

Leveraging CHIP Health Services Initiatives to fund *perinatal health.*



A practical financing pathway for state Medicaid and CHIP agencies to draw down federal match, at an average 71% enhanced rate, for direct cash assistance during pregnancy and the postpartum period.

48 + DC

JURISDICTIONS WITH
REMAINING CAPACITY

Legally permitted to spend on HSI activities today under the 10% CHIP administrative cap (2024 reporting).

35

STATES USING < 50% OF ADMIN
CAP

Substantial federal matching funds are currently unclaimed.

71%

AVERAGE ENHANCED FEDERAL
MATCH

Federal share for HSI expenditures at the state's E-FMAP rate, versus roughly 57% for Medicaid.

01 • THE PROBLEM

Coverage is necessary. It is not sufficient.

Among high-income nations, the United States posts the highest rates of infant mortality, premature birth, and, by a wide margin, maternal mortality. Poverty during pregnancy is one of the most potent predictors of these outcomes; coverage alone does not address the underlying economic stressors.

Low-income pregnant individuals face disproportionate rates of preterm birth, low birthweight, maternal mortality, and infant death,

disparities that fall hardest along lines of race and geography.

The perinatal period (pregnancy through the postpartum period) is a critical window in which financial insecurity generates compounding risks: inadequate nutrition, housing instability, foregone prenatal visits, and elevated physiologic stress in pregnancy.

WHAT THE EVIDENCE SHOWS

Unconditional cash transfers in utero and infancy have produced improved birth outcomes, increased breastfeeding initiation, significant reductions in infant maltreatment allegations, decreased evictions, and improved maternal mental health.

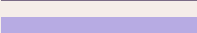
Research on expanded Child Tax Credit payments indicates meaningful improvements in birth outcomes among low-income, Medicaid-insured families. Despite robust federal coverage through Medicaid and CHIP, coverage alone does not address the underlying economic stressors that drive these outcomes.

The US underperforms peer high-income nations on perinatal outcomes.

MATERNAL MORTALITY PER 100,000 LIVE BIRTHS

United States		22.3
UK		10.0
France		7.6
Canada		7.5
Germany		3.6
Norway		1.8

PRETERM BIRTH RATE % OF BIRTHS < 37 WEEKS

United States		10.4%
UK		7.6%
Canada		7.4%
Germany		7.2%
France		7.0%
Sweden		5.7%

Illustrative reference values drawn from OECD Family Database and WHO/UNICEF comparative reporting (2020–2023 cohorts). Rates vary by definition and reporting year.¹



CHIP Health Services Initiatives are an existing, underused authority.

Under SSA §2105(a)(1)(D)(ii) and 42 CFR §457.10, states may establish state-designed public health programs (HSIs) using CHIP administrative funds, at the enhanced CHIP federal match.²

“Expenditures for the provision of services for the purpose of improving the health of children eligible for child health assistance under the State child health plan.”

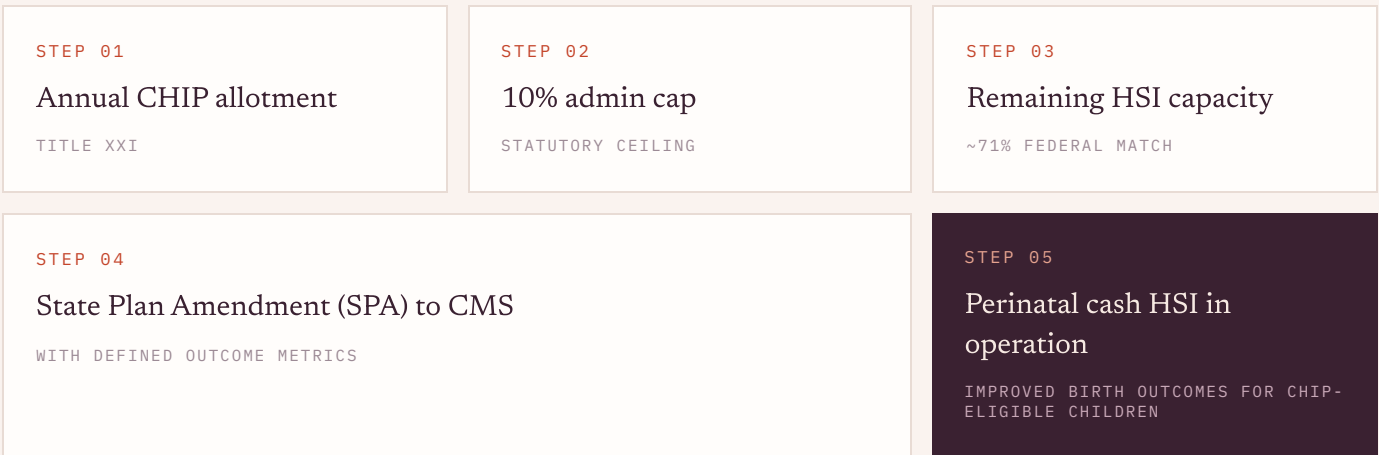
– SSA §2105(a)(1)(D)(ii)

HSIs must directly improve the health of low-income children under age 19 who are eligible for Medicaid or CHIP. They may serve a broader population, including pregnant individuals, when the health benefit to the child is the overarching focus.

A direct cash transfer program for pregnant individuals is structurally consistent with this authority when framed around fetal and infant health: the fetus and

newborn are the eligible CHIP beneficiaries. The perinatal period sits squarely within CHIP's “From Conception to End of Pregnancy” (FCEP) and postpartum frameworks. CMS has already approved HSIs for postpartum services using this logic in California, Illinois, and Minnesota.

HOW THE FUNDING FLOWS



Per state dollar spent, CHIP HSI draws meaningfully more federal investment than Medicaid.

CHIP enhanced match • national avg, HSI expenditures

71% / 29%



Medicaid match • national avg, FMAP baseline

57% / 43%



■ Federal share ■ State share

Enhanced CHIP match (E-FMAP) is set 30% above each state's Medicaid FMAP, capped at 85%. National average reflects state-by-state weighted means; individual states may see a higher leverage ratio.

03 • FUNDING CAPACITY

Most states have substantial unused capacity under the 10% cap.

CHIP administrative expenditures are capped at 10% of total CHIP spending. After standard admin costs like eligibility systems, managed care oversight, staffing, many states have significant capacity remaining inside the cap.

THE CATCH • CAPACITY IS NECESSARY, EXCESS ALLOTMENT MAKES IT USABLE

Remaining cap room only helps if the state has excess allotment to draw it down.

“Excess allotment” measures how much federal funding a state can actually pull down using its enhanced match. California shows the limit: its ~\$13.6M in excess allotment covers only a fraction of the ~\$363.6M in federal funds it would need to fully use its remaining administrative cap — so the headroom is real, but the drawable federal share is constrained.

HOW ALLOTMENTS GROW • REBASED EVERY OTHER YEAR

EVEN YEARS

Grown forward

The prior year's allotment is increased by child-population growth in the state and national health-care cost inflation.

ODD YEARS

Rebased

Recalculated from the state's actual prior-year spending, then grown by the same population and cost factors — keeping the formula grounded in real expenditures.

To unlock more federal dollars, total CHIP spending has to rise to lift the allotment. A state can shift money to draw down its excess allotment — but those dollars cannot themselves be federal, since federal match can't be claimed with federal funds.

States have used HSIs to fund a wide range of upstream interventions.

Home visiting

MA • MO • AL

Embedded clinical & coaching support for maternal–infant dyads.

Prenatal care coordination

NJ

Linkage & navigation services across the perinatal period.

Postpartum Medicaid extension

CA • IL • MN • VA

Coverage to 12 months postpartum.

Lead abatement & behavioral health

MULTI-STATE

Plus school-based health and poison control.



A reporting framework, grounded in published evidence.

CMS-required annual reporting maps cleanly onto four outcome domains. Each indicator ties to a measurable metric drawn from state vital statistics or quarterly program surveys, and to a published benchmark from direct-cash perinatal research.

Birth outcomes		SOURCE: STATE VITAL STATISTICS	
Preterm birth rate	% of births < 37 wks gestation	↓ 18%	RX KIDS • 2025
Low birthweight rate	% of births < 2,500g	↓ 27%	RX KIDS • 2025
Very low birthweight	% of births < 1,500g • Medicaid cohort	↓ 16%	HEALTH AFFAIRS • 2025
NICU admission rate	% of newborns admitted • ~\$6.2M avoided	↓ 29%	RX KIDS • 2025
Maternal health		SOURCE: PROGRAM SURVEYS, VITAL STATISTICS	
Prenatal care adequacy	Kotelchuck Index • % adequate	↑ +5.7pp	RX KIDS • 2025
Postpartum depression	% positive (Edinburgh / PHQ-9)	↓ 46→33%	RX KIDS AJPH • 2025
Third-trimester smoking	% reporting smoking in 3rd tri	↓ 1.7pp	RX KIDS • 2025
Economic stability		SOURCE: QUARTERLY PROGRAM SURVEYS	
Housing stability	% reporting eviction post-birth	↓ 91%	RX KIDS AJPH • 2025
Rent / mortgage debt	Avg. debt balance reduction	\$1,000+	RX KIDS AJPH • 2025
Health equity		SOURCE: STATE VITAL STATISTICS • KFF	
Racial disparity in LBW	Gap between Black and White infants	2.0× baseline	KFF • 2025

SPA NARRATIVE • THREE BODIES OF EVIDENCE

01 Birth outcomes Research demonstrating prenatal cash reduces preterm birth, low birthweight, and NICU admissions — adverse outcomes that impose lifelong health consequences on CHIP-eligible children.	02 Neurodevelopment Research demonstrating that poverty during the first 1,000 days causally alters infant brain development in ways that predict long-term cognitive and health trajectories.	03 Maternal health Research demonstrating that perinatal cash reduces postpartum depression, housing instability, and food insecurity — all of which impair infant health and early caregiving.
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From statute to SPA: what a state needs to do.

CMS works closely with states to define and refine HSIs prior to formal submission. Early coordination with the state's CHIP Project Officer significantly facilitates the review process.

- 01 Calculate remaining capacity under the 10% administrative cap, accounting for current eligibility systems, managed care oversight, and staffing.
- 02 Determine excess CHIP allotment sufficient to draw down the federal share at the state's enhanced match rate.
- 03 Contact the state's CMS CHIP Project Officer early to align on permissible expenditure framing and outcome metrics.
- 04 Draft outcome metrics from the four-domain framework, with data sources identified for each.
- 05 Submit the SPA with defined outcome metrics, geographic scope, eligibility framing, and program duration.

ESSENTIAL PROGRAM DESIGN ELEMENTS

TIMING

Early pregnancy

Maximize impact on birth outcomes. Stretch disbursement to capture postpartum maternal health gains.

TARGETING

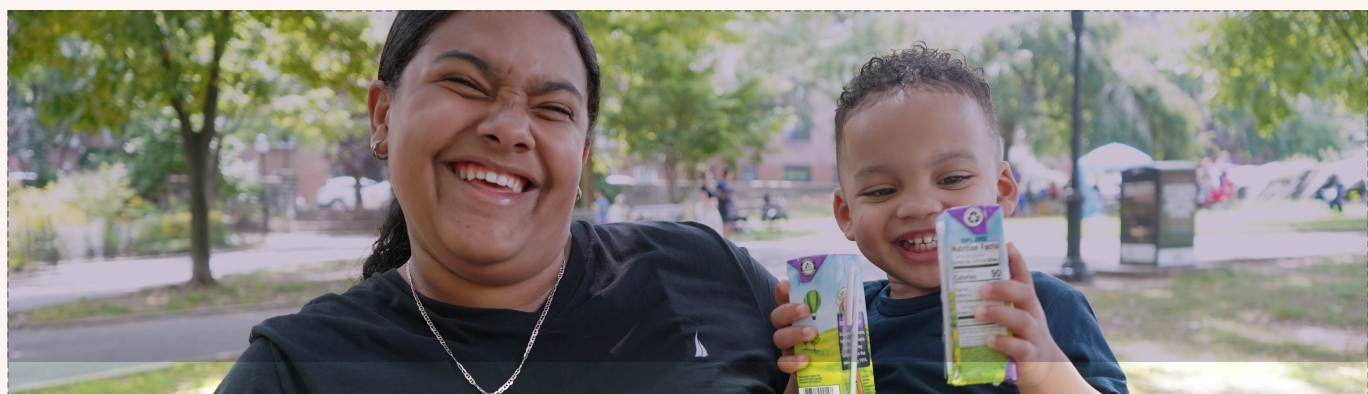
High-opportunity counties

Medicaid-eligible pregnant people in counties with high poverty and poor birth outcomes.

SUSTAINABILITY

Braided funding

Pair CHIP HSI with other public funding and philanthropic capital to scale long-term.



Anticipated questions from CMS and state staff.

Q.01 Is direct cash a permissible HSI expenditure?

HSI expenditures must improve child health but are not limited to clinical services. The broad statutory language has supported lead abatement, nutrition programs, and public health campaigns. Direct cash is the mechanism for delivering the health benefit, consistent with evidence that income is the most upstream determinant of health outcomes.

Q.02 How does cash directly improve child health?

Cash operates through multiple causal pathways: reduced maternal stress (lowering cortisol and inflammatory markers), increased prenatal care utilization, reduced smoking, improved nutrition, and housing stability, all of which directly improve fetal development and birth outcomes.

Q.03 What is the relationship to CHIP-enrolled children?

The perinatal window directly shapes the health of the soon-to-be-born or newborn CHIP-eligible child. Many studies have demonstrated that prenatal cash produces measurable improvements in the birth outcomes of children subsequently enrolled in public insurance.

Q.04 How will outcomes be measured?

Birth outcomes from state vital statistics; maternal mental health and economic stability from quarterly program surveys via the distribution partner. The four-domain framework maps to specific measurable metrics.

Q.05 What is the spending cap?

HSI expenditures are capped at 10% of a state's annual CHIP allotment. States should model program costs against this cap and consider phased rollout or geographic targeting (e.g., highest-need counties) to remain within limits while maximizing impact.

SOURCES

1 OECD Family Database and WHO/UNICEF comparative reporting, 2020–2023 cohorts. Illustrative reference values; rates vary by definition and reporting year.

2 Social Security Act §2105(a)(1)(D)(ii); 42 CFR §457.10 — CHIP Health Services Initiative authority.

3 MACPAC MACStats Exhibit 6 — E-FMAPs by state, FY2024.

4 Georgetown Center for Children and Families (Mar. 2026); CMS CHIP Financial Management Reports FY2024, Medicaid.gov.

5 Rx Kids program evaluations, 2025; Rx Kids findings published in the American Journal of Public Health, 2025.

6 Health Affairs, 2025 (very low birthweight, Medicaid cohort); KFF, 2025 (racial disparity in low birthweight).

Curious about leveraging a CHIP HSI to improve perinatal health outcomes in your state? Get in touch at motherinfantcash.org.