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

A practical financing pathway for California's Department of Health Care Services to draw down federal match, at a 65% enhanced rate, for direct cash assistance during pregnancy and the postpartum period, and to braid that federal anchor with the state's deep existing investments in maternal and infant health.

ABUNDANT BIRTH PROJECT · CALIFORNIA

AT A GLANCE

65%

ENHANCED FEDERAL MATCH

California's E-FMAP for CHIP HSI expenditures, versus 50% for standard Medi-Cal.

1st

IN THE NATION

The first publicly funded guaranteed-income pilot for pregnancy in the United States.

$1.8B+

ANNUAL CHIP ALLOTMENT

California's federal CHIP allotment; most administrative-cap capacity goes unclaimed.

3–4×

MATERNAL MORTALITY GAP

Black mothers in California die from pregnancy-related complications at three to four times the rate of any other group.

$1,000

LOWERS LOW BIRTHWEIGHT

Monthly cash has been shown to decrease low birthweight by 2–10%, depending on the study.

✓

HSI PRECEDENT EXISTS

CMS has already approved a California HSI for postpartum Medi-Cal extension, establishing the analytic pathway.

Coverage is necessary. It is not sufficient.

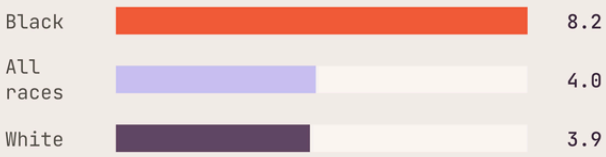
California has achieved the lowest maternal mortality rate in the United States, and its Black, Native, and Pacific Islander birthing people are still dying at three to four times the rate of their white peers.[2] Infant mortality among Black babies in California (8.2 per 1,000 live births) is more than twice the rate for white infants (3.9 per 1,000).[2] Among all races, 36,468 California babies were born preterm in 2024, a rate of 9.1%, earning the state a "C" grade from the March of Dimes.[3]

These are not failures of coverage. California has among the most expansive Medi-Cal eligibility in the nation, covering pregnancy through 12 months postpartum. **The gap is economic.** Poverty during pregnancy is one of the most potent predictors of preterm birth, low birthweight, and maternal mortality, and those risks fall hardest along lines of race and geography. Nearly one-third of Californians live at or near poverty.[1]

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

FIGURE 01 · CA PERINATAL DISPARITY

Infant mortality by race, per 1,000



All-race preterm birth: **9.1%** (36,468 births, 2024).[2]

WHAT THE EVIDENCE SHOWS

Unconditional cash transfers in utero and infancy have produced improved birth outcomes, higher breastfeeding initiation, significant reductions in infant-maltreatment allegations, fewer evictions, and better maternal mental health. California's own CDPH names economic stressors as a primary upstream driver of the racial disparities it targets through the Black Infant Health Program and Perinatal Equity Initiative[12], yet neither program deploys direct income support at scale.

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.[4]

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-transfer program for pregnant Medi-Cal 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.

California has already established the legal pathway. CMS has approved a California HSI for a 12-month postpartum Medi-Cal extension, demonstrating that DHCS and CMS have a working relationship under this authority and that perinatal framing has been accepted. This proposal builds directly on that precedent.

"

STATUTORY CITATION

"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)

REGULATION
42 CFR §457.10

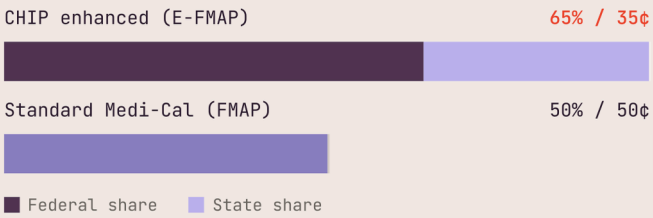
PROGRAM
Title XXI · CHIP

HOW THE FUNDING FLOWS

STEP 01	STEP 02	STEP 03	STEP 04	STEP 05	STEP 06
Annual CHIP allotment (Title XXI)	10% administrative cap (statutory ceiling)	Identify existing dollars to braid into the state contribution	Remaining HSI capacity drawn at 65% federal match	State Plan Amendment (SPA) to CMS with defined metrics	Perinatal cash HSI in operation - better birth outcomes

FIGURE 02 · FEDERAL MATCH COMPARISON — CALIFORNIA-SPECIFIC

Per state dollar spent, a CHIP HSI draws meaningfully more federal investment than standard Medi-Cal.



$1.86

Federal dollars drawn for every state dollar invested in a CHIP HSI, versus **$1.00** under standard Medi-Cal. California's FMAP is 50%, the statutory minimum, and the E-FMAP formula reduces the state share by 30% to yield a 65% match.[5]

Source: MACPAC MACStats Exhibit 6 (FY2024-25)[5] · CMS CHIP Financial Management Reports[6] · California FMAP confirmed at 50% per HHS, 88 FR 81090 (Nov. 2023).[7]

The California Context: Limited Cap Room

CHIP administrative expenditures are capped at 10% of total CHIP spending. California's annual CHIP allotment exceeds $1.8 billion, but after eligibility systems, managed-care oversight, and staffing, little remains inside the cap. If California wants to use the HSI authority, the initial program must be sized to available **excess allotment**, with a phased strategy to grow the allotment over time.

How to unlock more federal dollars. Because the allotment rebases in odd years from actual prior-year spending, a state that increases CHIP expenditures in even years sees its odd-year rebased allotment grow. A geographic pilot designed to demonstrate impact and scale spending is the most direct path to expanding drawable federal dollars over a 3–5 year horizon.[8]

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

PILOT SIZE	TOTAL OBLIGATED	STATE SHARE (35%)
~100 participants (Phase 1)	~$1.5M	~$525K, within current excess allotment
~500 participants (Phase 2)	~$7.5M	~$2.6M
~1,000 participants (statewide scale)	~$15M	~$5.25M

A Phase 1 pilot of ~100 participants, targeted to a single high-need county, is achievable within California's current excess allotment and positions DHCS to rebase its allotment and expand. Sources: Georgetown CCF (Mar 2026)[8]; CMS CHIP Financial Management Reports FY2024[6]; MACPAC MACStats Exhibit 6.[5]

California has already paved this road, and HSIs are commonly used for perinatal health.

HEALTH SERVICES INITIATIVE	STATUS	AUTHORITY USED
12-month postpartum Medi-Cal extension	Approved -- CA, IL, MN, VA	FCEP / postpartum HSI framing
Home visiting (MA, MO, AL)	Approved — multi-state	Maternal–infant dyad health
Prenatal care coordination (NJ)	Approved	Perinatal navigation
Lead abatement & behavioral health	Approved — multi-state	Upstream child health

The postpartum Medi-Cal extension precedent is especially significant: CMS accepted the argument that improving maternal health in the postpartum period is a legitimate HSI investment *because of its direct impact on the enrolled or soon-to-be-enrolled child.* That is exactly the causal logic a perinatal cash-transfer program would invoke.

CHIP HSI is the federal anchor. California has the state-side infrastructure to match it.

A braided strategy pairs the federal leverage of the HSI with existing California investments, enabling a program larger and more durable than any single-source approach.

SOURCE 01 — SSA §2105 · 65%

CHIP HSI: Federal Anchor

The primary vehicle for drawing down federal funds. Covers direct cash transfers to Medi-Cal-eligible pregnant individuals, structured as an HSI with the fetal and infant health benefit as the documented outcome focus.

ROLE IN PROGRAM

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

SOURCE 02 — Prop 1 / BHSA

Behavioral Health Services Act

Prop 1 (March 2024) restructured the Mental Health Services Act into the BHSA, retaining a prevention & early-intervention bucket. Postpartum depression affects roughly one in five California birthing individuals, a documented BHSA priority.

ROLE IN PROGRAM

State match and wraparound for postpartum-depression screening, referral, and support co-located with cash distribution.

SOURCE 03 — Title IV-A · CalWORKs

TANF Reserves

CalWORKs has documented allowable uses for direct cash to low-income families with children. Caution: TANF used as the state match must not itself be federal dollars; federal match cannot be claimed against federal funds.

ROLE IN PROGRAM

Non-federal match, particularly for participants who are also active CalWORKs recipients.

SOURCE 04 — MCH Bureau / HRSA

Federal Title V MCH Block Grant

California's Title V allocation (CDPH/MCAH) funds maternal and child health statewide. It cannot fund cash transfers, but can fund the community health worker role, data & vital-statistics linkage, and LHJ partnerships.

ROLE IN PROGRAM

Program infrastructure and workforce — CBO coach positions, data systems, LHJ coordination.

SOURCE 05 — General Fund

CA General Fund / Zero-to-Three

Historic line items for maternal mental-health grants, the Black Infant Health Program, and the Perinatal Equity Initiative represent existing political commitment, and the most flexible state funding for non-federal match.

ROLE IN PROGRAM

Primary non-federal match for Phase 1; scales into a sustaining appropriation as impact is demonstrated.

SOURCE 06 — Flexes by site

Managed Care Plan Re-Investment

Medi-Cal Managed Care Plans are required to reinvest 5–7.5% of annual income into community programs targeting upstream drivers of poor birth outcomes. These dollars are both flexible and mandated.

ROLE IN PROGRAM

Supplemental funding at any stage of the program lifecourse — one opportunity for braiding.

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

SOURCE	ROLE	EST. CONTRIBUTION
CHIP HSI (federal)	Direct cash, federal share	$975K (65%)
CA General Fund	Direct cash, state match	$525K (35%)
First 5 County Commission	CBO coach / distribution infrastructure	TBD by county
Title V MCH (CDPH)	Data, LHJ coordination, reporting	Existing staff
BHSA Prevention bucket	Postpartum MH screening / referral	County allocation
Managed Care Plans	Direct cash, braiding opportunity	Site & year dependent

Designed for impact, for what CMS will approve, and for California's equity goals.

CRITERIA	RECOMMENDATION	PROS	CONS
INCOME CEILING	≤200% FPL	Aligns with Medi-Cal pregnancy coverage and CHIP eligibility.	Harsh cutoff that doesn't respond to families just above the line.
AMOUNT	$500–$1,000/mo, varying by county cost of living	Responsive to the real needs of families.	Administratively more complex.
DURATION	15 months, from the second trimester	Starts early while minimizing miscarriage risk; 6 mo prenatal + 9 mo postpartum.	Doesn't cover the full first year; could extend to 18 months if funding allows.
POPULATION	Align with CalAIM Enhanced Care Management populations of focus	Advances the state's birth-outcomes strategy; equity-driven.	Narrower targeting may reduce access and public support.
GEOGRAPHY	High-need counties: LA, Fresno, San Bernardino, Alameda, Tulare/Kings	Equity-driven; single-county Phase 1 proves impact within excess allotment.	Multi-county partners are harder to manage.

A reporting framework, grounded in published evidence.

CMS-required annual reporting maps cleanly onto four outcome domains, each tied to a measurable metric from California vital statistics or quarterly program surveys.

Birth Outcomes

CA VITAL STATISTICS (CDPH/MCAH)

Preterm birth rate	% births < 37 wks
Low birthweight rate	% births < 2,500g
Very low birthweight	% < 1,500g (Medi-Cal)
NICU admission rate	% newborns admitted

Maternal Health

PROGRAM SURVEYS, CDPH

Prenatal care adequacy	Kotelchuck Index
Postpartum depression	% pos. (Edinburgh/PHQ-9)
Third-trimester smoking	% reporting, 3rd tri

Economic Stability

QUARTERLY PROGRAM SURVEYS

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

Health Equity

CA VITAL STATISTICS, KFF

Racial disparity in LBW	Gap: Black vs White
Infant mortality gap	Gap per 1,000 births

01
Birth Outcomes

Prenatal cash reduces preterm birth, low birthweight, and NICU admissions, outcomes that impose lifelong health consequences on CHIP-eligible children and generate substantial downstream Medi-Cal costs.

02
Infant Neurodevelopment

Poverty during the first 1,000 days causally alters infant brain development in ways that predict long-term cognitive and health trajectories, consistent with California's zero-to-three investment rationale.

03
Maternal Health

Perinatal cash reduces postpartum depression, housing instability, and food insecurity, all of which impair infant health and early caregiving, and all documented priorities in the 2024 Maternal Health Blueprint.

What DHCS needs to do.

CMS works closely with states to define and refine HSIs before formal submission. Early coordination with California's CHIP Project Officer significantly facilitates review, and California's existing postpartum-HSI relationship with CMS is an asset.

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 California's CMS CHIP Project Officer early to align on expenditure framing and outcome metrics. Reference the existing CA postpartum HSI approval.

04 Identify a non-federal match source — General Fund line item, private funding, or BHSA prevention allocation.

05 Draft outcome metrics from the four-domain framework, with California-specific data sources (CDPH vital statistics, MIHA survey, Medi-Cal encounter data).

06 Submit the SPA with defined outcome metrics, geographic scope (single county for Phase 1), Medi-Cal eligibility framing, and 15-month duration.

Questions from CMS and DHCS 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. Cash is the mechanism for delivering the health benefit, consistent with evidence that income is the most upstream determinant of health. CMS accepted this logic in approving postpartum HSIs; the perinatal cash application extends the same causal argument.

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 Medi-Cal-eligible families?

The perinatal window directly shapes the health of the soon-to-be-born child who will enroll in Medi-Cal or CHIP at birth. Multiple studies show prenatal cash produces measurable improvements in the birth outcomes of children subsequently enrolled in public insurance. In California, where Medi-Cal covers the vast majority of low-income births, the CHIP-beneficiary nexus is direct and documentable.

Q.04

How will outcomes be measured?

Birth outcomes from CDPH vital statistics, linked to Medi-Cal encounter data for the enrolled cohort; maternal mental health and economic stability from quarterly program surveys administered by the distribution CBO. CDPH/MCAH's existing Title V data infrastructure, including the MIHA survey, provides a validated, cost-effective measurement platform.

Q.05

How does this align with DHCS's Bold Goals?

DHCS's Bold Goal commits to reducing maternity-care disparities for Black and Native American persons by 50%. The evidence base for perinatal direct cash, including a 91% reduction in eviction rates and a 13-percentage-point reduction in postpartum depression, directly addresses the economic and social-stress pathways driving that disparity. This HSI is not a new priority; it is a new financing mechanism for an existing one.

Sources

1 Public Policy Institute of California (PPIC), “Poverty in California.” ppic.org/publication/poverty-in-california

2 California Dept. of Public Health / MCAH — Preterm Birth surveillance; infant mortality by race. cdph.ca.gov

3 March of Dimes — 2024 Report Card, California (“C” grade; 9.1% preterm, 36,468 births).

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

5 MACPAC — MACStats Exhibit 6, E-FMAPs by state (FY2024–2025).

6 CMS — CHIP Financial Management Reports (FY2024), Medicaid.gov.

7 HHS — Federal Register, 88 FR 81090 (Nov. 2023); California FMAP confirmed at 50%.

8 Georgetown University Center for Children & Families (CCF), March 2026 — CHIP allotment analysis.

9 Rx Kids — American Journal of Public Health (AJPH), 2025 — postpartum depression & eviction outcomes.

10 KFF (Kaiser Family Foundation) — infant mortality and maternal health-equity data.

11 California Health & Human Services — 2024 Maternal Health Blueprint.

12 CDPH — Black Infant Health Program & Perinatal Equity Initiative.

Mother & Infant *Cash Coalition*

A coalition of California clinicians, researchers, and community organizations advancing unconditional cash as perinatal health infrastructure.

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