EVERY MOTHER COUNTS

When Systems Falter, Invest in What Holds:

Community-Based Organizations as Critical Maternal Health Infrastructure

EVERY MOTHER COUNTS' ANALYSIS OF H.R. 1

MAY 2026

EXECUTIVE SUMMARY

The U.S. is in the midst of an ongoing maternal health crisis, with the worst maternal mortality rate of any high-income country and stark inequities in outcomes and experiences of care. Medicaid is essential to advancing maternal health in this country, as millions of families rely on the program for healthcare coverage during the perinatal period (before, during, and after pregnancy).

Passed in July 2025, H.R. 1, also called the "One Big Beautiful Bill Act", enacts the largest cuts to Medicaid in the program's 60-year history. Medicaid is a lifeline for millions of women and families throughout the perinatal period in the United States, financing a substantial share of births nationwide and an even greater share for communities impacted by the starkest inequities in maternal health outcomes and experiences of care, including Black women, American Indian/Alaska Native (AI/AN) women, women living in rural areas, and women experiencing displacement. As Medicaid becomes more fragmented, families will face worsening challenges around care continuity and affordability that threaten health outcomes and experiences of care.

> "Even though we are not directly reimbursed by Medicaid, we are deeply entangled in the consequences of its erosion."
>
> NATIONAL ASSOCIATION TO ADVANCE BLACK BIRTH

While the bill does not directly cut funding for Medicaid coverage during pregnancy, it introduces structural barriers, such as work requirements, more frequent eligibility redeterminations, and narrower eligibility criteria that are expected to drive coverage loss and instability for families during the perinatal period. These changes will disproportionately harm those already most impacted by maternal health inequities.

When formal systems become overburdened or fall short, community-based organizations (CBOs) act as an increasingly critical resource, offering trusted, culturally grounded care, facilitating access to services, maintaining continuity, and providing essential support for families — often without commensurate increases in funding or support.

The pressures introduced by H.R. 1 are likely to increase demand for the services of CBOs while simultaneously destabilizing the funding streams they rely on to operate.

This brief is designed to help funders in the maternal health ecosystem interpret, anticipate, and respond to the impacts of the bill on pregnant women, families, and the CBOs at the forefront of the care ecosystem. It integrates policy analysis with on-the-ground perspectives from CBOs to root these implications in real-time insights and experiences.[1]

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1 This report includes quotes from community-based organizations throughout to ground the policy analysis in real experiences, expertise, and insights from those leading this work.

We are grateful to all of Every Mother Counts' grantee partners that have shared their reflections with us and to those that have given us permission to amplify them in this report.

WHAT COMMUNITY-BASED ORGANIZATIONS (CBOS) ARE EXPERIENCING:

The examples below are illustrative, not exhaustive, and reflect common patterns and concerns emerging across community-based organizations in the months following the passage of H.R. 1.

System-level changes are driving new pressures: Many of the operational and financial challenges CBOs are navigating are not isolated but rather reflect broader system strain, coverage instability, and rising community need, which has shifted both responsibility and risk onto community-based care.

Demand is increasing faster than capacity: As coverage gaps widen and access to care becomes more fragmented for families, services are harder to access, less coordinated, and more frequently interrupted. At the same time, CBOs are experiencing growing demand for services without corresponding increases in funding, staffing, or infrastructure, and often without timely access to the resources needed to respond in real time.

There is a greater need to communicate evolving realities: Because they are closest to communities, CBOs are often the first to see, interpret, and sound the alarm on both the foreseen and unforeseen impacts of policy and ecosystem changes, but are often inadequately resourced to communicate these insights to broader audiences.

Planning is under sustained uncertainty: Organizations are navigating complex planning environments, balancing immediate service delivery with longer-term scenario planning as policy changes unfold and community needs evolve.

RECOMMENDATIONS FOR FUNDERS

For funders, this moment calls for both near-term stabilization and longer-term systems investments that help maternal health models endure.

We highlight four priority areas for action, recognizing that while philanthropy can play a catalytic role, it cannot substitute for sustained public financing in the long run. That said, there are key opportunities for funders to respond in this moment. The urgency of these recommendations reflects what community-based organizations are already experiencing in practice.

> This is not just a policy issue, it [this bill] is creating and exacerbating a public health crisis.
>
> AZA NEDHARI, PRESIDENT & CEO, MAMATOTO VILLAGE (WASHINGTON, D.C.)

1. Stabilize and Sustain Critical Infrastructure

- Recognize CBOs as essential maternal health infrastructure and reflect that role in portfolio strategy and commitments, rather than positioning them as supplemental or short-term service providers, especially during periods of coverage and safety-net instability.
- Recognize where policy shifts, reimbursement instability, and local budget cuts may place community-based organizations at heightened risk of service disruption, workforce loss, or closure, and plan proactively to stabilize critical infrastructure.
- Provide flexible, multi-year funding when possible, including stabilization and general operating support that protects organizational sustainability.
- Respond quickly to emerging needs, including bridge resources when reimbursement disruptions or coverage churn (frequent loss and re-enrollment in health insurance) increase demand for services.

2. Reduce Burden and Strengthen Organizational Capacity

- Reduce administrative burden and streamline reporting expectations so CBOs can prioritize service delivery.
- Invest in organizational capacity, including leadership, operations, technology, and financial systems, to help CBOs navigate sustained system changes and remain resilient over time.
- Invest in communications capacity so CBOs that want to engage in this work can document, interpret, and share real-time insights from communities, strengthening the field's ability to respond to emerging needs and policy impacts.

3. Invest in Workforce Sustainability and Wellbeing

- Invest in workforce sustainability, including fair compensation, benefits, retention supports, and practices that center care for community-based providers, and support the conditions needed for them to sustain their work over time.

A lactation specialist educates new mom Mia on breast pump usage as baby Abeni watches at Mamatoto Village in Washington, D.C. (Bonnie-Love Douglas, 2025)

4. **Support Systems Change and Long-Term Sustainability**

    - Support grantee partners' capacity to engage in policy and advocacy efforts that influence the long-term sustainability of the maternal health public funding and policy landscape, and where appropriate, align with or participate in those efforts.
    - Resource partners and the broader field to come together, identify shared priorities, and organize toward longer-term system solutions, particularly as services are reduced or lost.

THIS BRIEF IS ORGANIZED IN THREE SECTIONS

1. **Threats to Access & Coverage,** including coverage instability, affordability challenges, and risks to rural care access;

2. **Threats to Emerging Maternal Health Solutions,** including risks to postpartum coverage, workforce investments, and evidence-based models of care; and

3. **What H.R. 1 means for CBOs,** including rising demand, financial instability, and strain on care delivery systems.

It concludes with a timeline of H.R. 1's key policy changes and when they will take effect, to help anticipate how impacts may unfold, along with a list of external resources.

Midwife Rachel Voigt treats new mom Demetria in a clinic room at Roots Community Birth Center in Minneapolis, Minnesota. (Gather Birth Cooperative, 2023)

INTRODUCTION

Despite spending more per capita on healthcare than any other country in the world, the United States continues to have the highest maternal mortality rate of any high-income country. Racial inequities remain rampant, with Black and American Indian/Alaska Native (AI/AN) women being 3-4x more likely to die from complications of pregnancy and birth in the U.S. than their white counterparts. There are several systems-level factors that contribute to poor maternal health outcomes and experiences of care, including service delivery challenges, workforce shortages, discrimination, and lack of accountability.

Since the passage of H.R. 1 (also known as the "One Big Beautiful Bill Act") in July 2025, maternal health advocates, providers, and community-based organizations (CBOs) have been raising concerns about its anticipated impact on access to and delivery of care. Even though many of its provisions have not yet taken effect or are relatively new, the bill has had an immediate impact. Community-based organizations providing maternal and reproductive healthcare and support are already experiencing uncertainty, constrained resources, and growing community needs—evidenced by factors like clinic closures and immigrant families being afraid to seek care—and are navigating this moment with care, creativity, and increasing strain.

As the effects of H.R. 1 begin to roll out, this brief is meant to offer funders in the maternal health ecosystem a reference point to interpret, anticipate, and respond to the impacts of the bill on pregnant women, families, and CBOs at the forefront of the care ecosystem.

THE MATERNAL HEALTH ECOSYSTEM AND COMMUNITY-BASED ORGANIZATIONS

In this brief, the term 'community-based organizations' (CBOs) encompasses a range of maternal health organizations that are embedded in the communities they serve. This includes organizations that may rely on Medicaid reimbursement, like freestanding birth centers, midwifery practices, or Medicaid-enrolled doulas, as well as organizations that generally do not bill Medicaid directly but assist families with coverage enrollment and systems navigation.

CBOs are often the most trusted and easiest to reach for families who face compounding structural barriers and heightened maternal health risks, including displaced women, women in rural areas, American Indian/Alaska Native (AI/AN) women, and Black women.

They guide families through complicated coverage and referral systems, offer culturally relevant perinatal and wraparound support, and keep care going when formal systems break down or are hard to access. Because they are close to the community, CBOs can often spot early signs of systemic problems before they appear in official data.

BACKGROUND

H.R. 1 outlines a comprehensive federal policy plan with significant implications for health coverage, safety net programs, and systems supporting pregnant families, including the largest cuts to the Medicaid program in its 60-year history. While the bill does not directly cut funding for Medicaid coverage during pregnancy, it introduces significant changes to Medicaid, Medicare, and the Affordable Care Act (ACA) that shape how pregnant and postpartum families access care. The restrictions and requirements it imposes, such as work requirements, more frequent eligibility redeterminations, narrower eligibility criteria, and specific penalties targeting states that have expanded Medicaid to cover more low-income adults, will result in families losing coverage during the perinatal period.

Medicaid is a lifeline for women and families across the country, particularly those facing the greatest inequities in maternal health outcomes and experiences of care: Black women, American Indian/Alaska Native (AI/AN) women, those residing in rural areas, and those experiencing displacement.

While Medicaid covers 41% of births across the country, the program finances nearly half of all births in rural areas (47%), nearly two-thirds of all births among Black women (65%), and more than two-thirds of births to AI/AN families (67.3%). As such, cuts to the Medicaid program will have far-reaching and harmful implications for families across the country and disproportionately impact those from communities that rely on the program most.

> We are concerned that the barriers (work requirements, re-enrollment, etc.) will result in more people who are uninsured, but that the impact probably won't be felt until 2027. We will be carefully monitoring as implementation plans are developed to understand and prepare for that impact.
>
> COMMUNITY OF HOPE (WASHINGTON, D.C.)

The following sections outline some of the key ramifications of H.R. 1 for pregnant women and families—with a particular focus on the communities most impacted by maternal health inequities in the U.S.—and for CBOs providing maternal healthcare and support.

We hope this brief is a trusted information source to help funders navigate this moment, support internal planning and funding decisions, and reinforce support for community-based maternal health organizations that care for and support families across the U.S.

SECTION 1

Threats to Access & Coverage

H.R. 1's cuts to the Medicaid program will have meaningful consequences for healthcare access and affordability. The threats named below highlight how administrative shifts in the bill may impact families' experiences getting the care they need.

Health insurance coverage becomes harder to afford and maintain for both providers and families, especially for those without employer coverage.

WHAT'S CHANGING?

Reductions to ACA premium subsidies, more frequent eligibility checks, and the loss of protections that help people stay enrolled will make it harder for people to afford and keep health insurance purchased through the Affordable Care Act marketplace, increasing financial strain for providers and families. These factors will contribute to reduced affordability, increased coverage instability (also known as insurance churn), and gaps in continuous coverage for maternity care providers and women throughout the perinatal period.

WHO IS MOST AFFECTED?

ACA instability will impact families, likely leading to loss of coverage for women before, during, and after pregnancy, and care continuity gaps between pregnancy-related and ongoing care. Structural challenges like lack of support for dynamic life circumstances (i.e., employment changes, family changes) leading to insurance churn already disproportionately affect people with lower incomes and Black, Hispanic, and AI/AN women, placing these groups at increased risk of bearing the brunt of further coverage barriers.

> "With over 1.7 million Texans projected to lose health coverage due to policy 'rollbacks', access to even basic prenatal and postpartum care is becoming increasingly difficult.
>
> LUNA TIERRA BIRTH CENTER (TEXAS)

Additionally, many perinatal professionals do not receive employer-sponsored insurance and rely on ACA premium subsidies to stay covered. As such, perinatal workforce trainees and new professionals may also face intermittent gaps in coverage while training or working in roles that lack traditional employment protections. These coverage gaps and barriers to accessing care could significantly affect the stability of the perinatal workforce.

H.R. 1 introduces significant threats to maternity care access in rural areas.

WHAT'S CHANGING?

With an average of more than two rural labor and delivery unit closures in the U.S. each month since 2020, several provisions in H.R. 1 may force additional hospitals to scale back or shutter their maternity care units, particularly in rural areas.

Experts estimate that provisions like work requirements and restrictive eligibility criteria, even with exemptions for pregnancy, will result in nearly 12 million people losing coverage over the next decade, leading to a substantial increase in the number of uninsured patients hospitals must care for without insurance reimbursement (an estimated "$83 billion in uncompensated care").

The final version of the bill does include funding for a "Rural Health Transformation Program," but health administration experts have questioned its structure and impact. As written, the program does not require the Centers for Medicare and Medicaid Services (CMS) to provide any funding to rural healthcare facilities, and the allocated funding is projected to end after five years, which is when many communities will begin bearing the brunt of cuts from H.R. 1. In addition, the Program's $50 billion of allocated funding is anticipated to make up just over 1/3 of the total loss of federal Medicaid funding for rural areas.

Despite the narrow application window leaving little time for states to prepare, all 50 states applied to be part of the Program, further demonstrating the overwhelming, country-wide need for investment in rural health.

> "Cuts to Medicaid will directly impact Changing Woman Initiative... However, the deeper impact will be due to the projected 6-7 rural hospitals [in the area] that will close their doors due to Medicaid cuts... The elimination of rural hospital services creates a huge impact to our capacity to serve families.
>
> CHANGING WOMAN INITIATIVE (NEW MEXICO)

WHO IS MOST AFFECTED?

A September 2025 analysis from the National Partnership for Women & Families found that 131 rural hospitals across the country with labor and delivery units are now at risk of closing because of H.R. 1. Additionally, the bill imposes federal funding penalties on states that have expanded Medicaid eligibility to

cover a broader group of low-income adults. As a result, expansion states with high rural populations, where more residents rely on Medicaid and providers depend heavily on that funding, are at even higher risk. These closures will exacerbate the maternity care desert crisis and disproportionately impact the approximately 40% of AI/AN communities that live in rural areas.[1]

People may delay or avoid seeking needed care or risk experiencing financial hardship due to uncovered medical expenses.

WHAT'S CHANGING?

Retroactive Medicaid enrollment enables individuals who qualify but are not yet enrolled to access care when they need it, and insurance covers it after the fact. Many individuals rely on retroactive coverage to support the cost of care in a variety of circumstances and regardless of immigration status, including medical emergencies during the perinatal period. H.R. 1 shortens the window for retroactive Medicaid coverage from three months to as little as one month, leaving more prenatal, delivery, and postpartum care uncovered when enrollment is delayed and ultimately shifting costs onto families.

WHO IS MOST AFFECTED?

When a person is removed from their home or forced to relocate, they are considered displaced.[2] This provision will disproportionately impact women facing displacement during the perinatal period.

People experiencing displacement often face disruptions in paperwork, insurance enrollment, and continuity of care. Because their lives are in transition, many rely on retroactive Medicaid enrollment to obtain coverage.

Women experiencing displacement during pregnancy and the postpartum period are especially likely to depend on this safety net, placing them at increased risk of delaying care or experiencing financial strain as a result of getting the care they need.

> "Because a large proportion of the communities we serve rely on Medicaid or no insurance at all, any changes to reimbursement rates, eligibility, or covered services pose a direct risk to access."
>
> COMMONSENSE CHILDBIRTH (FLORIDA)

1 Maternity care deserts are defined as areas with zero obstetric care providers or facilities. Every Mother Counts uses the term "maternity care desert" to align with national data sources; however, we acknowledge the limitations of the term. We are committed to further conversation around the use of language that more accurately reflects structural differences in access to care.

2 In the United States, displacement can occur due to rising housing costs and housing instability, policy shifts such as the rollback of tenant protections, and climate-related disasters. The U.S. is also home to many displaced communities seeking asylum or refuge from other countries.

H.R. 1 authorizes federal funding cuts to full-spectrum reproductive health centers that offer abortion care (like Planned Parenthood).

WHAT'S CHANGING?

H.R.1 prohibits federal Medicaid reimbursements from going to health clinics that are primarily engaged in family planning services, have previously received more than $800,000 in Medicaid funding, and provide abortion care. These criteria apply to several essential healthcare providers for Medicaid recipients across the country, including many Planned Parenthood clinics.

Federal Medicaid funding is already prohibited from covering most abortion care under the Hyde Amendment, so these additional cuts will only serve to further reduce Medicaid enrollees' access to services like cancer screenings, primary care, and contraceptive access.

As of December 2025, more than 20 Planned Parenthood clinics have been forced to close, and an additional 200+ health centers are at risk of closing or scaling back services. These closures will exacerbate existing barriers and inequities in accessing essential primary and reproductive healthcare.

> The changing political landscape, cuts to federal funding, and the loss of major healthcare providers and clinics in our region has made the field of reproductive justice work even more precarious and in some cases, criminalized. Safe spaces for Black and Brown birthing people are more vital than ever.
>
> Birthmark is inundated with requests and calls for support from Black and Brown clients and community members seeking safe and equitable reproductive healthcare options, and we continue to do our best to meet their needs, but the closure of clinics like Planned Parenthood have left a huge hole in our public safety net.
>
> BIRTHMARK DOULA COLLECTIVE (LOUISIANA)

WHO IS MOST AFFECTED?

Restricting access to the full spectrum of reproductive healthcare is linked to worse maternal health outcomes and disproportionately impacts those already facing the greatest inequities: Black women, American Indian/Alaska Native women, people of color, and low-income communities. Research shows that a mother's risk of dying is almost twice as high in states with abortion bans and nearly 60% of all Black women ages 15-49 live in states that have banned or are likely to ban abortion.

H.R. 1 introduces increased coverage restrictions for immigrant women and families throughout the perinatal period.

WHAT'S CHANGING?

The bill drastically narrows eligibility criteria for Medicaid enrollees who are immigrants, specifying that federal Medicaid dollars will only cover "U.S. residents, U.S. citizens, [and] people with permanent residence status," excluding groups like refugees and asylum seekers. The bill also restricts eligibility criteria for premium tax credits for immigrant communities with insurance through the Affordable Care Act (ACA) marketplace.

WHO IS MOST AFFECTED?

These provisions will disproportionately affect those who are undocumented, possess temporary protected status, are seeking asylum, or belong to mixed-status households. By narrowing eligibility and restricting retroactive coverage, H.R. 1 increases the risk of delayed prenatal care, disrupted postpartum coverage, and medical debt for families who already encounter significant barriers to continuous care.

Doula Jayne from Accompany Doula Care (Boston, Massachusetts) helps a mom feed her twins during a postpartum well visit. (Vanessa Prohodski, 2025)

SECTION 2

Threats to Emerging Maternal Health Solutions

There has been meaningful momentum to strengthen the Medicaid program to better meet the needs of mothers and families, including through expanding the types of services and care that is covered and for how long. Through the funding cuts it imposes, H.R. 1 puts these advancements at risk. This section outlines some of these advancements and what will be important to proactively protect.

Funding cuts in H.R. 1 pose threats to recent Medicaid advancements, like postpartum Medicaid extension.

More than two-thirds of all pregnancy-related deaths in the United States occur during the postpartum period (1-365 days after birth). Continuous healthcare access is needed for people to be able to heal after giving birth, receive lifesaving care in the case of postpartum complications, and access adequate physical and mental healthcare for themselves while they adapt to caring for their baby. The American Rescue Plan Act of 2021 created an option for states to extend pregnancy-related Medicaid coverage through the full postpartum year. As of April 2026, all but two states (48 states and Washington, D.C.) have adopted this change, ensuring that families who rely on Medicaid have access to healthcare coverage through that essential first year postpartum.

WHAT'S AT RISK?

While H.R. 1 does not prevent states from continuing to offer coverage through the full postpartum year, policy experts have sounded the alarm that postpartum Medicaid extension may become a budget pressure point for states facing reduced federal Medicaid contributions. Even if not formally rolled back, states may consider adopting administrative restrictions or eligibility barriers that reduce practical access to continuous postpartum care to fill the funding gaps imposed by the bill.

> "Many of our clients depend on Medicaid for their primary healthcare, and any reduction in coverage may increase their reliance on our programs for mental health support, basic postpartum supplies, and system navigation.
>
> SHADES OF BLUE PROJECT (TEXAS)

WHO IS MOST AFFECTED?

If postpartum Medicaid extension rolls back, families that fall into coverage gaps face increased risk of losing healthcare coverage during the critical postpartum period. Loss of Medicaid coverage in the 12 months after birth will also disproportionately impact Black and AI/AN new mothers that are at increased risk of reporting symptoms of postpartum depression than their white counterparts. Cuts to postpartum Medicaid coverage would also greatly impact women in rural areas, where Medicaid finances nearly half of all births (47%), on top of factors like distance to care and provider shortages. Women experiencing displacement are also at elevated risk, as housing instability, climate disasters, migration, or forced relocation can disrupt enrollment, documentation, and continuity of care.

Funding gaps from H.R. 1 threaten the future of "optional benefits" in the Medicaid program that are essential to maternal health.

There has been growing momentum for states to provide Medicaid coverage for evidence-based models of maternity care such as maternal health quality initiatives, doula care, perinatal community health worker support, and certified professional midwifery (CPM) care. While these benefits are technically optional in Medicaid, they are central to evidence-based maternal health strategies that improve outcomes, expand access to high-quality and culturally responsive care, strengthen the perinatal workforce, and reduce inequities in maternal health. As of August 2025, nearly half of all states are actively reimbursing for doula care and 22 states offer at least partial Medicaid reimbursement for CPM care. These models are person-centered, cost-effective, and backed by strong evidence supporting their efficacy, particularly for communities most at risk for poor maternal health outcomes.

WHAT'S AT RISK?

While H.R. 1 does not prohibit states from continuing to cover these services under their Medicaid plans, maternal health advocates have raised concerns that states offering these benefits may choose to limit or eliminate them as they attempt to fill federal funding gaps. Meanwhile, states that have not yet taken up Medicaid coverage of these essential services will be even less incentivized to do so.

WHO IS MOST AFFECTED?

Like postpartum Medicaid extension, communities that are more likely to be enrolled in Medicaid during the perinatal period will be most impacted if these benefits are scaled back. This is both because these essential models of care would become less accessible to Medicaid-enrolled families, and because many of these models are proven to reduce the maternal health inequities that disproportionately impact these same communities.

Cuts to Medicaid funding could eliminate workforce programs.

WHAT'S AT RISK?

At a time when the maternity care workforce already faces persistent shortages, barriers to entry, and uneven access to providers across communities, H.R.1 creates a challenging fiscal environment for state health budgets, which presents two parallel threats to workforce training programs.

First, states may scale back investments in workforce training programs or incentive initiatives — such as stipends, internships, and loan repayment - that make it easier for students to access perinatal provider training. Second, the bill cuts federal funding for loan programs that make it possible for many to pursue the higher education necessary to enter the maternity care workforce. These strains on state health budgets introduce substantial barriers to enabling the growth, diversification, and sustainability of the maternity care workforce.

WHO IS MOST AFFECTED?

Cuts to workforce programs will significantly impact aspiring maternity care providers, especially those disproportionately impacted by existing barriers to accessing perinatal provider education. Scaling back scholarship and loan programs will make entry to the maternity care workforce even harder and introduce additional barriers for future providers from diverse backgrounds to access needed training pathways. This is particularly concerning given the lack of diversity in the current maternity care workforce. Nationally, Black, Hispanic, and AI/AN physicians are significantly underrepresented compared to the populations they serve. A similar disparity is reflected in the midwifery workforce. This will have a ripple effect that spans generations, impacting families' ability to receive culturally rooted and concordant care.

> The question that needs to be posed is: who are we as a nation if Black and Brown people cannot thrive- if they are deprived of the human right of healthcare and education? The same bill that cuts people off from Medicaid also makes sure that there won't be anyone to care for them even if they had coverage.
>
> AZA NEDHARI, PRESIDENT & CEO, MAMATOTO VILLAGE (WASHINGTON, D.C.)

SECTION 3

What H.R. 1 Means for Community-Based Organizations (CBOs)

The policy shifts from H.R. 1 are likely to create predictable, compounding pressures on community-based organizations that support pregnant and postpartum families. The pressures named below operate independently but reinforce one another in practice.

Cuts to Medicaid introduce financial uncertainty for community care providers.

Many community-based organizations rely on Medicaid reimbursements to sustain their work, or care for families that rely on the program. Existing Medicaid reimbursement rates for freestanding birth centers, midwifery care, and doula support are chronically inadequate, often leaving providers and facilities without the resources they need to serve families sustainably. Looming cuts from H.R. 1 will likely exacerbate these inequities as Medicaid reimbursement becomes a less reliable revenue stream.

Cuts to the Medicaid program may make CBOs increasingly reliant on private grant funding to stay afloat in the near term, underscoring the role of philanthropy as a critical bridge during a period of sustained policy change while reinforcing that long-term access to care and progress towards a more stable funding landscape depend on robust public financing. Organizations that do not directly rely on Medicaid reimbursements to sustain operations are also likely to feel the impact of growing competition for limited philanthropic dollars. Shifts in reliable funding streams can make it hard for CBOs to retain staff and operate core programs sustainably, and may force organizations to prioritize immediate response work over longer-term strategic planning.

> “The birth center will not survive cuts to pregnancy Medicaid. Not just Magnolia, but any birth center who serves large numbers of clients who rely on Medicaid to pay their bills.
>
> TAMARA TAITT, FOUNDER, MAGNOLIA BIRTH HOUSE (FLORIDA)

Coverage gaps drive more families to CBOs.

As individuals lose coverage or experience insurance disruptions, an increasing number of families will require assistance accessing and navigating affordable care. As a result of the cuts in H.R. 1, CBOs will likely see increased demand for care coordination, wraparound social support, and benefits navigation assistance, as families turn to these groups for support amid lapses in essential services like the Supplemental Nutrition Assistance Program (SNAP).

When formal systems are overburdened or falling short, community-based maternal healthcare and support organizations act as a critical lifeline, offering trusted, culturally grounded care and support for families. Too often, this increase in demand is not met with an increase in resources, placing strain on CBO staff and operational capacity.

> Even as we project continued Medicaid funding in FY2026, the instability of federal and state health policy means that we cannot rely on it with certainty.
>
> ANCIENT SONG (NEW YORK/NEW JERSEY)

> As Medicaid coverage shrinks, we anticipate more people will lose eligibility and turn to community-based midwifery care as one of the few remaining accessible options... These shifts only deepen the urgency of our work to build sustainable, community-led systems of support that do not depend on insurance access.
>
> LUNA TIERRA BIRTH CENTER (TEXAS)

Medicaid cuts strain referral networks and hospital partnerships.

> Changing Woman Initiative relies on excellent relationships with hospitals to provide higher level of care to clients when it is needed, and to be able to transfer appropriately in order to provide safe care.
>
> CHANGING WOMAN INITIATIVE (NEW MEXICO)

CBOs rely on effective referral and transfer relationships with hospitals and specialty providers within the broader clinical ecosystem to ensure comprehensive, continuous care for families throughout the perinatal period.

Cuts to Medicaid reimbursement, along with broader hospital closures, further destabilize referral pathways and transfer relationships, with the greatest impact on clinical and hybrid community-based providers. Reduced coverage and shrinking state budgets could force hospitals and clinics to scale back services or close altogether, disproportionately affecting underserved areas.

Under-resourced providers experience stretched capacity.

As more families turn to CBOs for perinatal care and support, providers and staff are likely to take on increased responsibilities–including complex care navigation, crisis response, safety planning, and emotional labor–without proportionate increases in funding or staffing support.

CBOs are experts in providing compassionate, wraparound support, and many are already responding to shifting community needs in the wake of H.R. 1 with agility and care. It is essential this support and responsiveness is met with intentional, adequate, and ongoing funding to decrease the risk of burnout and ensure the long-term sustainability of the workforce.

> We are a healthcare provider, standing in the gap for families at a time when maternal health services are under political attack and community need has never been greater. Our work is not a luxury; it is essential healthcare... [and] [w]e are carrying the weight of delivering essential care in a hostile environment where simply existing as a birth center is an act of resistance.
>
> TAMARA TAITT, FOUNDER, MAGNOLIA BIRTH HOUSE (FLORIDA)

A mom receives doula care at the SisterWeb cottage during a postpartum visit in San Francisco, California. (Amaya Edwards, 2025)

Midwife Valerie checking Faye's vitals during her prenatal appointment at the Magnolia Birth House in Miami Beach, Florida. (Mint and Cocoa, 2024)

WHAT COMES NEXT

Community-based organizations are often the first to observe the real-world consequences of policy change, long before impacts appear in administrative data or formal evaluations. CBOs are identifying emerging barriers, shifts in care-seeking behavior, and compounding risks in real time, providing critical early insight into how federal policy decisions like H.R. 1 are reshaping the lived realities of maternal health. But capturing and translating on-the-ground realities requires time, staff capacity, and infrastructure that many organizations do not have, especially as demand rises and systems become more unstable.

This moment calls for more than short-term stabilization. Funders have a critical role to play in ensuring that CBOs can both sustain services in the near term and help shape the longer-term direction of maternal health systems.

This includes supporting CBOs with flexible, multi-year support; reducing administrative burden; and resourcing spaces that bring together grantee partners and the broader field to identify shared priorities and organize around solutions.

At the same time, sustained access to care will depend on strong public systems. Alongside direct support for CBOs, funders must help reinforce the policy and funding conditions that underpin maternal health. This includes coverage continuity for families, protection of key "optional" maternal health benefits in the Medicaid program, and the preservation of investments in perinatal workforce development programs.

Without this combined approach, the burden of system disruption will continue to shift on organizations that were never designed nor resourced to absorb it alone and on the families who depend on them for access to care and support.

The choices made now will shape whether the maternal health ecosystem becomes more resilient or further strained in the years ahead.

POLICY CHANGES DUE TO H.R. 1 THAT IMPACT MATERNAL HEALTH

DATE	WHAT HAPPENS	WHY IT MATTERS
July 2025	H.R. 1 enacted	Starts the countdown to staggered implementation changes across Medicaid, Medicare, and ACA
	Federal funding cuts to essential reproductive health centers	Access to reproductive healthcare is directly linked to maternal health outcomes
Late 2025	Medicaid administrative funding changes begin	States begin developing reporting systems, preparing for eligibility tightening and reporting requirements
January 1, 2026	ACA subsidy reductions begin Enhanced Premium Tax Credits end	Marketplace insurance affordability declines; may lead to increased uninsured rates among the perinatal workforce and clients
October 1, 2026	Enhanced federal funding for emergency Medicaid for undocumented individuals ends	Potential for health disparities to widen for undocumented individuals living in the U.S.
	Medicaid eligibility ends for some "lawfully present" immigrant communities	Potential for health disparities to widen for "lawfully present" immigrant communities living in the U.S.; may lead to increased uninsured rates in several immigrant communities
2027	States can shift to capped Medicaid funding (though block grant/personal responsibility pilot models may be adopted by states)	Funding becomes less flexible; optional maternal health benefits may be cut
January 1, 2027	Medicaid work requirements begin	Increased risk of wrongful coverage loss and mass disenrollment, including for future perinatal providers
	States start reviewing Medicaid eligibility more often	More people may lose coverage due to paperwork or confusion, especially in the postpartum period
	Premium tax credit eligibility for some "lawfully present" immigrant communities ends	Marketplace insurance affordability declines for many immigrant communities; may lead to increased uninsured rates
	Bars those who do not meet Medicaid work reporting requirements from eligibility for premium tax credits	May lead to increased uninsured rates among formerly Medicaid eligible populations, including throughout the perinatal period
	Retroactive coverage period window narrows	May lead to increased medical debt for mothers and families
October 1, 2028	States required to start implementing cost sharing requirements for Medicaid enrollees	May take money away from other critical services which furthers inequities; may lead to increased uninsured rates
2028 – 2030	Medicare payment reductions to hospitals and providers	Maternity units and community clinics at risk of closure
2031 – 2035	Medicaid spending caps fully implemented	Deep, long-term impacts on maternal health infrastructure

ADDITIONAL RESOURCES

H.R. 1 implementation timelines and federal policy analyses

- Implementation dates for 2025 budget reconciliation law (Kaiser Family Foundation).
- Medi-Cal Timeline: OBBBA and CA budget implementation changes (National Health Law Program).
- New resource on state-by-state impacts of budget reconciliation law (Georgetown University McCourt School of Public Policy Center for Children and Families).
- Prepare. Enforce. Protect: Medicaid + ACA Defense (National Health Law Program).
- The implementation timeline of the One Big Beautiful Bill Act (Center for American Progress).

Impacts of H.R. 1 on maternal health

- How H.R. 1 will harm maternal health in the U.S. (Public Health Post).
- The One Big Beautiful Bill Act (OBBBA) and its impact on maternal mental health (Maternal Mental Health Leadership Alliance).

Impacts of H.R. 1 on communities & access to care

- How the Republican megabill impacts Black maternal health (The Century Foundation).
- H.R. 1: A turning point for health access (American College of Obstetricians & Gynecologists).
- Republican's new health care law will impact over 130 rural labor and delivery units (National Partnership for Women & Families).
- State actions to protect Black maternal health (The Century Foundation).

On best practices for funders in the maternal health ecosystem

- Birth justice landscape analysis: a funder's field guide to birth justice (Elephant Circle).

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- Commonsense Childbirth (Florida)
- Changing Woman Initiative (New Mexico)
- Luna Tierra Birth Center (Texas)
- Magnolia Birth House (Florida)
- Mamatoto Village (Washington, D.C.)
- National Association to Advance Black Birth
- Shades of Blue Project (Texas)

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ABOUT EVERY MOTHER COUNTS

Motivated by the intrinsic human right to maternal health, Every Mother Counts is dedicated to ensuring that all people, everywhere, experience a safe, respectful, and equitable journey through pregnancy, childbirth, and the postpartum period. We started by spotlighting stories told by those closest to the issue. Over time, these personal accounts have shone a spotlight on the global imperative to transform maternal health. Since 2010, EMC has invested tens of millions of dollars to advance system-wide change through the development of professional, dedicated, and compassionate providers in every setting who are focused on respectful care that centers mothers.

COVER PHOTO: Midwifery Fellow Angelique Steadman conducts a prenatal visit with an expecting mom at Changing Woman Initiative in New Mexico. (Keith Scott, 2025)