Researchers at Penn have pioneered text-based home blood-pressure monitoring for postpartum women (Hirshberg 2018), work that directly supports House Bill 1234 mandating Medicaid coverage for blood pressure monitors.

Paid family leave: Guaranteed pay during leave has been shown to improve perinatal outcomes, including decreased infant mortality (Montoya-Williams 2020).

Policy Recommendations

Learn from successful doula-integration programs across the state. Improve doula credentialing and oversight to support professionalization. Partner with community-based organizations to overcome barriers to doula engagement. Create workforce-pipeline incentives, such as embedding doula training in nursing and allied health education. Expand access to evidence-based remote patient monitoring and telehealth with appropriate reimbursement. Advance a state-based tax to fund paid family leave.

2. Supporting Health Care Finances

2.1 Medicaid and Postpartum Extension

All states except Wisconsin and Arkansas have extended Medicaid coverage to 12 months postpartum; Pennsylvania's extension took effect April 1, 2022. Before these policies, postpartum individuals who no longer met the stricter non-pregnancy Medicaid criteria churned off coverage—often into uninsurance. Continuous insurance increase recommended prenatal, birth, and postpartum care utilization (Admon 2021). Early evidence shows postpartum extension has increased Medicaid-financed care for contraception, primary care, mental health, and substance use disorders, with a significant increase in treatment for perinatal mood and anxiety disorders (Gordon 2024; Swatz 2025). Both the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine endorse 12-month postpartum extension as a core component of comprehensive postpartum care (American College of Obstetricians and Gynecologists 2018; Society for Maternal-Fetal Medicine 2024).

2.2 Hospital Financial Health

A quarter of rural hospital leaders report uncertainty about sustaining obstetric services, even though 65% prioritize community need over profit (Kozhimannil 2022). Hospitals with weaker financial health provide fewer obstetric and neonatal services (Salazar 2025).

2.3 Private Equity

Private equity ownership has been a growing presence in women's health practices (Bruch 2020); however, the impact on patient outcomes remains unknown. Private equity acquisition of acute care hospitals has been associated with decreased access to newborn and pediatric care as well as access for birthing parents on Medicaid (Jiao 2025; Goldstein Novick 2026, Under Review).

Policy Recommendations

Continue Pennsylvania's 12-month postpartum Medicaid extension even amid potential federal Medicaid reductions. Maintain coverage for Medicaid services despite declining reimbursement. Consider postpartum carve-outs through 12 months to shield this high-risk population from potentially harmful policy changes. Ensure contraception coverage to prevent short interpregnancy intervals. Strengthen private-insurance regulation. Enhance oversight of hospital acquisitions—particularly by private equity–funded corporations—and of hospital liquidations and closures.

3. Communities, Environment, and Structural Drivers of Health

We have extensively documented how structural drivers—including the built environment, housing policy, and neighborhood conditions—shape maternal and infant health and drive disparities. Research demonstrates health benefits from neighborhood walkability (Kash 2023) and tree canopy during pregnancy for cardiovascular (Nguemeni Tiako 2023) and mental health (Nguemeni Tiako 2021). Conversely, neighborhood deprivation and community vulnerability are harmful to perinatal and infant health (Dolin 2023; Salazar 2023; Murosko 2024).

Housing and segregation: Infants born to individuals living in segregated communities face greater risk of preterm birth, complications of prematurity, and death—magnified among Black birthing people (Murosko 2020). Pittsburgh and Philadelphia remain highly segregated. Well-intentioned neighborhood revitalization can paradoxically widen inequities: the group's research links gentrification-driven increases in housing costs to elevated infant mortality risk (Murosko 2024a). Stable, affordable, high-quality housing is a key driver of health during pregnancy and early life.

Immigrant health: Immigrants, including pregnant individuals, underutilize recommended care due to fears about punitive immigration policy. Culturally congruent perinatal care—including clinician training, confidentiality assurance, and interpreter access—can improve engagement (Montoya-Williams 2024).

Black birthing people: Black birthing people are more than twice as likely to die from pregnancy-related causes as White birthing people and disproportionately experience morbidity, mistreatment, and delivery in lower-quality hospitals (Howell 2016; Wang 2021). In Pennsylvania, the maternal mortality rate is 17.5 per 100,000 births; Black birthing people are twice as likely as White birthing people to experience pregnancy-associated death, and the preterm birth rate among Black birthing people is 1.4 times higher than for all other infants.

Policy Recommendations

Update Pennsylvania's Qualified Allocation Plan for affordable-housing development under the recently expanded LIHTC program to prioritize high-opportunity areas and pregnant people and families with young infants. Advance inclusionary zoning to increase affordable housing supply in high-opportunity neighborhoods. Educate and train health care staff on immigrant rights and culturally congruent care. Support the PA MOMNIBUS 2.0 legislative package to address racial disparities in maternal outcomes.

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