Mother & Infant
Cash Coalition

POLICY & FINANCING BRIEF
GEORGIA · 2026

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

A practical financing pathway for the Georgia Department of Community Health (DCH) to draw down federal match — at a 76.12% enhanced rate — for direct cash assistance during pregnancy and the postpartum period.

76.12%

ENHANCED FEDERAL MATCH

Georgia's E-FMAP for CHIP HSI expenditures.[9]

$3.19

PER STATE DOLLAR

Federal dollars drawn for every state dollar invested in a Georgia CHIP HSI, versus $1.00 under standard Medicaid.[1]

$14.6B

STATE RESERVES

Georgia entered FY2026 with more than $14.6 billion in general fund reserves, including $9.1 billion in undesignated funds lawmakers can allocate freely — no new tax required to fund this proposal.[2]

Not Medicaid expansion

EXISTING AUTHORITY ONLY

This proposal uses CHIP's existing Health Services Initiative authority and Georgia's current Medicaid eligibility rules — it is separate from, and does not require changes to, Georgia Pathways to Coverage or full Medicaid expansion.[3]

F

2025 REPORT CARD GRADE

Georgia's preterm birth rate (11.8%, 14,907 babies in 2024) earned the state an F and a rank of 45th of 52 states, DC, and Puerto Rico.[4]

✓ POSTPARTUM PRECEDENT EXISTS

Georgia has already run its own state-designed perinatal coverage waiver — a 2021 Section 1115 postpartum extension demonstration, later converted to the federal ARPA 12-month option — showing DCH has direct experience building and operating exactly this kind of state-specific perinatal financing vehicle.[5]

A crisis Georgia's own data already names.

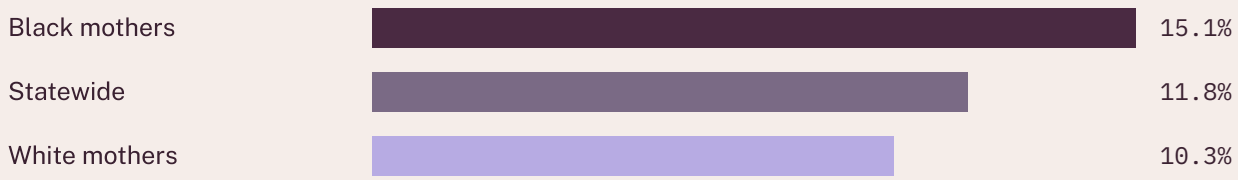
Georgia's 2025 March of Dimes Report Card grade was an F: an 11.8% preterm birth rate, 14,907 babies born preterm in 2024, and a rank of 45th out of 52 states, DC, and Puerto Rico — unchanged from the year before.[4] The state's infant mortality rate is 7.0 per 1,000 live births (rank 43rd of 52), and inadequate prenatal care affects 20.6% of pregnancies.[4] Disparities are real and documented in the state's own data: babies born to Black mothers face a 15.1% preterm birth rate, compared to 10.3% for white mothers.[4] Every one of these outcomes carries a direct cost to Georgia taxpayers — in NICU admissions, extended hospital stays, and downstream Medicaid spending that healthier births would avoid.

This is not primarily a failure of coverage or of access to care. Georgia already extends Medicaid postpartum coverage to a full 12 months, and Right from the Start Medicaid covers pregnant women up to 220% of the federal poverty level.[5] **The gap is economic.** Financial strain during pregnancy is one of the most potent predictors of preterm birth, low birthweight, and maternal complications, and it hits hardest for working families across the state, from rural South Georgia to metro Atlanta.

The perinatal period — pregnancy through the postpartum window — is the critical stretch in which financial strain compounds: inadequate nutrition, housing instability, missed prenatal visits, and elevated physical stress. A short, targeted period of direct financial support at this specific window is a narrowly scoped, fiscally efficient way to help families stay stable and avoid far more expensive downstream costs to the state — and Georgia's own Pathways to Coverage program already frames its mission in exactly these terms, describing its goal as supporting members "on their journey to financial independence."[6] A perinatal cash pilot extends that same logic to the moment in a family's life when financial stability does the most good for a child's lifelong health.

FIGURE 01 · GEORGIA PRETERM BIRTH, 2024

PERCENT OF LIVE BIRTHS



Infant mortality: 7.0 per 1,000 live births, rank 43rd of 52. Inadequate prenatal care: 20.6% of pregnancies.[4]

WHAT THE EVIDENCE SHOWS

Direct cash assistance during pregnancy and the postpartum period has been linked to improved birth outcomes, higher breastfeeding rates, fewer child-welfare investigations, fewer evictions, and better maternal mental health — outcomes that reduce reliance on other public assistance over time rather than increase it.

Georgia has direct experience building state-specific perinatal coverage mechanisms: its 2021 Section 1115 postpartum extension demonstration was a homegrown Georgia policy innovation years before the federal ARPA option existed.[5] What Georgia lacks is a mechanism to extend that same innovative approach to direct financial support — funded by dollars the state already has sitting in reserve.

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 — Health Services Initiatives (HSIs) — using CHIP administrative funds, at the enhanced CHIP federal match, with flexibility to innovate for their local context.[7]

> *"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 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 assistance program for pregnant Medicaid/PeachCare recipients 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. This is a targeted use of existing federal authority already available to Georgia — it requires no new state entitlement, no expansion of Medicaid eligibility, and no new tax.

Georgia has already built and operated its own perinatal coverage demonstration — the July 2021 Section 1115 Postpartum Extension Demonstration, which increased coverage from 60 days to six months postpartum before the state converted to the federal ARPA 12-month option in 2022.[5] That history shows DCH has both the technical capacity and the CMS working relationship to stand up a new, state-specific perinatal financing mechanism.

HOW THE FUNDING FLOWS

STEP 01

Annual CHIP allotment (Title XXI)

STEP 02

10% administrative cap (statutory ceiling)

STEP 03

Identify existing HSI dollars to braid into the state contribution

STEP 04

Remaining HSI capacity drawn at 76.12% federal match

STEP 05

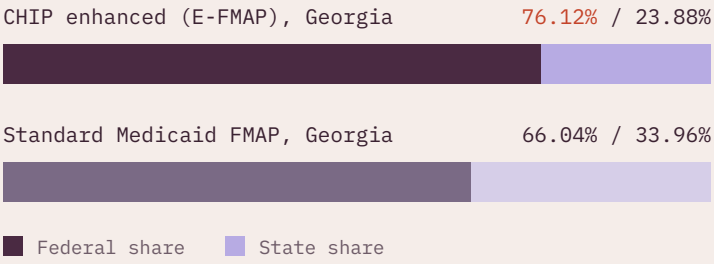
State Plan Amendment (SPA) to CMS with defined metrics and accountability reporting

STEP 06

Perinatal cash assistance HSI in operation — healthier births, lower downstream costs

FIGURE 02 · FEDERAL MATCH COMPARISON

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



$3.19

Federal dollars drawn for every state dollar invested in a Georgia CHIP HSI, versus $1.00 under standard Medicaid. Georgia's regular Medicaid FMAP is 66.04%, and the E-FMAP formula reduces the state share by 30% on top of that, yielding the 76.12% enhanced rate Georgetown CCF applies in its CHIP capacity analysis.[9]

SOURCE: GEORGETOWN CCF ANALYSIS OF FY2024 CHIP FINANCIAL MANAGEMENT REPORTS.[9]

The Georgia Context: Cap Room and an Unusually Well-Timed Surplus

CHIP administrative expenditures are capped at 10% of total CHIP spending, and Georgetown CCF's analysis of the FY2024 CHIP Financial Management Reports puts Georgia squarely in the scenario where that cap room is fully usable: a $60.2M administrative cap, $18.9M used, and $41.3M in remaining capacity – a $31.4M federal share against a $9.9M state share – set against an excess allotment of $438.5M.[9]

How to unlock more federal dollars. Because the allotment rebases based on prior-year spending, a state that increases CHIP expenditures sees its rebased allotment grow over time. A geographic pilot designed to demonstrate impact – for example, in a rural South Georgia region with documented maternity care access gaps, or in a metro Atlanta area with high preterm birth rates – is the most direct path to expanding drawable federal dollars over a 3–5 year horizon.

10% ADMIN CAP, FY2024	USED AGAINST THE CAP	REMAINING CAPACITY	EXCESS ALLOTMENT
$60.2M	$18.9M	$41.3M	$438.5M

ILLUSTRATIVE PILOT COST · NOT NECESSARILY A DESIGN RECOMMENDATION
$1,000/MO · 15 MONTHS

PILOT SIZE	TOTAL OBLIGATED	STATE SHARE (23.88%)
~100 participants (Phase 1)	~$1.5M	~$358K
~500 participants (Phase 2)	~$7.5M	~$1.79M
~1,000 participants (statewide scale)	~$15M	~$3.58M

A Phase 1 pilot's entire state match — roughly $358K — is a rounding error against Georgia's $9.1 billion in undesignated reserves, giving legislators a low-cost, low-risk way to test the model before any larger commitment.

Georgia has direct experience with exactly this kind of state-designed perinatal financing.

HEALTH SERVICES INITIATIVE	STATUS	AUTHORITY USED
Section 1115 Postpartum Extension Demonstration (2021)	Georgia-originated, later folded into the ARPA 12-month option	State-designed Medicaid waiver
12-month postpartum Medicaid extension	Adopted — GA (Nov. 2022)	ARPA state plan amendment
Planning for Healthy Babies (P4HB)	Adopted — GA	Section 1115 family planning waiver, up to 211% FPL
Georgia Pathways to Coverage	Adopted — GA, extended through Dec. 2026	Section 1115 work-requirement demonstration
Perinatal cash HSI (proposed)	Not yet attempted by any state	FCEP / fetal & infant health

Georgia would be a first mover on the specific cash-assistance HSI application nationally — but Georgia has more direct experience designing and running its own bespoke Medicaid waivers and demonstrations than almost any other state, from the postpartum extension to Pathways to Coverage to P4HB. This is squarely within DCH's existing wheelhouse, not a novel administrative lift.

CHIP HSI is the federal anchor. Georgia's own surplus is the match.

A braided strategy pairs the federal leverage of the HSI with existing Georgia funding vehicles — several of which are large, flexible, and specifically not tied to a tax increase or new appropriation fight.

$9.1B
UNDESIGNATED RESERVES

~$638M
OPIOID SETTLEMENT, 18 YRS

~$358K
PHASE 1 STATE MATCH

FUNDING SOURCE 01

CHIP HSI (Federal Anchor)

SSA §2105 · 76.12%

The primary vehicle for drawing down federal funds already available to Georgia. Covers direct cash assistance to Medicaid/PeachCare-eligible pregnant individuals, structured as an HSI with the fetal and infant health benefit as the documented outcome focus. State match (23.88%) provided by any of the sources below.

ROLE IN PROGRAM

Federal share of direct payments, phased by excess allotment capacity.

FUNDING SOURCE 02

State General Fund Undesignated Reserves

$9.1B · FREELY ALLOCABLE

$9.1 billion in undesignated reserves as of the close of FY2025 · freely allocable by the Legislature. Georgia closed FY2025 with more than $14.6 billion in total general fund reserves, including $5.6 billion in its constitutionally capped Revenue Shortfall Reserve (already at its 15% statutory maximum) and $9.1 billion in undesignated reserves the Legislature can direct to any purpose.[2] These reserves have grown for four consecutive years due to conservative revenue estimating, and state budget analysts have specifically noted that Georgia has “the necessary resources to support both major investments and ongoing needs.”[2] A Phase 1 state match of roughly $358K is a negligible draw against this reserve — a low-cost way for the Legislature to act on a problem the state's own data (an F grade, rank 45th of 52) already names as urgent.

ROLE IN PROGRAM

The strongest and most defensible non-federal match candidate for Georgia; requires no new tax and no reduction to any other program.

NOTE: REQUIRES A LEGISLATIVE APPROPRIATION DECISION

FUNDING SOURCE 03

Georgia Opioid Crisis Abatement Trust

~$638M · 18 YEARS

~$638 million statewide allocation over 18 years · competitive grant process. Georgia is receiving approximately $638 million from national opioid settlements, split 75% to the state and 25% to local governments, with at least 70% required to go toward abatement purposes.[8] Parental substance use is a documented contributor to poor birth outcomes nationally. A perinatal cash pilot framed around stabilizing pregnant and postpartum women in or near recovery, in counties with documented substance-use burden, is consistent with the settlement's approved uses.

ROLE IN PROGRAM

A secondary or geographically targeted non-federal match candidate; requires an application through the Georgia Opioid Crisis Abatement Trust's competitive grant cycle.

NOTE: ANNUAL APPLICATION WINDOW — COORDINATE WITH THE TRUST'S PUBLISHED CYCLE

FUNDING SOURCE 04

Federal Title V MCH Block Grant

MCHB / HRSA

Georgia Department of Public Health. Georgia's Title V allocation funds maternal and child health programs statewide. Title V cannot fund cash assistance directly but can fund the community health worker/care coordinator role, data collection and vital-statistics linkage for CMS-required reporting, and local health department partnerships that co-deliver the program.

ROLE IN PROGRAM

Program infrastructure and workforce — the non-cash components of a community-based delivery model.

FUNDING SOURCE 05

Medicaid Managed Care (Georgia Families CMO)

COMMUNITY INVESTMENT

Amerigroup, CareSource, Peach State Health Plan. I could not confirm a mandated community-reinvestment requirement for Georgia's Care Management Organizations (CMOs) comparable to some other states' rules — this should be confirmed directly with DCH before being relied on. Georgia's three CMOs commonly fund community health investments and local partnerships on a voluntary basis, and DCH's existing contract relationship with them could be a channel for supplemental or in-kind program support.

ROLE IN PROGRAM

Supplemental funding or in-kind support, to be pursued directly with CMO contacts rather than assumed as a requirement.

Designed for impact, for what CMS will approve, and for Georgia's priorities.

CRITERIA	RECOMMENDATION	PROS	CONS
INCOME CEILING	≤220% FPL, aligned with Right from the Start Medicaid pregnancy eligibility	Matches Georgia's existing Medicaid pregnancy threshold exactly	Families just above the line still get nothing
AMOUNT	$500–$1,000/mo	Meaningful support without excessive administrative complexity	Doesn't account for regional cost-of-living differences (metro Atlanta vs. rural Georgia)
DURATION	15 months, from the second trimester	Starts early while minimizing miscarriage-related risk; 6 mo prenatal + 9 mo postpartum	Doesn't cover the full first year; could extend if funding allows
POPULATION	Align with counties with documented maternity care deserts and the worst preterm birth trends	Directly targets the outcomes behind Georgia's F grade	Narrower targeting may reduce reach
GEOGRAPHY	A rural South Georgia region with hospital-closure-driven maternity care gaps, and/or a high-need metro Atlanta area, as parallel Phase 1 sites	Demonstrates the model works in both rural and urban Georgia contexts simultaneously	Running two sites at once is more complex to manage than one

A reporting framework, grounded in published evidence and built for accountability.

CMS-required annual reporting maps cleanly onto four outcome domains, each tied to a measurable metric from Georgia vital statistics or quarterly program surveys — giving legislators and DCH leadership a clear, auditable record of what the state's dollars are buying.

FOUR OUTCOME DOMAINS

Birth Outcomes

GEORGIA DPH VITAL STATISTICS

Preterm birth rate	% births < 37 wks
Low birthweight rate	% births < 2,500g
NICU admission rate	% newborns admitted

Maternal Health

PROGRAM SURVEYS, GEORGIA DPH

Prenatal care adequacy	Kotelchuck Index
Postpartum depression	% pos. (Edinburgh/PHQ-9)
Severe maternal morbidity	Rate

Economic Stability

QUARTERLY PROGRAM SURVEYS

Housing stability	% reporting eviction
Rent / mortgage debt	Avg. debt reduction

Population Outcomes

GEORGIA DPH · CMS REPORTING

Outcome gap by county/subgroup, per CMS reporting standards

Preterm birth rate, tracked against the March of Dimes benchmark (national average 10.4%)

SPA NARRATIVE · THREE BODIES OF EVIDENCE

01

Birth Outcomes

Direct financial assistance during pregnancy reduces preterm birth, low birthweight, and NICU admissions — outcomes that impose lifelong health consequences on CHIP-eligible children and generate substantial downstream Medicaid costs in a state where Medicaid pays for a large share of Georgia births.

02

Infant Development

Financial strain during the first 1,000 days is linked to disruptions in infant development that predict long-term cognitive and health outcomes.

03

Maternal Health

Financial assistance during the perinatal period is linked to reductions in postpartum depression, housing instability, and food insecurity, all of which impair infant health and early caregiving — directly responsive to the drivers behind Georgia's F grade for preterm birth.

What DCH needs to do.

01 Calculate remaining capacity under the 10% administrative cap, accounting for eligibility systems, managed-care oversight, and staffing.

02 Determine excess CHIP allotment sufficient to draw down the federal share.

03 Contact Georgia's CMS CHIP Project Officer early to align on expenditure framing and outcome metrics.

04 Identify a non-federal match source — the undesignated General Fund reserve is the clear first candidate, with opioid settlement funds as a targeted alternate.

05 Draft outcome metrics from the four-domain framework, with Georgia-specific data sources (DPH vital statistics, Medicaid encounter data).

06 Submit the SPA with defined outcome metrics, geographic scope (rural and/or metro Phase 1 sites), Medicaid eligibility framing, and 15-month duration.

Questions from CMS and DCH staff.

Q.01

Is direct cash a permissible HSI expenditure?

HSI expenditures must improve child health but are not limited to clinical services. Broad statutory language has supported lead abatement, nutrition programs, and public-health campaigns. Direct financial assistance is the mechanism for delivering the health benefit, consistent with evidence that financial stability is a key upstream factor in health outcomes.

Q.02

How does financial assistance directly improve child health?

Financial assistance operates through multiple pathways: reduced maternal stress, increased prenatal-care utilization, improved nutrition, and housing stability, all of which directly improve fetal development and birth outcomes.

Q.03

What is the relationship to Medicaid-eligible families?

The perinatal window directly shapes the health of the soon-to-be-born child who will enroll in Medicaid or PeachCare at birth. In Georgia, where Right from the Start Medicaid covers pregnant women up to 220% FPL, the CHIP-beneficiary nexus is direct and documentable.

Q.04

How will outcomes be measured?

Birth outcomes from Georgia DPH vital statistics, linked to Medicaid encounter data for the enrolled cohort; maternal mental health and economic stability from quarterly program surveys administered by the distribution partner, with results reported publicly against defined benchmarks.

Q.05

How does this align with Georgia's own priorities?

Georgia's 2025 F grade for preterm birth is a public, state-specific data point the Legislature can point to directly. The evidence base for perinatal financial assistance addresses the economic pressures behind that grade, using an existing state reserve — not a new tax — and an existing federal authority Georgia has already shown it knows how to use through its own history of building bespoke Medicaid waivers. This HSI is not a new priority; it is a new, accountable financing mechanism for a problem the state's own report card already names.

Sources

1 MACPAC, MACStats Exhibit 6 — Federal Medical Assistance Percentages and Enhanced FMAPs by State, FYs 2023–2026 (Georgia FMAP: 66.04%).

2 Georgia Budget and Policy Institute, “Georgia Starts Fiscal Year 2026 with $14.6 Billion in General Fund Surplus Accounts” (Oct. 2025); Atlanta Journal-Constitution, “Georgia has $14.6 billion in reserves. What to do with it?” (Oct. 2025).

3 Georgia Department of Community Health — Georgia Pathways to Coverage program materials; Governor's Office press release on the CMS-approved Pathways extension (Sept. 2025).

4 2025 March of Dimes Report Card, Georgia (PeriStats); PRNewswire, “Georgia Receives F Grade in March of Dimes 2025 Report Card” (Nov. 2025).

5 NASHP, “Georgia Extends Medicaid Postpartum Coverage for Pregnant Women”; Brevy Care, “Georgia Medicaid Postpartum Coverage: The 12-Month Extension.”

6 Governor's Office of Georgia, CMS Pathways to Coverage extension announcement (Sept. 2025).

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

8 Georgia Opioid Crisis Abatement Trust (gaopioidtrust.org); Center Square, “Georgia Could Receive $636 Million As Part Of Opioid Settlement” (May 2022).

9 Yafimenka, Kaneb & Brooks, “Is Your State Leaving Money on the Table? How CHIP Health Service Initiatives Can Help States Support Children's Access to Care,” Georgetown University Center for Children and Families (Mar. 25, 2026) — analysis of FY2024 CHIP Annual Financial Management Reports; Georgia used as the Scenario 1 example (eFMAP 76.12%).

ABOUT THE COALITION

Mother & Infant Cash Coalition — A coalition of national clinicians, researchers, and community organizations advancing direct cash assistance as perinatal health infrastructure.

motherinfantcash.org