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

A practical financing pathway for Med-QUEST (Hawaiʻi's Medicaid division) to draw down federal match — at a 71.36% enhanced rate — for direct cash assistance during pregnancy and the postpartum period, and to braid that federal anchor with the state's existing family economic security commitments and deep, largely untapped reserve funds.

71.36%

ENHANCED FEDERAL MATCH

Hawai‘i's E-FMAP for CHIP HSI expenditures, FY2025.[1]

$2.49

PER STATE DOLLAR

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

$400M+

UNSPENT RESERVE

Hawai‘i is currently sitting on more than $400 million in unspent TANF reserves — the 4th-largest such reserve of any state in the country, and one already under legislative pressure to be put to use for exactly this kind of family support.[2]

1st

IN THE NATION — STATED VALUES COMMITMENT

In 2017, Hawai‘i became the first state to formally declare that “all families deserve basic financial security,” unanimously passing a resolution to study direct income support — a values commitment this proposal can help fulfill.[3]

4.9 / 1,000

INFANT MORTALITY

Hawai‘i's overall infant mortality rate is comparatively low (rank 15th of 52), but Pacific Islander infants die at 1.3x the state rate — showing that the state's strong average outcomes mask a real, unaddressed gap.[4]

✓

POSTPARTUM & EXPANSION PRECEDENT

Hawai‘i has already adopted both Medicaid expansion and the 12-month postpartum coverage extension — DOH and Med-QUEST have a demonstrated track record of extending coverage and financing around the perinatal window.[4]

The high cost of living is a maternal and infant health issue.

Hawai‘i's headline maternal and infant health numbers look better than most of the country's — infant mortality ranks 15th of 52 and maternal mortality ranks 7th of 48, among the best in the nation.[4] But averages mask real gaps. Pacific Islander infants die at 1.3 times the statewide rate, and Pacific Islander mothers face inadequate prenatal care at 2.1 times the statewide rate.[4] Preterm birth sits at a “C” grade statewide (10.0%, 1,494 babies in 2024) — and on Hawai‘i Island specifically, the rate is 11.3% and worsening, a “D-” grade that stands out against Maui's “A.”[4] Severe maternal morbidity — the rate of serious complications during labor and delivery — has also been worsening.[4]

The reason isn't primarily coverage. Hawai‘i has adopted full Medicaid expansion and the 12-month postpartum extension, and Med-QUEST paid for over a third of all Hawai‘i births in 2024.[4] The gap is the cost of living. Hawai‘i has the highest cost of living of any state in the country, and a large share of working families — measured by the ALICE (Asset Limited, Income Constrained, Employed) framework — earn above the federal poverty line but still can't cover a basic household budget. Financial strain during pregnancy is one of the most potent predictors of preterm birth, low birthweight, and maternal complications, and in Hawai‘i that strain often has nothing to do with unemployment or lack of insurance — it's rent, food, and childcare costs that outpace almost anywhere else in the country.

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. Hawai‘i has already said, as a state, that every family deserves basic financial security. A CHIP HSI perinatal cash pilot is a concrete, federally leveraged way to act on that commitment specifically at the moment it matters most for a child's lifelong health.

FIGURE 01 · HAWAI‘I PRETERM BIRTH, 2024
PERCENT OF LIVE BIRTHS

Infant mortality: 4.9 per 1,000 live births, rank 15th of 52. Pacific Islander infants die at 1.3x the state rate; Pacific Islander mothers face inadequate prenatal care at 2.1x the state rate. Maui, by contrast, grades an “A.”[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**.

A national researcher review of Hawai‘i's own safety-net system has specifically recommended that the state *“provide cash assistance to pregnant people without children earlier in pregnancy”* as a way to build positive developmental outcomes for children from the very start.[5]

This proposal is a direct, federally matched way to do exactly that.

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.[6]

> *"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/Med-QUEST 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.

Hawai'i has already extended Medicaid postpartum coverage to a full year and adopted full Medicaid expansion — evidence that DOH and Med-QUEST have both the coverage infrastructure and the CMS working relationship to support a perinatal-window financing proposal.[4]

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

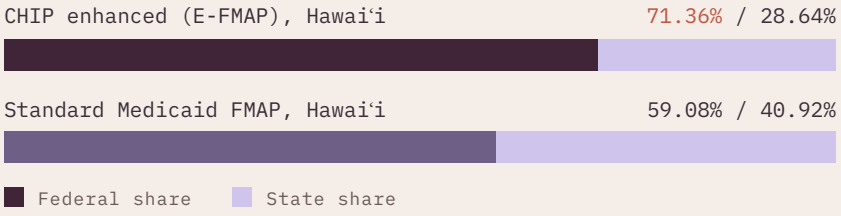
STEP 04
Remaining HSI capacity drawn at 71.36% federal match

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 Hawai'i CHIP HSI draws meaningfully more federal investment than standard Medicaid.



$2.49

Federal dollars drawn for every state dollar invested in a Hawai'i CHIP HSI, versus $1.00 under standard Medicaid. Hawai'i's regular Medicaid FMAP is 59.08%, and the E-FMAP formula reduces the state share by 30% on top of that, yielding 71.36%.[1]

SOURCE: MACPAC MACSTATS EXHIBIT 6, FY2025.[1]

The Hawai‘i context: cap room and a real reserve to draw on.

States may use up to 10% of total CHIP expenditures for administrative costs, including outreach, translation, and HSIs, provided spending stays within the state's CHIP allotment.[7] Most states use only a fraction of that cap: 35 states use less than half of it, and only six — Alaska, Massachusetts, Minnesota, New Jersey, New York, and Vermont — approach the 10% limit. Hawai‘i is not among them, and in 2024, 48 states and the District of Columbia had remaining capacity under the cap, meaning they are legally permitted to spend additional funds on HSI activities.[7] As a smaller state by population, Hawai‘i's total CHIP allotment is modest in absolute dollars, which argues for a tightly scoped, single-island or single-region Phase 1 pilot rather than a statewide launch at the outset — a phased approach CMS has already accepted for HSI applications elsewhere.

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, on Hawai‘i Island, where preterm birth rates are worst and worsening — is the most direct path to expanding drawable federal dollars over a 3–5 year horizon.

ILLUSTRATIVE PILOT COST · $1,000/MO · 15 MONTHS

PILOT SIZE	TOTAL OBLIGATED	STATE SHARE (28.64%)
~100 participants (Phase 1)	~$1.5M	~$430K
~500 participants (Phase 2)	~$7.5M	~$2.1M
~1,000 participants (statewide scale)	~$15M	~$4.3M

A Phase 1 pilot of ~100 participants, targeted to Hawai‘i Island or another single high-need region, positions Med-QUEST to demonstrate impact and rebase its allotment for expansion — and the state's own unspent TANF reserve (below) is large enough to cover the entire Phase 1 state match many times over.

Hawai‘i has not yet paved this specific road — but its own coverage record shows the willingness to act.

HEALTH SERVICES INITIATIVE	STATUS	AUTHORITY USED
Medicaid expansion	Adopted — HI	ACA Medicaid expansion
12-month postpartum Medicaid extension	Adopted — HI (via ARPA option; also GA, MS, and others via various authorities)	Postpartum coverage extension
Home visiting (MA, MO, AL)	Approved — multi-state	Maternal–infant dyad health
Prenatal care coordination (NJ)	Approved	Perinatal navigation
Perinatal cash HSI (proposed)	Not yet attempted by any state	FCEP / fetal & infant health

Hawai‘i would be a first mover on the specific cash-assistance HSI application — a harder ask for CMS in one sense, but Hawai‘i's high existing coverage baseline, its stated 2017 commitment to basic financial security for all families, and its large unspent TANF reserve together make an unusually strong and low-friction case for this specific proposal, since the state doesn't need to find new money — it needs to spend money it already has.

CHIP HSI is the federal anchor. Hawai‘i's own unspent reserves are the match.

A braided strategy pairs the federal leverage of the HSI with existing Hawai‘i funding vehicles — several of which are, unusually, sitting substantially unspent and under active legislative pressure to be put to use.

THE FEDERAL ANCHOR AND FOUR NON-FEDERAL MATCH OPTIONS

FUNDING SOURCE 01

CHIP HSI (Federal Anchor)

SSA §2105 · 71.36%

The primary vehicle for drawing down federal funds already appropriated to Hawai‘i. Covers direct cash assistance to Medicaid/Med-QUEST-eligible pregnant individuals, structured as an HSI with the fetal and infant health benefit as the documented outcome focus. State match (28.64%) provided by any of the sources below.

ROLE IN PROGRAM

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

FUNDING SOURCE 02

TANF Reserves (Department of Human Services)

~$400M+ · 4TH-LARGEST IN THE NATION

Hawai‘i receives about $99 million a year in federal TANF block-grant funds but currently holds an unobligated reserve of more than $400 million — roughly 4.5 years' worth of federal allocations sitting unspent.[2] This is a well-documented, publicly criticized pattern (the state's own tax policy groups have called it “TANF hoarding”), and DHS has already stated it is actively exploring new uses, including diaper assistance and housing support for families.[2] TANF has documented allowable uses for direct cash assistance to low-income families with children, and a national child-poverty research center has specifically recommended Hawai‘i use TANF-adjacent authority to fund cash assistance to pregnant people earlier in pregnancy — exactly this proposal.[5]

ROLE IN PROGRAM

The strongest single non-federal match candidate identified for Hawai‘i; large enough to fund a multi-year, multi-phase pilot on its own, and directly responsive to existing legislative and public pressure to put the reserve to use.

NOTE: TANF DOLLARS USED AS MATCH MUST NOT THEMSELVES BE FEDERAL DOLLARS CLAIMED AGAINST OTHER FEDERAL FUNDS

FUNDING SOURCE 03

Hawai‘i Tobacco Settlement Special Fund

1998 MASTER SETTLEMENT AGREEMENT

Hawai‘i's Tobacco Settlement Special Fund receives the state's share of the national tobacco settlement and statutorily directs a portion toward health-related purposes, including the Department of Health and community health programs. This is a clean, apolitical, health-earmarked non-federal match source with no federal strings attached.

ROLE IN PROGRAM

Secondary or supplemental non-federal match; can scale into a sustaining appropriation as the pilot demonstrates results.

FUNDING SOURCE 04

State General Fund / Family Economic Security Line Items

SUBJECT TO ANNUAL APPROPRIATION

Hawai‘i's 2017 unanimous legislative resolution declaring that “all families deserve basic financial security” remains a live, citable political commitment that has never been fully acted on. A modest General Fund line item tied explicitly to that resolution — and to the state's cost-of-living crisis more broadly — gives legislators a clear, values-consistent vehicle. At a 71.36% federal match, $1 of General Fund investment draws $2.49 in federal funds.

ROLE IN PROGRAM

Flexible non-federal match; a natural fit alongside the TANF reserve as a second funding stream.

FUNDING SOURCE 05

Medicaid Managed Care (Med-QUEST Health Plans)

COMMUNITY INVESTMENT

AlohaCare, HMSA, Kaiser Permanente, UnitedHealthcare Community Plan, ‘Ohana Health Plan. Several of these plans already fund community health investments and Native Hawaiian health partnerships on a voluntary basis, and Med-QUEST's existing contract relationship with them could be a channel for supplemental or in-kind program support (care coordination, doula or lactation support, member outreach).

ROLE IN PROGRAM

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

BRAIDED FUNDING MATRIX · ILLUSTRATIVE PHASE 1 — ~$1.5M, 100 PARTICIPANTS

SOURCE	ROLE	EST. CONTRIBUTION
CHIP HSI (federal)	Direct payments, federal share	~$1.07M (71.36%)
TANF unobligated reserve and/or Tobacco Settlement Fund	Direct payments, state match	~$430K (28.64%)
Community delivery partner (e.g., Native Hawaiian health care system, community action agency)	Distribution infrastructure, trust, coaching	In-kind / philanthropic
Title V MCH (Hawai‘i DOH)	Data, local coordination, reporting	Existing staff
Med-QUEST health plans	Supplemental, in-kind support (screening, referral)	TBD — pursue directly, not guaranteed

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 Hawai‘i vital statistics or quarterly program surveys.

FOUR OUTCOME DOMAINS

Birth Outcomes

HAWAI‘I DOH VITAL STATISTICS

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

Maternal Health

PROGRAM SURVEYS, HAWAI‘I DOH

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

Economic Stability

QUARTERLY PROGRAM SURVEYS

Housing stability	% eviction or cost move
Food security status	Survey measure

Population Outcomes

HAWAI‘I DOH · CMS REPORTING

Outcome gap by geography/subgroup (e.g., Native Hawaiian/Pacific Islander vs. statewide)	Per CMS standards
Infant mortality rate	vs. HP2030 5.0/1,000

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.

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 — a particularly acute concern in a state where the cost of living, not lack of coverage, drives financial strain during pregnancy.

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.

What Med-QUEST 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 Hawai‘i's CMS CHIP Project Officer early to align on expenditure framing and outcome metrics.

04 Identify a non-federal match source — the unobligated TANF reserve is the clear first candidate, with the Tobacco Settlement Fund or a General Fund line item as alternates.

05 Draft outcome metrics from the four-domain framework, with Hawai‘i-specific data sources (DOH vital statistics, PRAMS survey data, Medicaid encounter data).

06 Submit the SPA with defined outcome metrics, geographic scope (single island/region for Phase 1), Medicaid eligibility framing, and 15-month duration.

Questions from CMS and Med-QUEST 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 — pathways that are especially relevant in a state where housing cost, not employment status, is the dominant financial stressor.

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 CHIP at birth. In Hawai‘i, where Med-QUEST pays for over a third of all births, the CHIP-beneficiary nexus is direct and documentable.

Q.04

How will outcomes be measured?

Birth outcomes from Hawai‘i DOH 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 Hawai‘i's own stated priorities?

Hawai‘i's 2017 legislative resolution already declares that all families deserve basic financial security. The evidence base for perinatal financial assistance directly addresses the cost-of-living pressures that a national researcher review specifically flagged in recommending cash assistance for pregnant Hawai‘i residents.[5] This HSI is not a new priority; it is a federally matched financing mechanism for a commitment the state has already made — funded largely by dollars Hawai‘i already has sitting unspent.

Sources

1 MACPAC, MACStats Exhibit 6 — Federal Medical Assistance Percentages and Enhanced FMAPs by State, FYs 2023–2026 (Hawaiʻi FY2025 E-FMAP: 71.36%; FMAP: 59.08%).

2 Hawaiʻi Public Radio, “$400M stockpile for Hawaiʻi low-income families could soften effects of federal cuts” (Oct. 2025); Tax Foundation of Hawaii, “TANF Hoarding” and “Even More TANF Hoarding.”

3 Hawaiʻi House Concurrent Resolution 89 (2017); Hawaiʻi News Now, Civil Beat, and World Economic Forum coverage of Hawaiʻi's basic income study resolution.

4 2025 March of Dimes Report Card, Hawaiʻi (PeriStats); Hawaiʻi Health Matters (Hawaiʻi Department of Health).

5 National Center for Children in Poverty (NCCP), “TANF Profile: Hawaii” (2024).

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

7 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 (March 2026), analyzing FY2024 CHIP Annual Financial Management Reports.

ABOUT THE COALITION

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

motherinfantcash.org