

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



A practical financing pathway for the Mississippi Division of Medicaid (DOM) to draw down federal match — at an 83.83% enhanced rate, the highest in the nation — for direct cash assistance during pregnancy and the postpartum period.

83.83%

ENHANCED FEDERAL MATCH

Mississippi's E-FMAP for CHIP HSI expenditures for FY2025 — the highest enhanced match rate of any state in the country

\$5.19

PER STATE DOLLAR

Federal dollars drawn for every state dollar invested in a Mississippi CHIP HSI

9.7 / 1,000

HIGHEST IN THE NATION

Mississippi's 2024 infant mortality rate — nearly double the national average of 5.6 — the highest of any state, prompting a state public health emergency declaration in August 2025.²

1st in the nation

GUARANTEED INCOME PRECEDENT

Home to Magnolia Mother's Trust (Jackson, launched 2018), one of the first modern guaranteed income pilots for mothers in the U.S. — proof of concept and community trust already exist here.³

83%

PREVENTABLE

Share of Mississippi pregnancy-related deaths (2017–2021) deemed preventable by the state's own Maternal Mortality Review Committee.⁴



A crisis every Mississippian already agrees is a priority.

Mississippi has the highest infant mortality rate in the country – 9.7 deaths per 1,000 live births in 2024, essentially unchanged from the prior year and the worst it has been in more than a decade.² The state's own Department of Health took the extraordinary step of declaring a public health emergency in 2025 in response.² Preterm birth affects 15% of all Mississippi births (5,017 babies in 2024) – a rate that has climbed steadily from 12.9% a decade ago.⁷ Maternal mortality tells the same story: 23.2 deaths per 100,000 live births, well above the national rate, with 83% of those deaths judged preventable by the state's own review committee.⁴ Every one of these outcomes carries a direct cost to Mississippi taxpayers – in NICU admissions, extended hospital stays, and downstream Medicaid spending that a healthier start in life would avoid.

This is not primarily a failure of coverage or of access to care. Mississippi has already extended Medicaid postpartum coverage to a full 12 months, and Medicaid pays for more than half of all births in the state.⁵ **The gap is economic.** Poverty during pregnancy is one of the most potent predictors of

preterm birth, low birthweight, and maternal complications, and it hits hardest for working families in the state's poorest counties, from the Delta to Jackson.

The perinatal period – pregnancy through the postpartum window – is the critical stretch in which financial strain generates compounding risk: 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.

Mississippi has also already staked out a public commitment on this front, reflected in the 12-month postpartum Medicaid extension and in Attorney General Lynn Fitch's Empowerment Project, which includes the Mississippi Access to Maternal Assistance (MAMA) resource platform connecting expectant mothers to services statewide. A direct cash assistance program during pregnancy is a natural, concrete next step in that same commitment.

FIGURE 01 · MISSISSIPPI INFANT MORTALITY, 2024

RATE PER 1,000 LIVE BIRTHS



All-race preterm birth: 15.0% (5,017 births, 2024).⁷ CMS's HSI reporting requirements call for outcome data broken out by subgroup and county, which the program's four-domain measurement framework (below) is built to satisfy.

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 programs over time rather than increase it.

Mississippi already has a home-grown proof point: a privately funded direct-cash pilot in Jackson has provided short-term cash assistance to new mothers since 2018 and has generated published evidence on housing stability and financial independence.³ What Mississippi lacks is a public financing mechanism to take a model like that to scale using dollars the state is already leaving on the table.



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.⁸

“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 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 an existing federal program already on the books – it requires no new state entitlement, no Medicaid expansion, and no new tax.

Mississippi has already extended Medicaid postpartum coverage to a full year – evidence that DOM and CMS have a working relationship that supports perinatal-window financing decisions, even if that specific extension was structured through a different Medicaid authority (the ARPA state plan option) rather than HSI. This proposal establishes the parallel HSI pathway for direct cash assistance, building on DOM’s demonstrated comfort extending benefits across the perinatal period.⁵

HOW THE FUNDING FLOWS

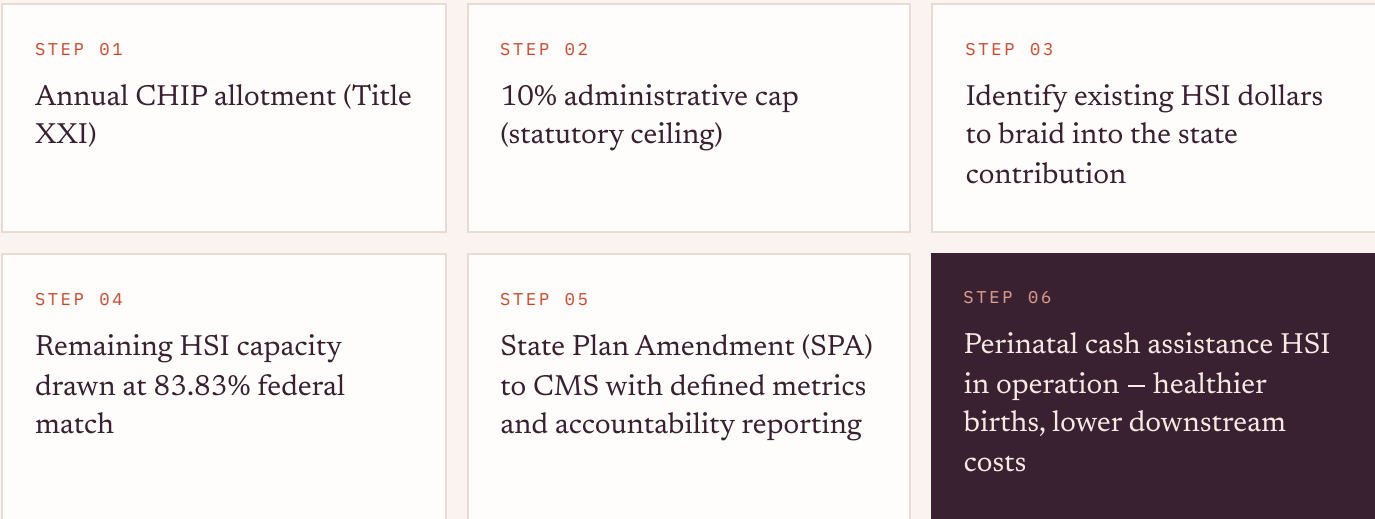
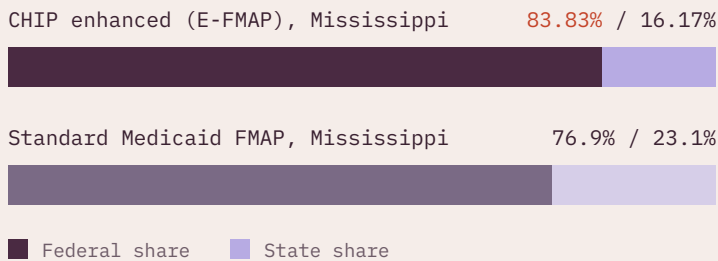


FIGURE 02 • FEDERAL MATCH COMPARISON

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



\$5.19

Federal dollars drawn for every state dollar invested in a Mississippi CHIP HSI, versus \$1.00 under standard Medicaid.

Mississippi's FMAP of 76.9% is the highest in the nation (the statutory ceiling is 83%), and the E-FMAP formula reduces the state share by 30% on top of that, yielding 83.83%.¹

SOURCE: MACPAC MACSTATS EXHIBIT 6, FY2025.¹

The Mississippi Context: Cap Room and Political Landscape

CHIP administrative expenditures are capped at 10% of total CHIP spending nationally. Georgetown CCF's March 2026 analysis of the FY2024 CHIP Financial Management Reports estimates every state's 10% cap, the share already used, the remaining capacity, and the federal and state shares of that capacity at the state's E-FMAP.¹³ Mississippi clears both conditions that have to hold at once: it has \$21.9 million of remaining capacity under the 10% cap, and CCF finds its excess allotment sufficient to draw the federal share against that capacity.¹³ As a non-expansion state, Mississippi's CHIP allotment is likely modest relative to its overall Medicaid footprint, which argues for starting with a tightly scoped, single-region Phase

1 pilot rather than a statewide launch – a phased approach CMS has already accepted for other states' HSI applications.

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 the Delta region (Bolivar, Coahoma, Sunflower, Washington counties) or in Hinds County/Jackson, where Magnolia Mother's Trust already operates and community infrastructure exists – is the most direct path to expanding drawable federal dollars over a 3–5 year horizon.

ILLUSTRATIVE PILOT COST (NOT NECESSARILY A DESIGN RECOMMENDATION)
\$1,000/MO • 15 MONTHS

PILOT SIZE	TOTAL OBLIGATED	STATE SHARE (16.17%)
~100 participants (Phase 1)	~\$1.5M	~\$243K
~500 participants (Phase 2)	~\$7.5M	~\$1.2M
~1,000 participants (statewide scale)	~\$15M	~\$2.4M

Mississippi has not yet paved this road – but the precedent exists elsewhere, and the postpartum extension shows DOM's willingness to act.

HEALTH SERVICES INITIATIVE	STATUS	AUTHORITY USED
12-month postpartum Medicaid extension	Approved – MS (via ARPA option)	Postpartum coverage extension
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
Perinatal cash HSI (proposed)	Not yet attempted by any state	FCEP / fetal & infant health

Mississippi would be a first mover on the specific cash-assistance HSI application – a harder ask for CMS in one sense, but Mississippi's uniquely high E-FMAP, its declared public health emergency, and its existing 12-month postpartum extension together make an unusually strong and timely case for this specific proposal.

REMAINING CAPACITY IN 10%
CAP**\$21.9M**

\$21,895,862

FEDERAL SHARE OF THAT
CAPACITY**\$18.4M**

\$18,412,230

STATE SHARE REQUIRED

\$3.5M

\$3,483,632

EXCESS ALLOTMENT
SUFFICIENT?**Yes**

\$136.2M available

Mississippi is in the scenario CCF describes as fully usable: room under the cap and enough excess allotment to draw the federal match against it. The whole \$15M statewide illustrative pilot fits inside the \$21.9M of remaining capacity, and its ~\$2.4M state share fits inside the \$3.5M of state dollars that capacity requires. What remains is finding the non-federal match.

CHIP HSI is the federal anchor. Mississippi has state-side and philanthropic infrastructure to braid it with.

Mississippi's non-federal match options are arguably politically well-primed right now, because several of these pools already carry public criticism for sitting unspent or underspent on exactly this population. A braided strategy pairs the federal leverage of the HSI with these existing Mississippi funding vehicles, enabling a program larger and more durable than any single-source approach.



FUNDING SOURCE 01

CHIP HSI (Federal Anchor)

SSA §2105 • 83.83%

The primary vehicle for drawing down federal funds already appropriated to Mississippi. Covers direct cash assistance to Medicaid-eligible pregnant individuals, structured as an HSI with the fetal and infant health benefit as the documented outcome focus. State match (16.17%) provided by any of the sources below — no new tax or broad-based appropriation required.

ROLE IN PROGRAM

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

FUNDING SOURCE 02

Mississippi Opioid Settlement Funds

~\$400M+ STATEWIDE

State legislature and Opioid Settlement Advisory Council. Mississippi is set to receive more than \$400 million from national opioid settlements, and reporting has documented that the state has spent little of its share so far. Parental substance use is a documented contributor to Mississippi's infant and maternal mortality crisis.¹¹ A perinatal cash pilot, framed around stabilizing pregnant and postpartum women in or near recovery and reducing substance-exposed pregnancy risk, sits squarely within the settlement's core, court-approved purpose and gives legislators a concrete, accountable way to put dollars already designated for exactly this problem to work.

ROLE IN PROGRAM

A strong non-federal match candidate, particularly for a pilot cohort in counties with documented substance-use burden; may require Opioid Settlement Advisory Council review before legislative appropriation.

NOTE: REQUIRES LEGISLATIVE APPROPRIATION

FUNDING SOURCE 03

MS Health Care Trust Fund / Health Care Expendable Fund

1997 MSA

State fund seeded by the 1997 tobacco Master Settlement Agreement. Mississippi's Health Care Trust Fund receives the state's tobacco settlement payments, and the Health Care Expendable Fund (HCEF) receives statutorily authorized transfers from it; HCEF dollars are earmarked for health-related purposes.¹² This is one of the few Mississippi funding pools with an explicit, uncontroversial statutory health purpose and no federal strings attached — a clean, defensible non-federal match source that doesn't require a new appropriation fight.

ROLE IN PROGRAM

Primary or supplemental non-federal match for Phase 1; can scale into a sustaining state appropriation as the pilot demonstrates results.

FUNDING SOURCE 04

TANF Reserves (MS Dept. of Human Services)

TITLE IV-A

Federal block grant • state MOE and state share. TANF has documented allowable uses for direct cash assistance to low-income families with children. Mississippi's TANF program, however, has been under sustained federal and state scrutiny following high-profile past misuse findings, and any use here would need to be visibly, rigorously compliant from day one — clean beneficiary eligibility documentation, an explicit tie to TANF's statutory purposes, and audit-ready recordkeeping.

ROLE IN PROGRAM

A possible but higher-scrutiny non-federal match option; better suited to a later program phase once the coalition has an established compliance track record with DOM, or as a smaller supplemental piece rather than the primary match.

NOTE: TANF DOLLARS USED AS MATCH MUST NOT THEMSELVES BE FEDERAL DOLLARS

FUNDING SOURCE 05

Philanthropic / Private Capital

PRIVATE CAPITAL

Funders with an economic-mobility mandate in Mississippi and the Delta are natural early, de-risking capital — a public-private partnership model where private capital enables speed while public partners contribute access and legitimacy. The existing funder relationships behind Jackson's direct-cash pilot may also be a starting point for identifying funders already comfortable with this model in this exact geography.

ROLE IN PROGRAM

Launch capital and de-risking for Phase 1, particularly useful for costs the HSI/match structure doesn't reach (distribution infrastructure, participant support services, evaluation).

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

CRITERIA	RECOMMENDATION	PROS	CONS
INCOME CEILING	≤200% FPL, or align with MS Medicaid pregnancy eligibility (194% FPL for infants)	Aligns with existing Medicaid/CHIP thresholds	Harsh cutoff for families just above the line
AMOUNT	\$500–\$1,000/mo	Grounded in an already-proven local model	—
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 MSDH's public-health-emergency target populations and highest-mortality counties	Directly advances the state's own emergency-response priorities	Narrower targeting may reduce reach
GEOGRAPHY	Delta counties (Bolivar, Coahoma, Sunflower, Washington) and/or Hinds County/Jackson	Concentrates limited state dollars where need and existing infrastructure are strongest	Delta counties are harder to reach administratively; rural distribution logistics

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 Mississippi vital statistics or quarterly program surveys – giving legislators and DOM leadership a clear, auditable record of what the state's dollars are buying.

FOUR OUTCOME DOMAINS

Birth Outcomes

MSDH VITAL STATISTICS

Preterm birth rate

% births < 37 wks

Low birthweight rate

% births < 2,500g

Very low birthweight

% < 1,500g, Medicaid

NICU admission rate

% newborns admitted

Maternal Health

PROGRAM SURVEYS, MSDH

Prenatal care adequacy

Kotelchuck Index

Postpartum depression

% pos.
(Edinburgh/PHQ-9)

Third-trimester smoking

% reporting

Economic Stability

QUARTERLY PROGRAM SURVEYS

Housing stability

% reporting eviction

Rent / mortgage debt

Avg. debt reduction

Population Outcomes

REQUIRED FOR CMS REPORTING

Outcome gap by county/subgroup, per CMS reporting standards

Infant mortality rate, tracked against the statewide public health emergency benchmark

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, a particularly acute concern in a state where Medicaid pays for the majority of 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 named in Mississippi's own 2024 Maternal Mortality Report.

What DOM 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 Mississippi's CMS CHIP Project Officer early to align on expenditure framing and outcome metrics.
- 04 Identify a non-federal match source — opioid settlement funds, Health Care Expendable Fund, General Fund line item, or philanthropic bridge funding.
- 05 Draft outcome metrics from the four-domain framework, with Mississippi-specific data sources (MSDH vital statistics, Title V needs assessment, Medicaid encounter data).
- 06 Submit the SPA with defined outcome metrics, geographic scope (single county/region for Phase 1), Medicaid eligibility framing, and 15-month duration.



Questions from CMS and DOM 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, reduced smoking, 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 CHIP at birth. In Mississippi, where Medicaid pays for over half of all births, the CHIP-beneficiary nexus is direct and documentable.

Q.04 How will outcomes be measured?

Birth outcomes from MSDH 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. MSDH's existing Title V data infrastructure provides a validated, cost-effective measurement platform, with results reported publicly against defined benchmarks.

Q.05 How does this align with Mississippi's public health priorities?

Mississippi's 2025 public health emergency declaration on infant mortality commits the state to addressing the crisis at scale. The evidence base for perinatal financial assistance — including documented reductions in eviction rates and postpartum depression from the state's own pilot in Jackson — directly addresses the economic pressures driving the outcomes the state has just named a public health emergency. This HSI is not a new priority; it is a new, accountable financing mechanism for an existing, urgent one, built on federal dollars Mississippi is already entitled to draw down.

Sources

- 1 MACPAC, MACStats Exhibit 6 — Federal Medical Assistance Percentages and Enhanced FMAPs by State, FYs 2022–2025 (Mississippi FY2025 E-FMAP: 83.83%; FMAP: 76.90%).
- 2 CBS News / Mississippi State Department of Health — public health emergency declaration on infant mortality, Aug. 2025; 9.7 infant deaths per 1,000 live births in 2024.
- 3 Springboard to Opportunities — Magnolia Mother's Trust, Jackson, MS (launched 2018).
- 4 Mississippi State Department of Health, 2024 Mississippi Maternal Mortality Report; Forbes coverage, Aug. 2025 (83% of pregnancy-related deaths 2017–2021 deemed preventable; maternal mortality rate 23.2/100,000).
- 5 March of Dimes 2025 Report Card, Mississippi; WJTV coverage — 12-month postpartum Medicaid extension in place.
- 6 Mississippi State Department of Health / news coverage of the 2025 public health emergency declaration; historical infant mortality trend via 15 Miss. Code R. 8-90-04-401.
- 7 March of Dimes 2025 Report Card, Mississippi — preterm birth rate 15.0%, 5,017 births (2024).
- 8 Social Security Act §2105(a)(1)(D)(ii); 42 CFR §457.10 — CHIP Health Services Initiative authority.
- 9 Mississippi Legislative Budget Office — Health Care Expendable Fund / Health Care Trust Fund (tobacco settlement).
- 10 HRSA Title V MCH Block Grant, Mississippi State Snapshot, FY2026 Application/FY2024 Annual Report.
- 11 Mississippi Public Broadcasting / USC Center for Health Journalism, “As Mississippi waits to spend opioid settlement funds, children and families suffer” (2026) — \$400M+ opioid settlement allocation, underspending on family/maternal programs, parental substance use as a driver of MS infant/maternal mortality.
- 12 Mississippi Legislative Budget Office budget terminology — Health Care Trust Fund / Health Care Expendable Fund statutory purpose.
- 13 Yafimenka, Kaneb & Brooks, Georgetown University Center for Children and Families, “Is Your State Leaving Money on the Table? How CHIP Health Service Initiatives Can Help States Support Children's Access to Care,” Mar. 25, 2026 — state-by-state 10% administrative cap, remaining capacity, and excess allotment estimates from the FY2024 CHIP Annual Financial Management Reports.