

Public / Private Partnerships as *a Bridge to Scale.*

Public / private partnership is not a substitute for public funding but the necessary bridge to it, pairing government's capacity for scale and durability with philanthropy's capacity for speed and flexibility, so that perinatal cash transfer programs can launch within today's political and fiscal constraints while building deliberately toward the sustained public investment only government can provide.

MOTHER & INFANT CASH COALITION



Mom and baby from the Abundant Birth Project

A national movement, built on a simple idea.

From Oakland to Philadelphia and Milwaukee to Atlanta, direct cash transfer programs for mothers and babies are gaining real traction as a life-changing, and often life-saving, intervention. In the years since the first pioneering pilots launched with exclusively philanthropic funding, the field has grown into a national movement, with programs now operating across city, county, and state levels, because government agencies have stepped in as key collaborators. Public / private partnerships are a crucial mechanism for growing the adoption of this innovative approach to perinatal health care. The resulting programs share two common insights: 1) that cash, given without restriction and with dignity, is among the most effective tools we have to improve outcomes for pregnant people and newborns, and 2) public / private partnerships are a crucial mechanism for growing the adoption of this innovative approach to health care.

When families have the financial breathing room to attend prenatal appointments, buy nutritious food, reduce working hours, or simply worry less, the health benefits ripple outward: lower rates of preterm birth, healthier birth weights, longer breastfeeding duration, and reduced risk of postpartum depression.

The Mother and Infant Cash Coalition (MICC) was formed to bring these programs together, connecting practitioners, researchers, and advocates working to advance the policies and funding streams that can bring unconditional cash to every eligible pregnant person in the country. On our path toward full public adoption, we are leveraging the reach, leadership, and durability of government partnership while preserving the speed, flexibility, and capacity to innovate that private and philanthropic partners provide, implementing public / private partnerships to scale this work now.

Together, the MICC sites operating as blended public and private partnerships illuminate a clear and replicable path; one that combines public accountability with private innovation, braids multiple funding streams for resilience, and grounds program design in the lived experience of the families it serves.

The through line across every program in this report is simple: **full public funding is the destination, and public / private partnership is how programs get there.** The sections that follow lay out why that combination works, and how MICC programs are putting it into practice.



BRIDGE PROJECT MOM AND BABY IN NYC

WHAT ARE PERINATAL CASH TRANSFERS?

Perinatal cash transfer programs provide direct, unconditional cash payments to pregnant people and new parents during pregnancy and the first months (or years) of a child's life.

Unlike traditional safety net programs, these transfers come with no restrictions on how funds are spent and no work requirements, recognizing that families themselves are best positioned to know what they need during this critical, high-cost period. Programs are typically delivered on a recurring monthly basis and paired with wraparound services or peer support.

Why public / private partnership?

The story of maternal cash programs in America begins in the philanthropic sector. The earliest programs, like the Magnolia Mother's Trust in Jackson, Mississippi, were built on philanthropic grants and donor dollars, generating early evidence and building the community trust that showed unconditional cash could be administered responsibly and effectively.

But evidence alone does not sustain programs and philanthropic funding, however generous, is inherently limited in scale and subject to shifting priorities. To reach every eligible pregnant person year after year, cash programs need the durability and scale that only public investment can provide. **That remains the field's ultimate goal.**

Getting from philanthropic pilot to full public funding, however, is rarely a single leap. This is where public / private partnership does its most important work: pairing what government does best with what philanthropy and nonprofit operators do best, so that programs can move now, in the political and fiscal environment that actually exists, while building steadily toward the sustained public investment only government can ultimately provide.

The pandemic created a turning point. Emergency federal funds, combined with growing public attention to maternal mortality and infant poverty, opened new pathways for publicly funded cash programs. The expanded Child Tax Credit, enacted by the Biden Administration in 2021, functioned as a cash transfer for nearly every family in the U.S. Its effects were swift and impactful, leading to a record-drop in childhood poverty. While advocates and some congressional leaders fought to make it permanent, Congress allowed it to expire in 2022, leading to a more than 40% spike in child poverty.

FIGURE 01 • THE ARC OF THE FIELD

From donor dollars to the public budget line

- Pre-2020** Philanthropic pilots — the Magnolia Mother's Trust and others — prove unconditional cash can be delivered responsibly and build community trust.
- 2021** The expanded Child Tax Credit functions as near-universal cash and drives a record drop in child poverty.
- 2022** Congress lets the credit expire; child poverty spikes more than 40%.
- 2022–now** States, counties, and cities braid TANF, Medicaid, ARPA, and general-fund dollars to sustain and expand programs.

Around the same time, states, counties, and cities began experimenting with TANF, Medicaid, ARPA, and general fund dollars to sustain and expand initiatives that had previously relied entirely on philanthropy. That wave of public investment continues today, in different configurations, across the country.



BRIDGE PROJECT MOMS AND BABIES WITH GOVERNOR KATHY HOCHUL

What each partner brings.

PUBLIC PARTNERS

Access, leadership, and public standing

Government partnership gives a program reach that no grant can buy: eligibility systems, Medicaid and WIC referral pipelines, and the standing to invite an entire jurisdiction's eligible families in, not just the few hundred a foundation can underwrite.

It also brings leadership. A governor, mayor, or agency commissioner who puts a cash program at the center of a maternal health agenda gives it a permanence and a public accountability that no foundation grant replicates. And it brings publicity that money can't buy – when a program becomes a state's flagship investment, it gains a platform and a constituency that help it survive turnover in leadership.

PRIVATE PARTNERS

Flexibility and the freedom to innovate

Private and philanthropic funding brings a flexibility that public dollars are structurally unable to offer: the freedom to launch before a budget cycle or legislative session allows it, to adjust program design in response to what participants actually need, and to serve people, including undocumented pregnant residents, whom public funding streams are often barred from reaching.

It is also where innovation happens first. New disbursement methods, community-led design, and rigorous randomized controlled trials are all easier to pursue when a program isn't yet bound by the conditions that come attached to public dollars.

PUBLIC CHAMPION

“Bringing in a partner allowed us to expedite our vision for direct cash in Indianapolis and launch our program. They came in with expertise, passion, and a framework to follow that made launching a new initiative more palatable. Their partnership allowed us to get money into the hands of moms much sooner than otherwise would've been possible. The City of Indianapolis' collaboration with the Bridge Project demonstrates how quickly we can launch major initiatives, and change lives, when public / private partnerships work well.”

— Ben Tapper

Chief DEI Officer, City of Indianapolis

Why now: the ball is in the states' court.

Federal funding for low-income families has been broadly slashed by the current Administration, with policy shifts creating real uncertainty about the future of programs like TANF, Medicaid, and the Child Tax Credit. In the face of fickle federal funding, states can partner with philanthropy and community based organizations to provide cash and stabilize families during the most critical months of development of a child's life.

States and localities control the TANF design choices, CHIP HSI authority, general fund appropriations, and dedicated revenue streams that don't rise or fall with any single federal administration's posture. For the moment, states and localities, not the federal government, are where the real decisions about this field's growth are being made.



GOVERNOR KATHY HOCHUL WITH BABY DIANGELO

What partnership delivers right now.

In this environment, public / private partnership isn't a consolation prize while programs wait for full federal buy-in, it is the model best suited to the moment. It delivers three things MICC programs need most right now.

01

Durability Through Braided Funding

Programs that combine state general funds, county budgets, dedicated revenue, foundation grants, and health system contributions are not dependent on any single funder's priorities or any single legislative session's outcome. If one stream slows or a funder's focus shifts, others carry the program forward. Braiding is not a workaround, it is a resilience strategy.

02

Speed That Matches the Urgency of This Issue

Preterm birth, maternal mortality, and infant poverty do not wait for a state budget cycle. Private capital can launch a program within months, while public partnership is still being negotiated, so families are enrolled and outcomes are being generated well before a full public funding pathway is in place. Speed and a demonstrated proof of concept today build the evidence that leads to a faster— and larger— public yes tomorrow.

03

De-Risking the Path to Public Investment

Legislators and agency officials are understandably cautious about committing new public dollars to a new model, especially amidst tightening budgets and federal funding withdrawals. When private funding underwrites the pilot, the evaluation, and the early operational kinks, it absorbs the risk that would otherwise fall on the first public dollar. By the time a program approaches a state legislature or Medicaid agency, it is asking for continued investment in a proven model, not a bet on an experiment that might feel like less of a responsible “yes” for agency staff.

None of this changes where the field is headed. The goal for MICC and its member programs remains full public funding: sustained federal, state, and local investment sufficient to reach every eligible pregnant person, not indefinite reliance on philanthropic bridge funding. **Public / private partnership is the vehicle for this moment, not the destination.** Every private dollar deployed today should be understood as building the evidence, relationships, and administrative infrastructure that make full public funding possible tomorrow.

PRIVATE CHAMPION

“Philanthropy's task is not to sustain programs indefinitely, it is proof and risk absorption: demonstrating that bold, innovative solutions work, and shouldering their uncertainty until government is ready to carry them forward. That is what private funding's flexibility makes possible, the freedom to test, to iterate on what the evidence shows, and to move at the pace this moment demands.”

— Holly Fogle

Co-Principal, The Monarch Foundation

What the evidence shows.

Across these programs and the broader body of research on unconditional cash transfers to families, the evidence is consistent and compelling. Programs that provide cash to pregnant people and new parents, without restrictions, without surveillance, and without stigma, produce meaningful, measurable improvements in health outcomes for both mother and child.

BIRTH

Decreased likelihood of preterm birth

with cash transfers associated with reduced physiological stress during pregnancy, a leading driver of preterm labor. ⁹

BIRTH

Increased birth weight

with studies linking income supplements to healthier fetal development and improved nutrition. ⁹

STABILITY

Decreased time in shelter or unstable housing

as cash enables families to maintain housing stability during the high-cost postpartum period. ¹⁰

INFANT

Increased breastfeeding duration

as financial security allows parents to extend leave and reduce barriers to nursing. ¹¹

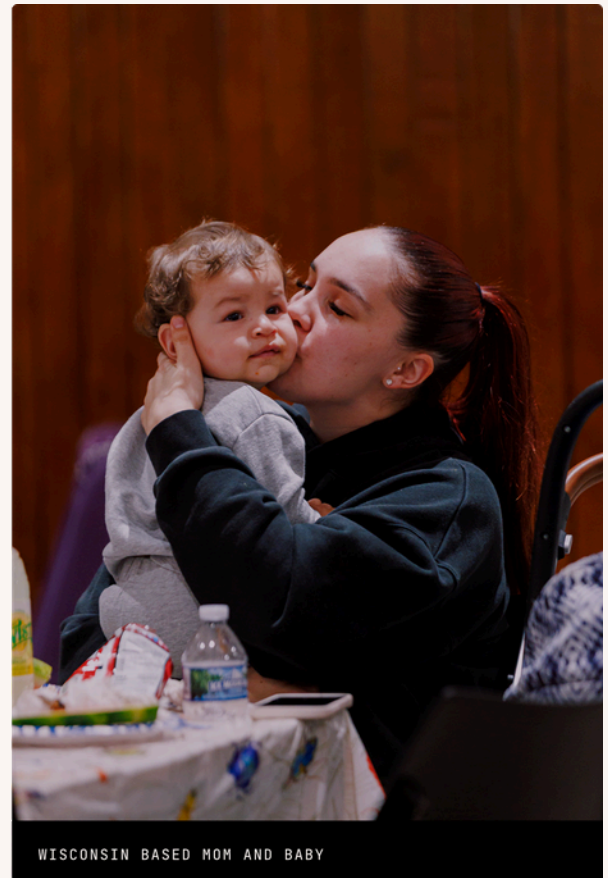
MATERNAL

Decreased likelihood of postpartum depression

with research linking financial stress reduction to improved maternal mental health outcomes. ⁹

\$71,158

Average NICU cost saved for every preterm birth averted. ¹



These outcomes are not just good for families, they are good for society. Every preterm birth averted saves an average of \$71,158 in NICU costs. ¹ Reductions in maternal depression reduce emergency department utilization. Improved infant health in the first year of life predicts better educational, economic, and health outcomes for decades to come.



Governor Wes Moore with baby Nala, whose mother, Briana, received cash transfers during her pregnancy and Nala's first 1,000 days

Design elements that drive success.

Beyond funding, the design of a program shapes whether families enroll, stay enrolled, and experience meaningful benefit. MICC programs have identified a set of design principles, grounded in community feedback and implementation experience, that consistently correlate with strong participation and positive outcomes.

1 Upfront or prenatal stipends

Starting cash support before birth, rather than waiting for the postpartum period, reduces stress during the developmentally critical prenatal window and improves crucial health outcomes like low birthweight and preterm birth.

2 Flexible payment options

Offering multiple disbursement methods, including prepaid debit cards, direct deposit, and mobile payment platforms, removes barriers to access, particularly for participants without traditional bank accounts.

3 No SSN requirements

Removing documentation barriers dramatically expands program reach to undocumented families, recently housed individuals, and others who face systemic barriers to enrollment in traditional social programs. The use of public funds, however, can bring citizenship requirements, a critical reason private funding alongside public investment remains valuable even after a program secures government support.

4 Fee-free withdrawals and multilingual support

Cash loses its power if families pay fees to access it or cannot navigate enrollment systems in their primary language.

5 Integration with supplemental programs

Cash is most powerful when paired with complementary supports: coaching, doula care, peer support, WIC, housing assistance, and mental health services.

Building public funding: a roadmap.

One of the most important lessons from the Mother and Infant Cash Coalition programs is that there is no single route from pilot to public funding. The pathways are varied: some programs moved through state legislative processes, others through county budget negotiations, and still others through agency-level program development. What they share is a strategy of building evidence, cultivating public champions, and aligning program outcomes with the priority metrics of government partners.

PHASE 1

Establishing Proof of Concept with Private Funds

Every publicly funded baby cash program in America began the same way: with a funder who believed the idea was worth testing before governments were ready to fund it.

PHASE 2

Engaging Public Agencies and Mapping the Funding Landscape

When a program has demonstrated proof of concept, solid outcomes data, operational track record, community trust, and a clear cost-per-participant figure, it is ready to begin the work of public partnership.

PHASE 3

Building Bipartisan Champions

Policy windows open, and stay open, because of champions.

TIP • START WITH A LANDSCAPE ANALYSIS, NOT A FUNDING ASK

Before approaching any public agency, conduct a thorough review of the funding sources available in your state or locality. What is the state's TANF balance? Is there capacity to draw down additional funds, or is the state already fully committed? Has the state used its CHIP Health Services Initiative authority? Are there human services reserves or public savings that could be directed toward upstream investment? In the current federal environment, this analysis is best focused on state and local options first, since state TANF balances, CHIP HSI authority, county budgets, and dedicated state revenue are where most near-term public funding decisions are actually being made. Understanding this landscape before you walk in the door is what separates a productive first meeting from a frustrating one.



Bridge Project moms and staff in NYC

The step-by-step process.

- 01 Map available funding streams in your geography. Use the tables in the following section as a starting point. For each potential source, assess: Does this state/locality have capacity? Is the political environment favorable? Does this funding stream have design implications that fit our program model?
- 02 Identify the public agency that administers the most promising stream and request an exploratory conversation. Frame the meeting around their goals, reducing maternal mortality, improving infant health outcomes, reducing future Medicaid costs, not your program's needs. Come prepared with your outcomes data, your cost-per-participant figures, and a clear articulation of how your program advances their performance measures.
- 03 Align your program's outcomes with the agency's existing accountability metrics. Public agencies fund programs that help them hit their targets. If a state Medicaid agency is measured on preterm birth rates, frame your program's impact on preterm birth. If a TANF office is measured on caseload reduction, demonstrate the connection between early cash investment and reduced future TANF enrollment. This alignment is not spin, it is how public money flows.
- 04 Understand the administrative pathway for each funding stream. Some streams require legislation; others are purely administrative. Some require a formal Request for Proposals (RFP) or bidding process; others can be activated through a direct contract or grant. Know what you are asking for before you ask.
- 05 Build a braided funding model. No single stream will likely cover everything, and diversification is itself a form of resilience. Think about which streams are most appropriate for the cash transfers themselves versus program administration, evaluation, and participant navigation. Different funders have different allowable uses, and a well-designed braiding strategy plays to each funder's strengths.
- 06 Negotiate program design flexibility as part of the funding agreement. Some public funding streams carry design requirements: TANF-compliant programming, for example, typically requires a behavioral intervention component. Know what constraints come with each stream and negotiate for the maximum flexibility possible while remaining within legal and regulatory bounds.

Federal funding sources.

The following table summarizes the federal funding streams that have been tested or have potential for perinatal cash programs, based on MICC members and aligned programs currently in operation. Each stream carries its own eligibility requirements, design implications, and political considerations.

FUNDING SOURCE	STATUS	HOW IT WORKS FOR PERINATAL CASH	PROGRAMS USING IT
TANF Block Grant	USED	Two pathways: (1) TANF-compliant programming: design activities satisfying TANF's primary goals, no plan amendment required; (2) Non-Recurrent Short-Term (NRST) payments: up to 4 unrestricted cash payments per household, no behavioral conditions. [2]	The Bridge Project (NY), Rx Kids (MI), BABY Benefit (NY) [3]
ARPA	USED	Pandemic-era federal payments to states and localities, required to be obligated by deadline. Not a permanent source, but was a major early-stage funder for several MICC programs.	The Bridge Project (WI), Multnomah Mother's Trust (OR), Delaware HWHB, People's Prosperity Pilot (MN)
Medicaid §1115 Waivers	NOT YET TESTED	Allows states to waive standard Medicaid requirements and test new approaches. Biden-era guidance permitting nonmedical services has been rescinded; future administrations may restore flexibility. H.R. 1 now requires budget neutrality for all 1115 waivers beginning FY2027. [4]	Not yet used for perinatal cash
CHIP Health Services Initiatives	NOT YET TESTED	States may use up to 10% of annual CHIP allotment for administration, including HSLs (public health programs targeting child health). [5] Draws enhanced federal match (~71% nationally). Purely administrative, no legislation required.	Not yet used for perinatal cash; being explored across a few states
Title V MCH Block Grant (SPRANS)	NOT YET TESTED	~15% of MCH block grant (~\$100M nationally) set aside for Special Projects of Regional and National Significance. Viable for pilots; not sufficient for statewide programs. Allocated by HRSA; competitive and constrained under current federal priorities.	Conceptual; Not yet used for perinatal cash
Family First Prevention Services Act (FFPSA)	PENDING	Services approved by the Title IV-E Clearinghouse are eligible for federal reimbursement. Cash transfers themselves are not yet approved, but some supplemental program models have been.	Kentucky Family First Prevention Program (flexible cash component)
MIECHV Innovation Dollars	NOT YET TESTED	MIECHV grantees can apply for innovation awards that enable them to improve or enhance service delivery. While gift cards are commonly supplied via these dollars, cash transfers have not yet been tested through this mechanism. [6] Importantly, they'd have to be paired with home visiting.	Not yet used for perinatal cash
NIH Research Grants	EVALUATION	Federal research grants support rigorous evaluation of perinatal cash programs. Not a source for direct transfers, but funds the evidence base that justifies public investment.	Baby's First Years, CA Abundant Birth Project, Preterm Infant Care Study

NOTE ON THE CURRENT FEDERAL ENVIRONMENT

Several federal funding pathways that were more accessible under the previous administration have been restricted or complicated under the current one. Medicaid 1115 waivers for nonmedical services have become harder to obtain, and H.R. 1 imposes new budget neutrality requirements beginning in FY2027. MICC recommends that programs consult with policy counsel before investing significant organizational resources in federal pathways that may shift; state and local streams, below, are for now the steadier bet.

State and local funding sources.

State and local funding streams are the backbone of MICC programs and, in the current federal environment, represent the most reliable near-term path to sustained public investment. The landscape varies significantly by state: a state like Michigan, with a dedicated tobacco tax fund and significant TANF capacity, has very different options than a state like Vermont, which has exhausted its TANF reserves but holds a substantial Human Services Caseload Reserve. The first step in any state-level strategy is understanding what is actually available.

FUNDING SOURCE	STATUS	HOW IT WORKS FOR PERINATAL CASH	PROGRAMS USING IT
State/City General Funds	USED	Direct legislative appropriation from state or municipal general fund. Requires a legislative champion and budget process engagement. Most durable pathway once established.	Bridge Project (NYC), Abundant Birth Project (CA), Delaware HWHB, Philadelphia Joy Bank
Dedicated State Revenue (Tobacco/Vice Taxes)	USED	Several states direct tobacco or other excise tax revenue to public health programs. Provides a dedicated, recurring funding stream outside the general fund appropriations process.	Rx Kids (Healthy Michigan Fund), Mother's Rising (CA Prop 10)
County General Funds	NOT YET USED	County budget appropriations, often requiring engagement with county commissioners or boards of supervisors. Faster to move than state legislation in some jurisdictions.	Multnomah Mother's Trust (OR), Born Well (San Diego County), Birth Justice Collaborative (Hennepin County, MN)
State Reserves	NOT YET USED	Some states have accumulated surplus funds in reserves. Accessing these funds typically requires legislative appropriation and a compelling link to the reserve's goals.	Not yet used for perinatal cash
State Public Savings Reinvestment	NOT YET USED	Savings from reduced shelter utilization, emergency housing support, or other social programs could be reinvested in upstream perinatal cash. Requires establishing the connection between cash transfers and downstream system savings.	Conceptual; no tested programs to date
Medicaid MCO Community Benefit Investments	USED	Medicaid MCOs are increasingly investing in social determinants of health interventions. Not public dollars per se, but often function as quasi-public funding given the regulatory context.	San Mateo Baby Bonus (San Mateo, CA)

CASE STUDY • THE BIRTH FUND, INDIANA

The BIRTH Fund launched in Indianapolis in 2025 through the tireless efforts of Ben Tapper at the City of Indianapolis who not only raised enough funds to get the program off the ground but exceeded the fundraising goal by more than **150%**, a result that has since sparked ongoing conversations about statewide expansion. Ben's success underscores two critical lessons: the value of broad base-building, and the power of cultivating champions who can advocate for the work from within, lending it the credibility and visibility needed to scale. By partnering with a nonprofit to handle program operations and implementation, Ben was able to concentrate his energy where his expertise could have the greatest impact and expedite the program's expansion.

Building bipartisan champions.

Policy windows open, and stay open, because of champions. Funding streams matter, but they are ultimately activated by people: legislators who promote the policy, agency officials who approve the program, and community leaders who make the political case. Building that base of support is not ancillary to the funding work; it is the funding work.

One of the most important lessons from MICC programs is the value of bipartisan support. Baby cash programs have found champions on both sides of the aisle: Republicans who see unconditional cash as consistent with family values and limited government intervention in flexible family decision-making, and Democrats who see it as an essential investment in equity and child well-being. Programs that have cultivated both have proven more durable across changes in political leadership, and can do so without betraying their values or other movements to support reproductive health.

In an era of deep political polarization, programs that are perceived as partisan are vulnerable every time the balance of power shifts. The Bridge Project, for example, which operates in West Virginia, Kentucky, Tennessee, Arkansas, Wisconsin, and Ohio, has built support among both Democratic and Republican legislators by emphasizing the potential for cost savings, its connection to infant health outcomes, and the role of private philanthropic matching as a demonstration of community investment—all issues that cross party lines. When advocates can bring a Republican and a Democrat to the same press conference, a program becomes significantly harder to defund. In some states, bipartisan champion building isn't necessary for legislative efforts, but can still add durability.

TIPS AND TRICKS

01 Start with a health focus, not an income focus

For legislators who may be skeptical of cash transfers as an anti-poverty tool, the maternal and infant health outcomes are often more persuasive and less politically charged. Preterm birth rates, maternal mortality, breastfeeding duration: these are outcomes that virtually every legislator, regardless of party, cares about, and where economic returns are most obvious.

02 Engage agency partners early and openly

Public agency staff are not just administrators of funding streams, they are potential advocates for your program within the government. Agency officials who understand your program, trust your data, and see alignment with their own priorities can become powerful internal champions who open doors that external advocates cannot.

03 Identify the right committee assignments

Legislative champions are most valuable when they sit on the committees that control relevant budget lines or authorize the programs you need. A champion on the Health Committee who can move a Medicaid waiver, a champion on Appropriations who can insert a line item, and a champion on Human Services who can defend TANF flexibility are three different assets, and ideally, you have all three.

04 Equip champions with constituent stories

Data makes the intellectual case; stories make the political one. Champions who have heard directly from pregnant people in their districts about what cash support meant for their families, their health, their housing, their ability to be present with their newborns, carry those stories into budget negotiations and floor debates.

05 Build for continuity, not just passage

The goal is not a single legislative victory but a durable coalition that can defend the program across election cycles and budget pressures. Programs that invest in ongoing relationship maintenance with public partners, regular data sharing, good press, joint presentations, co-authored publications, build the kind of institutional buy-in that survives turnover in political leadership.

PRIVATE FUNDER

“Public-private partnerships are essential to moving ideas like cash transfers from successful pilots to sustainable systems change. Philanthropy lays the foundation by supporting innovation, helping generate evidence, and strengthening implementation while public investment is critical in expanding that impact and ensuring programs that work can reach more families long-term.”

— Rachel Wick

Senior Program Officer, Strengthening Economic Security and Mobility, Blue Shield of California Foundation

Conclusion & recommendations.

The programs profiled in this report represent the leading edge of a movement, one that is proving, city by city and state by state, that unconditional cash can change the trajectory of maternal and infant health in America. Together, they point toward a future in which every pregnant person, regardless of zip code or income, has access to the financial support they need to have a healthy pregnancy, a healthy baby, and a stable start to family life.

That future is within reach. But it requires sustained commitment from policymakers, funders, and community-based implementers working together, and working in partnership.

KEY TAKEAWAYS

Public / private partnership is the near-term path to a public / funding destination, not a substitute for it

Right now, that means focusing on states and localities while continuing to build the case for permanent federal funding.

Design matters

The strongest programs invest in access: removing barriers to enrollment, offering flexible payment methods, and integrating cash support with the perinatal services families are already using. Community-informed design is not a nicety; it is a driver of impact.

Braided funding is durable funding

Programs that rely on a single source are vulnerable. Programs that combine Medicaid/CHIP, TANF, hospital community benefit, and philanthropic dollars are better positioned to survive shifts in any one funding stream, and better able to move at the speed the current moment demands.

The evidence is there

The programs profiled here, and the broader research literature on unconditional cash transfers, make a powerful case for investment. The task now is translation: turning evidence into policy, and policy into sustained public funding.

The evidence for maternal and infant cash transfers is strong. The programs are proven. The public appetite, from policymakers, funders, and communities, is growing. What comes next is the same partnership model that got each program this far: full public funding as the goal, states holding the near-term keys, and private capital doing what only private capital can do until that goal is reached. MICC is committed to that work, and **this report is an invitation to join it.**



Full public funding is the destination, and public / private partnership is how programs get there.

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