NORC at the University of Chicago

Final Report

Progress Towards Vitality: A Review of Maternal Health Financing Mechanisms in Georgia

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Executive Summary

Over the past decade, Georgia has made meaningful strides in improving maternal health through policy reforms, expanded coverage, and targeted programmatic investments. In addition, Georgia is well positioned to build on recent advances to drive continued improvement. By strengthening and sustaining maternal health financing, the state can expand access to high-quality care, reduce preventable maternal deaths, and advance equitable health outcomes.

Financing for maternal health in Georgia is drawn from a mix of federal, state, local, and private sources, but these resources are often fragmented and difficult to align across programs and agencies. Across the United States, particularly in the Southeast, progress in strengthening maternal health systems has been uneven, with financing infrastructure, service availability, and health outcomes remaining below national benchmarks.

This report examines how maternal health funding in Georgia flows from federal, state, and private sources through state agencies, local institutions, and community partners to support care delivery. It also analyzes the pooling and purchasing mechanisms used to allocate funding, the primary models of care delivering maternal healthcare across the state, and the extent to which these care models align with existing funding streams.

Looking ahead, there are clear opportunities to strengthen maternal health financing and delivery. Improving data transparency and establishing long-term funding commitments can support sustainability and continuity of care. Maximizing the use of federal matches, exploring innovative financing mechanisms, and coordinating investments around shared objectives will increase and focus available resources and amplify their impact.

Understanding these financing strategies with the lessons from the companion report on ***10-Year Retrospective Analysis of Systems Focused Efforts to Improve Maternal Health in Georgia*** and deepening partnerships with community, clinical, public, and philanthropic stakeholders will be essential to advancing maternal health vitality for all Georgians.

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Roadmap for the Report and Reader's Guide

Progress Toward Vitality: A Review of Maternal Health Financing Mechanisms in Georgia examines how maternal health is funded across the state, how dollars move through public and private systems, and how financing structures shape access, quality, and outcomes across the perinatal continuum. The roadmap below summarizes each major section to orient readers and highlights how financing mechanisms influence care delivery and maternal health outcomes.

- **Introduction.** The report grounds its purpose in the missions of the Maternal Health Vitality Think Tank (MHVTT) and Georgia Health Initiative. It defines the financing scope—federal, state, and philanthropic—and explains why a financing-focused analysis complements prior systems research. The section also outlines methods (literature review, interviews, quantitative analysis) and the core questions guiding the study.
- **Background.** This section provides national context, emphasizing Medicaid and other federal programs' central role and recent federal policy shifts, including postpartum coverage extensions. It then details Georgia's financing mix—federal funds, state appropriations, and private investment—and how these sources underpin maternal health services statewide.
- **Maternal Health Financing Landscape in Georgia.** This section maps how funds flow from federal, state, and private sources to state agencies, health systems, academic institutions, and community organizations. It outlines major federal programs, state-funded initiatives, philanthropic investments, and recent funding shifts, to collectively illustrate the scale and fragmentation of Georgia's financing ecosystem.
- **Care Delivery Areas and Outcomes.** This section delineates how financing is linked to care delivery across five areas—prenatal care, labor and delivery, postpartum care, community supports, and workforce. Each subsection summarizes primary funders, major investments, delivery models, outcomes, and examples of innovations, illustrating how financing shapes access and quality.
- **Successes in Georgia's Maternal Health Financing.** This section summarizes cross-cutting strengths that include effective use of supplemental federal and private funds, innovative pilots,

community-led initiatives, and state policy shifts that expanded coverage and improved continuity.

- **Ongoing Challenges.** This section describes key barriers that include unstable supplemental funding, fragmented and opaque data, administrative burdens for smaller organizations, rural access and workforce shortages, and regulatory limitations.
- **Key Considerations for Strengthening Financing.** This section describes considerations spanning federal (longer-term funding, clearer guidance, rural supports), state (optimizing federal match, leveraging care management organization [CMO] procurement, workforce, and financing innovations), and philanthropic investments (multi-year, flexible, pooled funding) and proposes a cross-sector strategy that emphasizes coordination, shared evaluation, scalable pilots, improved data systems, and cross-sector strategy planning.
- **Conclusion.** The report concludes by highlighting the value of an integrated financing framework that aligns federal, state, and philanthropic investments to support sustainable infrastructure and long-term maternal health vitality in Georgia.

Introduction

The Georgia Health Initiative® is a non-partisan, non-profit private foundation that aims to transform systems that shape maternal health by improving how care is accessed, delivered, financed, and experienced. Part of how the Initiative is working to transform these systems is through its support of the Maternal Health Vitality Think Tank (MHVTT). The newly launched MHVTT is a collaborative of Georgia leaders across health care, public health, social services, research, academia, philanthropy, and other community partners. Together, the MHVTT works to align efforts and advance sustainable, systems-level solutions to improve maternal health outcomes across Georgia.

About the Maternal Health Vitality Think Tank (MHVTT)

The focus of the MHVTT is on:

- Coordinating fragmented maternal health systems
- Strengthening the perinatal workforce,
- Aligning public and private resources through upstream strategies that promote access, efficiency, and parity

Serving as a strategic forum for alignment, learning, and action, the MHVTT translates evidence into practical strategies that inform policy, funding, and programmatic decisions that support long-term impact across Georgia's maternal health ecosystem.

In partnership with and commissioned by the Initiative on behalf of the MHVTT, NORC at the University of Chicago developed this report to examine Georgia's maternal health financing landscape, highlight key challenges and successes, and identify actionable opportunities to strengthen maternal health statewide.

For the purposes of this report, the maternal health financing landscape refers to models and mechanisms supported through government funds (federal and/or state) and private philanthropic dollars. While this report does not address initiatives and programs funded through county or local governments, we recognize the important role these entities play in addressing regional gaps in access and enabling tailored interventions that reflect local needs.

This report builds on NORC's recent prior analysis of maternal health improvement efforts in Georgia over the past decade. By positioning this report as a companion analysis, we aim to deepen understanding of the financial context of Georgia's maternal health system. While previous research has focused on clinical interventions and workforce strategies, less is known about how maternal health services are financed and sustained and why financing reform is essential to improving

outcomes. As such, this analysis examines Georgia's maternal health financing landscape, care delivery models, success, challenges, and actionable opportunities to strengthen financing mechanisms.

Research Methodology and Questions

In collaboration with the Initiative, NORC collected, mapped, and analyzed maternal health financing data to summarize the current state of maternal health financing in Georgia and highlight actionable recommendations for strengthening or otherwise improving financing mechanisms that advance maternal health equity and vitality in Georgia. To this end, NORC conducted:

- **A rapid and targeted literature review** of maternal health financing in Georgia, drawing on peer-reviewed and grey literature and, where relevant, credible news organizations. Sources included academic journals, policy briefs, state financial and narrative reports, and evaluations of maternal health programs. The review aimed to identify existing knowledge on financing mechanisms, gaps in coverage, and innovative funding models in Georgia.
- **Key informant interviews** with 14[i] individuals and organizations working in the field of maternal health research, service delivery, financing, program administration, and state government who collectively offered a range of perspectives on maternal health financing in Georgia. These interviews aimed to identify and describe current funding pathways, as well as barriers and facilitating factors to acquire, use and sustain maternal health funding. Insights from these interviews are highlighted throughout the report as excerpted quotes to illustrate key findings and themes.
- **Quantitative analyses** of publicly available data on maternal health investments and associated performance measures, gathered via a structured scan of budget documents, grant databases, program reports, and state performance dashboards. For each funding source, we extracted available information on investment amounts, scope, and implementation timelines, along with any reported performance or outcome metrics. These data were synthesized to characterize Georgia's maternal health financing landscape and assess where outcomes were reported or measurable.

The research was guided by four core questions that provide a roadmap for the analysis:

1. What are the current sources of maternal health funding in Georgia at the federal, state, and private level?
2. What pooling and purchasing mechanisms are currently used to allocate such funding?
3. What are the primary models of care used to deliver maternal healthcare in Georgia?
4. To what extent do these models of care align with current funding streams?

Background

Maternal Health Financing: National Context

Maternal health financing in the United States underpins access to care and equity for millions of women and families. The system relies on a mix of public and private sources. Nationally, Medicaid, as a state-federal program, covers approximately 41% of all births.[1] Medicaid also plays an especially critical role in rural areas of the U.S., financing nearly 47% of all births in rural communities nationwide.[1]

[i] This count includes one interview where we analyzed feedback where relevant from another NORC study with the Georgia Health Initiative on maternal health.

Beyond Medicaid, private insurance remains the primary payer for many births, around 52% of deliveries.[2] Federal funding, including the Health Resources and Services Administration (HRSA)'s Title V Maternal and Child Health (MCH) Services Block Grant and the Healthy Start program, complement these efforts by supporting preventive and community-based maternal health efforts nationwide.

Certain policy reforms have strengthened maternal health financing. Under the American Rescue Plan Act in 2021, states were authorized to extend postpartum Medicaid coverage from the standard 60 days to 12 months via a State Plan Amendment.[3] This provision was made permanent under the Consolidated Appropriations Act of 2023.[3] By early 2025, 49 states had implemented this extension, including Georgia.[4]

Maternal Health Financing: Georgia Context

Medicaid plays a central role in Georgia's maternal health financing, covering approximately 46% of births. The program is administered by Georgia's Department of Community Health (DCH).[5] Georgia expanded postpartum services under Medicaid to 12 months in November 2022.[6]

In Georgia, federal, state, and private funding collectively shape the maternal health ecosystem by financing essential services, driving policy implementation, and supporting innovative programs. Federal and state investments ensure access to core benefits and safety-net programs, while private funding often fills gaps, fosters innovation, and enables community-based solutions that advance quality and parity in care delivery.

Georgia leverages multiple funding streams, including:

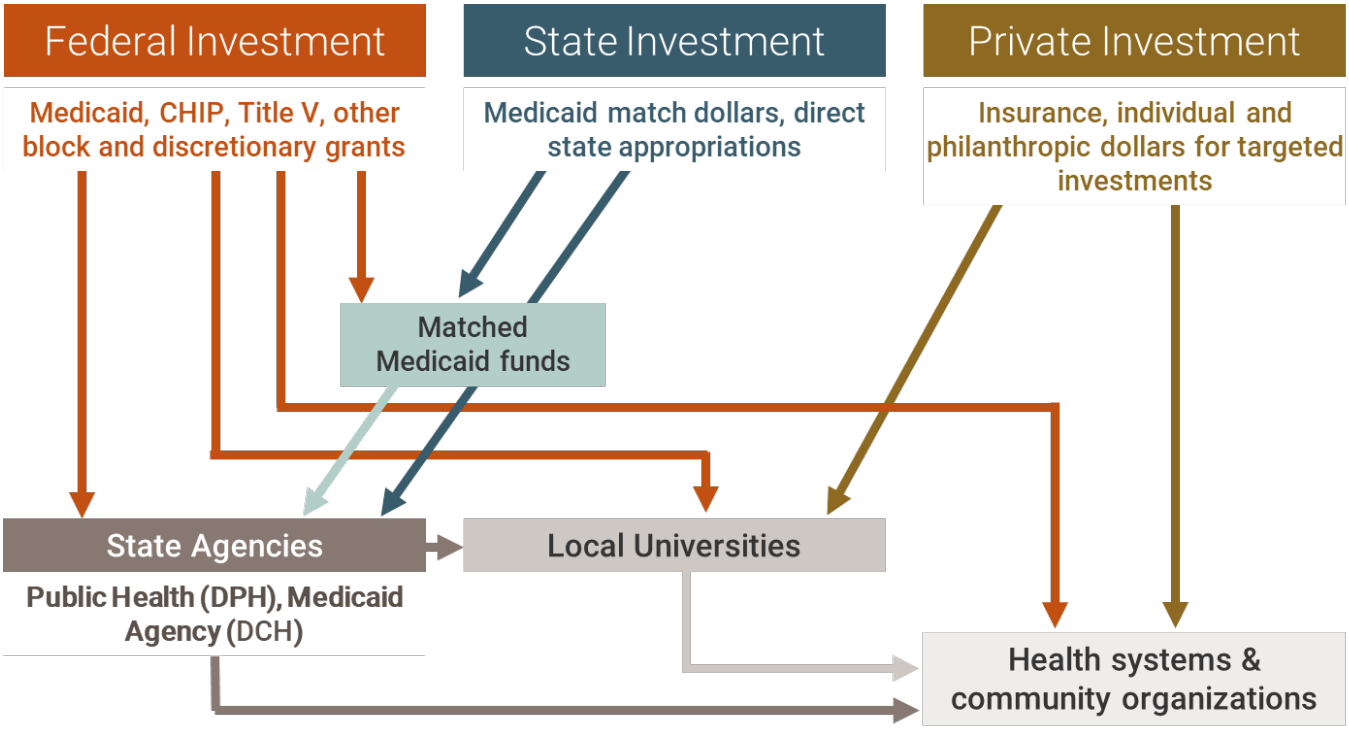
- **Federal Investment,** which flows primarily through programs such as Medicaid, the Children's Health Insurance Program (CHIP), the Title V MCH Services Block Grant,[7] and includes other block and discretionary grants. These dollars support preventive and community-based maternal health programs like Healthy Start,[8] which targets high-risk populations. Funds are administered through state agencies, including DCH and the Department of Public Health (DPH), and often combine federal oversight with local implementation.
- **State Investment**, including the state's required contribution to Medicaid financing and other direct appropriations, which are critical for sustaining maternal health services. These funds support programs such as Georgia's Perinatal Health Partnership Program.[9] State investments also flow to local universities for research and program development, as well as to health systems and community organizations.
- **Private Investment,** which includes employer-sponsored health insurance, out-of-pocket spending, and charitable and philanthropic dollars for targeted investments. These investments include but are not limited to funding research and innovation in maternal health, advancing evidence-based interventions, and accelerating the development and scaling of new care models. In addition, philanthropic and corporate giving often provides flexible resources to address local funding shortfalls—particularly in communities where public dollars are limited or slow to reach.

Maternal Health Financing Landscape in Georgia

Perinatal care refers to the continuum of health services provided to individuals during pregnancy, childbirth, and the postpartum period.[10] Georgia's perinatal care system is supported through a multi-level financing system that combines and coordinates funding acquired through federal, state, local and private sources. This approach reflects both the diversity of maternal health needs and the challenges of sustaining care across urban and rural Georgia.

Figure 1. Pathways of Maternal Health Financing Across Georgia's Public and Private Sectors

This figure illustrates how maternal health investments in Georgia flow from federal, state, and private sources through state agencies and local universities to health systems and community organizations that deliver services.



These funding streams support maternal health clinical care, workforce development, quality improvement, and community-based services across the perinatal continuum.

Federal Funding

Federal maternal and child health programs are supported through two primary federal funding mechanisms: entitlement program funding and supplemental program funding. Federal entitlement program funding provides guaranteed and ongoing support to states based on statutory eligibility criteria and beneficiary enrollment levels. Programs such as Medicaid and CHIP exemplify entitlement funding because states receive federal financial participation automatically when eligible services are delivered to eligible individuals. The amount of federal support therefore adjusts to reflect actual need and utilization, ensuring that states can rely on a stable and predictable funding stream to cover core health services for qualifying populations.

In contrast, federal supplemental program funding consists of time-limited, competitive, or discretionary financial resources that are intended to complement but not replace entitlement funding. Examples of supplemental funding include Title V MCH Services Block Grant allocations, competitive grant programs offered by federal agencies, and emergency supplemental appropriations made available in response to specific events or identified gaps. These funds do not adjust automatically based on service needs or enrollment trends. Instead, supplemental funding is typically awarded for defined program activities, capacity-building efforts, pilot initiatives, or targeted priorities identified at the federal or state level.

Building on this distinction, Medicaid serves as the primary entitlement funding source for maternal health in Georgia. Medicaid is jointly financed by federal and state governments, with federal policy

establishing eligibility options and matching structures and states responsible for administering benefits and delivery systems. DCH administers both Medicaid and CHIP, called PeachCare for Kids® (PCK) in Georgia, which together form the core coverage platform for pregnancy, delivery, and postpartum care in the state. A comprehensive dollar total for maternal health spending is not publicly available, as Medicaid expenditures are distributed across eligibility groups, benefits, and managed care contracts rather than tracked as a discrete maternal health category.

Beyond Medicaid, federal investments play a significant role in Georgia's maternal health financing landscape by supporting a range of grant-based and programmatic initiatives that span prenatal, labor and delivery, postpartum services, and community-based supports. These federal funds flow through programs such as the Title V MCH Services Block Grant, HRSA's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, and United States Department of Agriculture (USDA)'s Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). While federally funded, these programs are typically administered by state agencies, such as DPH or other state-affiliated entities, including academic and community-based organizations.

Financing Models Using a Federal-State Match

Medicaid

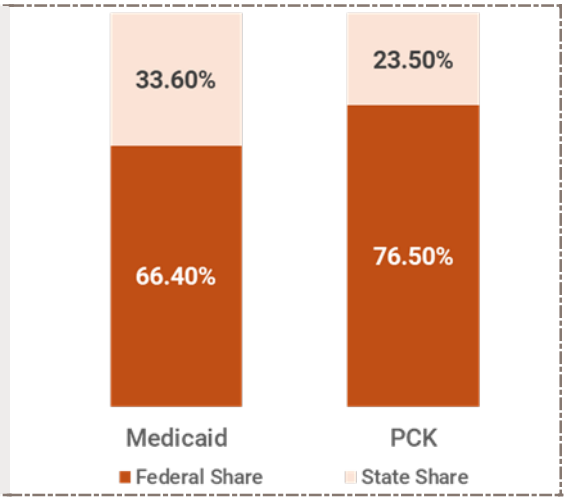
Georgia finances Medicaid and CHIP through a federal–state partnership that uses a Federal Medical Assistance Percentage (FMAP) ratio and requires the state to contribute matching funds.[11] These dollars flow through the overall Medicaid budget rather than a dedicated maternal health appropriation.

DCH is responsible for administering the Medicaid program, including **Planning for Healthy Babies (P4HB),** a Section 1115 Medicaid demonstration waiver[ii] in operation since 2011, and **PCK,** the state's CHIP.[11,12] (**Figure 2**).

Figure 2. Federal and State Match for Medicaid and PCK in Fiscal Year (FY) 2025 and FY 2026

Georgia's Medicaid FMAP was **66.0% in FY 2025**, increasing slightly to **66.4% in FY 2026**, meaning the state receives about **$3 in federal Medicaid funds for every $1 it spends**.

For PCK, the enhanced FMAP was **76.2% in FY 2025** and **76.5% in FY 2026**, or roughly **$4.25 in federal funds for every $1 in state spending**.



Medicaid Policy: Postpartum Coverage Extension

DCH also oversees implementation of Georgia's 12-month Medicaid postpartum coverage extension, which now provides continuous coverage throughout the full postpartum period.[13] This expansive coverage strengthens continuity of care for postpartum enrollees and represents one of the state's

[ii] Section 1115 Medicaid demonstrations are federal waivers that allow states to test new approaches in Medicaid that differ from standard federal requirements.

most significant recent investments in maternal health. **Figure 3** describes Georgia's path to 12-month postpartum coverage.

Figure 3. Federal Funding for Georgia's Path to 12-Month Postpartum Coverage

	FY 2021 (First Extension to 6 Months)	FY 2023 (Extension to 12 Months)
Georgia leveraged roughly two-thirds federal funding to extend postpartum Medicaid coverage from six weeks to six months in FY 2021 and then to 12 months in FY 2023, locking in this policy as a continuous 12-month postpartum benefit. The Centers for Medicare & Medicaid Services (CMS) approved Georgia's Medicaid and PCK state plan amendments to provide a full year of postpartum eligibility, effective November 1, 2022, and in place through March 31, 2027, ensuring that eligible enrollees remain covered for 12 months after pregnancy even if their circumstances change.	**$59.7M** $19.7M state funds $40M federal match	**$83.5M** $28.2M state funds $55.3M federal match

Georgia's Medicaid program additionally draws upon federal-state matched dollars to augment maternal health services, by:

- Providing increased reimbursement rates for select primary care and obstetrician-gynecologists (OB-GYN) codes (totaling $29.4 million for Low-income Medicaid (LIM) beneficiaries and $8 million for the Aged, Blind and Disabled (ABD) beneficiaries);[14]
- Expanding coverage for home visiting in at-risk and underserved rural communities to improve birth outcomes and reduce infant and maternal mortality; and[14]
- Introducing doula reimbursement pilots, expanding eligibility to reimburse for select perinatal services to include doulas.[15]

Major Medicaid Programming Administered by Georgia DCH

As noted, Georgia's maternal and child health coverage is delivered through a set of Medicaid and CHIP programs administered by DCH. These programs below (P4HB and PCK) provide family planning, prenatal, postpartum, and pediatric services across the continuum of care.

"Many women [still] don't know that they have [access to] a resource mother. They have no real idea what a resource mother is. So, [there remains a] lack of understanding and communication to women who are in the Medicaid program."

— Key Informant Interviewee

P4HB

Launched in 2011, P4HB is Georgia's Section 1115 Medicaid demonstration[iii] aimed at reducing very low birth weight and improving maternal well-being. It provides:

- Family planning services
- Interpregnancy care for eligible women with prior very low-birthweight deliveries
- "Resource mothers" who offer care management and navigation support

[iii] Section 1115 Medicaid demonstrations are federal waivers that allow states to test new approaches in Medicaid that differ from standard federal requirements.

While valuable, interviews revealed that women may not be fully aware of these additional benefits, specifically the availability of resource mothers who are intended to guide them through care.

PCK

PCK covers children born to women eligible under household incomes up to 247% of the Federal Poverty Level.[16,17] The program is administered through contracts with private Care Management Organizations (CMOs) which are private health plans contracted by DCH to manage and deliver services to Medicaid beneficiaries through a managed care model.[18] Effective November 1, 2022, PCK provides 12 months of postpartum maternal health care.[19] PCK covers individuals under the age of 19, so postpartum coverage applies only to those who are pregnant and enrolled in PCK (such as older teens who become parents). It does not extend to adult postpartum women, who instead may receive coverage through Medicaid.

Medicaid CMOs

Most Medicaid members in Georgia, including pregnant and postpartum women, receive services through Georgia Families (GF), the state's Medicaid managed program administered by DCH. Under GF, members are enrolled in one of three CMOs (Amerigroup, Peach State Health Plan, and CareSource) through Georgia's Medicaid managed care budget, which is jointly funded by state and federal Medicaid dollars. CMOs administer benefits, coordinate care, and run value-based maternal health initiatives such as:[iv]

- **Amerigroup's *Taking Care of Baby and Me:*** This program provides proactive case management and care coordination for pregnant and postpartum members.[20]
- **Peach State Health Plan's *Start Smart for Your Baby:*** They offer resources and guidance for parents after delivery, which members can continue to access while covered.[21]
- **CareSource Georgia's Obstetrics Quality Program:** This program incentivizes providers to complete postpartum visits within 7–84 days by offering enhanced payments aligning provider effort with plan quality goals.[22]

Other Federal-State Partnership-Driven Investments

Beyond Medicaid, HRSA uses a state-federal matching ratio to fund two large investments in the state—the Title V MCH Services Block Grant and MIECHV. As with Medicaid, these funding streams operate through a federal-state partnership model that requires participating states to contribute matching funds. As a result, states can receive substantial federal funding to support core maternal health initiatives and expand upon these efforts with state-matched dollars.

[iv] Note: Georgia is in the process of implementing a new contract period for CMOs. The CMOs listed here reflect where these organizations operate during our study period; final initiatives may differ in future years.

Figure 4. Additional Federally Funded Programs Using a Federal-State Match

	$120.7 M **Title V Block Grant (2024)** State: $103,574,337 Federal: $17,161,644	**$9.6 M** **MIECHV (2024)** State: $725,892 Federal: $8,922,509
Program Description	Funds statewide systems that ensure quality prenatal, delivery, and postpartum care, reduce maternal and infant deaths, and advance equity through data-driven public health initiatives.	Supports voluntary, evidence-based home visiting for pregnant people and young families in high-risk communities to improve maternal and child health, early development, and care coordination; serves as a core funding source for the state's broader home visiting infrastructure.
Federal-State Matching Mechanisms	Federal funding is allocated, the state matches $3 for every $4 in federal funds, and DPH oversees implementation, with program income reported in select years (e.g., $210,633,769 in FY 2024).	Federal funding is allocated, the state provides $1 for every $3 in federal funds, and DPH oversees implementation.

Sources: HRSA Maternal and Child Health Bureau (MCHB) program award data retrieved from HRSA's public grant records and MCHB funding announcements.
Note: The funding total represents the federal and state dollar amount appropriated for the most recent year of publicly available data only (i.e., 2024 or 2025).

Geographic Reach of Federal Investments Supporting Maternal Health in Georgia

The Title V MCH Services Block Grant functions as statewide maternal and child health infrastructure funding, supporting activities **across all 18 public health districts**. MIECHV-funded home visiting is statewide in administration but targeted in implementation: in FY 2023, HRSA reports MIECHV services were delivered in a defined set of counties—**five rural (Burke, Crisp, Macon, Sumter, Twiggs)** and **11 non-rural (Bartow, Chatham, Clarke, DeKalb, Glynn, Houston, Liberty, Muscogee, Richmond, Rockdale, Whitfield**).[23]

Financing Models Using Federal Funding

Several of the largest federally funded MCH initiatives are administered by DPH, which acts as third-party administrators for federal grants. Significant examples include:

- **WIC.** Administered by DPH, WIC provides nutrition assistance, breastfeeding support, and nutrition education to pregnant individuals, infants, and children under the age of five with the goal of promoting healthy growth and development during critical life stages. The program is entirely federally funded, with allocations split between food benefits and Nutrition Services and Administration (NSA) costs. In 2024, WIC funding in Georgia totaled approximately $248.8 million, including $172.9 million for food benefits and $75.9 million for NSA activities, making it one of the largest federal maternal and child health investments in the state.
- **Maternal Mortality Review Committee (MMRC).** Administered by DPH, the MMRC conducts multidisciplinary reviews of all pregnancy-associated deaths in Georgia to identify preventable factors and inform equity-centered policy and practice changes aimed at reducing maternal

mortality statewide. The committee is funded through a CDC cooperative agreement awarded on an annual basis. In 2024–2025, $1.24 million has been obligated to date within a five-year grant period running from September 30, 2024, through September 29, 2029.

- **CDC MMRC Expansion Initiatives.** Administered by DPH, the CDC-supported initiatives such as *Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) and Safe Motherhood* strengthen the state's maternal mortality review capacity and advance evidence-based strategies to prevent maternal deaths.

Several federally funded maternal health initiatives award funding to academic research institutions, medical centers, and community-based organizations, who in turn design and implement programming. Of note:

Emory University operates the *Maternal and Child Health Center of Excellence*, supported by a multi-year HRSA Center of Excellence award.[24] Their goal is to improve the health of mothers, infants, children, youth, and their families by training future and current MCH practitioners.[25]

Morehouse School of Medicine is the recipient of HRSA's *Primary Care Training and Enhancement - Community Prevention and Maternal Health* that provides about $3 million over five years (2021–2026) to train primary care physicians in maternal population health, with an emphasis on serving rural and underserved communities in Georgia.[26]

Mercer University School of Medicine leads *South Georgia Healthy Start*, a federally funded initiative aimed at reducing maternal and infant mortality in rural Georgia.[27] This is a $5.5 million grant from HRSA and received an additional $2 million from United Health Foundation.[28] The program provides comprehensive maternal and child health services, including prenatal care, case management, doula support, and health education, across ten HRSA-designated rural counties.

Financing Models Using Primarily State Funding

In addition to supporting federally funded and federal–state matched initiatives, DPH and DCH play a central role in identifying, managing, and overseeing maternal health investments that use state appropriated dollars, some of which build upon and coordinate funding with federally-funded investments. These initiatives may layer state funding onto existing federally supported programs, expanding, enhancing, and augmenting maternal health services beyond the scope of federal funding alone.

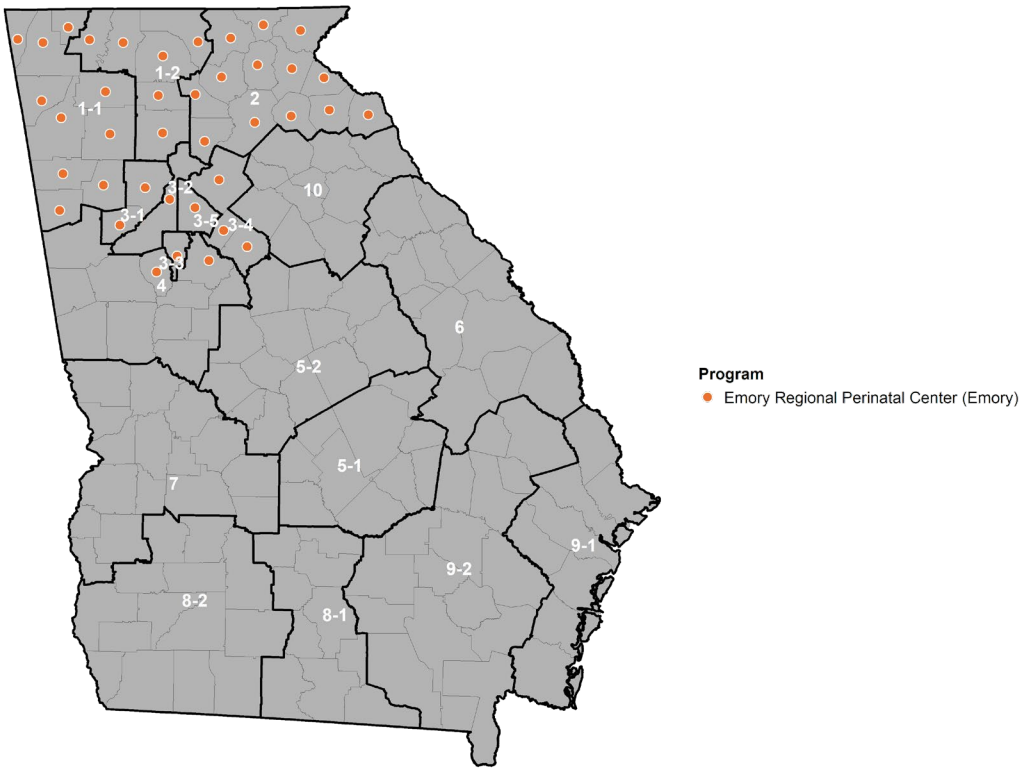
For example, DPH oversees and implements several key maternal health investments that draw upon a mix of federal and state funding. These include *PEACE for Moms*, Georgia's perinatal psychiatry access program,[29] which was launched with an initial $1 million investment and is funded through a DPH contract but supported in part by Title V MCH Services Block Grant dollars. Collectively, these programs illustrate DPH's role in operationalizing both federal and state investments to strengthen maternal health systems across Georgia.

Figure 5 highlights Georgia's use of direct state appropriations to launch targeted maternal health initiatives, such as the perinatal echocardiography pilot and the Georgia DPH Home Visiting Program, while also sustaining essential maternal health infrastructure through ongoing investments in the state's Regional Perinatal Centers. **Figure 6** illustrates how Emory's Regional Perinatal Center functions as a referral and care-coordination hub for the Atlanta/North Georgia perinatal region, serving a 39-county area spanning metro Atlanta and North Georgia.

Figure 5. Maternal Health Programs Supported Through State Initiatives

	$600K Perinatal Echocardiography Pilot	**$3.4M** Georgia's DPH home visiting program	**$20M** Regional Perinatal Centers (RPCs)
Program Description	Launched FY 2023 for DPH-designated perinatal centers to provide cardiac screening and evaluation for pregnant and postpartum patients at risk of cardiovascular complications.	Launched in FY 2024 and continues to expand through new and repurposed maternal health investments, extending services to additional counties and strengthening supports for pregnant and postpartum families across the state.	Launched in the early 1970s and focusing on research, training, and clinical services to improve maternal and infant outcomes.
State Appropriations	A one-time state appropriation, allocated to DPH-designated perinatal centers.	State appropriation of $1.68 million in FY 2024 and an additional appropriation of $1.75 million in FY 2025.	State appropriation of about $20 million each year in state funds to support its six Regional Perinatal Centers (RPCs) statewide

Figure 6. Example of Atlanta Regional Perinatal Centers' Geographic Reach Supporting Maternal Health in Georgia



Source: Georgia—III.E.2.c. State Action Plan—Annual Report (2024). Georgia Department of Public Health. Georgia Board of Public Health Meeting Presentation (FY 2024 Appropriations Highlights). Published May 9, 2023.
Note: This map illustrates the geographic reach of the Atlanta RPCs in Georgia and does not represent an exhaustive inventory of all the programs/regions or the full extent of each reach.

Private Funding

Philanthropic entities and nonprofits are stepping in alongside public programs to fund maternal health in Georgia. There is particular focus on maternal mental health, doulas, perinatal supports, and rural care access, often with multi-year gifts and targeted grants to community-based organizations.

"The Maternal Mental Health Equity Fund... [is] about 30 foundations [who] pool funding to support small community-based organizations focused on maternal health."

— Key Informant Interviewee

On occasion, private funders have pooled funding to maximize investments. Some examples of this pooling include the Maternal Health Vitality Think Tank Pooled Fund, funded by Georgia Health Initiative and multiple private and corporate foundations; Community Innovation Fund resourced by multiple private foundations and managed by Healthy Mothers Healthy Babies Coalition of Georgia (HMHBGA) that offers grants to maternal health projects; the Arthur M. Blank Family Foundation's work in maternal child health; and the Maternal Mental Health Equity Fund, funded by multiple private and family foundations, including Perigee Fund, W.K. Kellogg Foundation, Community Health Acceleration Partnership, Maritz Family Foundation, and Roots & Wings Foundation, as well as several others.[30]

One notable initiative using private investments is the **Black Birthing Initiative.**[31] HMHBGA[32] funds the Black Birthing Initiative to build an accessible, culturally relevant, and responsive intervention model that addresses prematurity, infant mortality, and maternal mortality in Georgia, which disproportionately affects Black women. Additionally, HMHBGA partnered with CMOs to conduct a Doula Medicaid Reimbursement Pilot,[33] evaluating health outcomes for Georgians on Medicaid, and identifying best practices to support doula retention and economic stability in Georgia's healthcare workforce.

While not an exhaustive list of all investments in Georgia, **Figure 7** summarizes some of the private and corporate philanthropic investments in maternal and infant health in Georgia. These investments focus on areas such as mental health, prenatal/postnatal care, doula support, rural health outcomes, and hypertension education.

Figure 7. Private Investments Focusing on Maternal Health in Georgia

Funding Organization	Estimated Investment (Year)	Description of Recipient	Focus Areas
Arthur M. Blank Family Foundation[34]	**$2M+ (2024)**	Nonprofit MCH mental health organizations	• Maternal and infant mental health • Systems capacity
Kaiser Permanente (GA)[35]	**$200K (2023)**	Healthcare and community-based organizations improving maternal and children's health	• Prenatal/postnatal care • Low birthweight reduction • Health disparities
Georgia Health Initiative	**$700K (2023)**	Maternal health research and program innovations	• Maternal health
Georgia Health Initiative	**$500K (2024)**	Maternal health research, program innovations, and collaborative systems focused strategies.	• Maternal health
Georgia Health Initiative	**$1.3M+ (2025)**	Maternal health research, program innovations, and collaborative systems focused strategies.	• Maternal health

Funding Organization	Estimated Investment (Year)	Description of Recipient	Focus Areas
MolinaCares Accord (Molina Healthcare)[36]	**$200K (2023)**	Community-based perinatal support organizations (e.g., HMHBGA)	• Doula care • Perinatal education • Peer support • Home visiting
CareSource Foundation (GA)[37]	**$100K (2025)**	Statewide or regional community health collaboratives (e.g., Georgia Family Connection Partnership)	• Rural maternal and infant outcomes • Tech-enabled engagement • Community collaboration
CVS Health Foundation / Aetna Foundation[38]	**$1.45M+ (2024)**	Healthcare and community-based organizations delivery maternal and women's health interventions (e.g., ATL "Health Zones" investment activity in 2024)	• Postpartum hypertension education • Remote blood pressure monitoring
Jesse Parker Williams Foundation[39]	**$1.78 M (2025)**	MCH service providers (e.g., Alanta Birth Center)	• Women, infants, and children health programs
Kaiser Permanente Community Health Fund at East Bay Community Foundation[40]	**$1M (2023)**	Academic medical centers and research institutions advancing maternal health equity (e.g., Morehouse School of Medicine Center for Maternal Health Equity)	• Maternal near-miss & severe maternal morbidity • Racial inequities • Community education • Practice and policy change
Kaiser Permanente Community Health Fund at East Bay Community Foundation[40]	**$750K (2023)**	Community-based perinatal workforce development organizations (e.g., HMHBGA).	• Perinatal workforce (doulas and support professionals) • Perinatal education • Resource access for high-need pregnant and postpartum women.
35000MacKenzie Scott Yield Giving Open Call[41]	**$2M (2024)**	Community-based organizations advancing Black women's health and health equity (e.g., Center for Black Women's Wellness [CBWW]).[42]	• Black women's health • Maternal health access • Preventive care • Community wellness • Health equity

Geographic Reach of Private Investments Supporting Maternal Health in Georgia

Across these private and philanthropic organizations, the **geographic reach in Georgia is a mix of statewide supports, Atlanta metro area-concentrated activities, and targeted rural investment**. Several funders explicitly support **statewide maternal health capacity** through grants to organizations that serve families across Georgia (e.g., Georgia Health Initiative's investment in the MHVTT which supports statewide systems focused efforts, HMHBGA's **Pickles & Ice Cream Georgia** virtual education platform is designed for families statewide[43], and MolinaCares describes partnerships "throughout the state," including investments framed around reaching rural Georgians).

Other funding is more **Atlanta metro area-focused**: the CVS Health Foundation's Health Zones investments are explicitly centered in **Atlanta**, for example, and the Jesse Parker Williams Foundation defines its service

footprint as the **five-county Atlanta area (Clayton, Cobb, DeKalb, Fulton, Gwinnett)**, with documented maternal/infant health support also flowing through Cobb and Douglas local public health partners. Meanwhile, some private-sector philanthropy is intentionally **rural-facing**—for example, CareSource's[66] Georgia maternal and infant health collaboration is explicitly framed as improving outcomes **across rural Georgia**, and Morehouse School of Medicine's Center for Maternal Health Equity[69] describes rural maternal health programming. Finally, the Arthur M. Blank Family Foundation's[63] maternal/infant mental health grants include **Georgia-based nonprofits** (alongside another state), indicating a **Georgia-local** reach that can vary by grantee rather than a single statewide footprint.

Recent Funding Changes over the Past Two Years

Georgia's maternal health financing landscape has experienced several notable shifts, especially in the past two years, driven by reductions in or eliminations of some previously relied-upon funding sources. While there have been state developments that reflect progress, such as expanded Medicaid postpartum coverage and targeted investments in maternal mental health, other shifts signal emerging threats to sustainability. Our interviews suggest that this has created uncertainty among stakeholders about the future availability of federal support, and a pressing need to maintain and/or identify new stable and consistent funding sources to sustain maternal health. **Figure 8** provides illustrative examples of recent policy shifts in maternal health financing in Georgia.

Figure 8. Recent or Potential Changes in Maternal Health Financing in Georgia

Category	Program or Policy Change	Description
Reductions in Federal Funds	Medicaid - Federal Budget Reconciliation Package (HR.1)	As a result of financing policy changes within H.R.1, Georgia is estimated to lose nearly $5.4 billion in federal funds from Medicaid State Directed Payments for hospitals over the next decade.[44]
	WIC Funding Instability	In late 2025, WIC experienced a potential funding shortfall during federal budget negotiations. Temporary and emergency funds were used to maintain benefits, but this highlighted the instability in funding for nutrition and breastfeeding support programs.[45]
State-Level Policy Changes	DPH Maternal Health Programs	The Amended FY 2026 state budget proposal increases DPH funding by less than 1%, with much of the new funding directed to expanding the maternal home visiting pilot and other maternal health initiatives.[46]

Emerging and Planned Investments

Georgia is making efforts to establish or expand a range of programs and initiatives to improve maternal health outcomes across the state through state- and privately funded investments and pursuit of new federal funding opportunities. Current initiatives include Georgia's recent receipt of federal support under CMS's Rural Health Transformation (RHT) Program, for which the state's application proposed efforts to expand rural maternity care access and workforce capacity, and the upcoming Virtual Prenatal Care Pilot launching in 2026 to bring care to maternity care deserts.

Virtual Prenatal Care Pilot (Georgia HB 925)

Launching in 2026, Georgia's Virtual Prenatal Care Pilot (HB 925) will implement a three-year pilot to expand prenatal care access in maternity care deserts or counties with limited maternity services. The program will complement, not replace, in-person care, allowing eligible patients to begin care earlier, stay connected between visits, and reduce travel and time burdens. It authorizes up to five virtual prenatal visits per patient, with implementation details and clinical protocols to be determined.

Funding for the pilot is provided through state appropriations authorized in Georgia's FY 2026 state budget. Funds flow through state agencies who are responsible for lead rollout, site enrollment, and annual reporting on access, utilization, and outcomes. While the pilot has been authorized and funds have been appropriated in the state budget, detailed funding levels and allocation decisions are still being finalized.[47]

Cardiac Obstetric Program

The FY 2026 budget includes a $778,239 increase to expand access to maternal-fetal medicine by supporting a cardiac obstetric program, building on existing perinatal and maternal cardiac care capacity within the state.

CMS' RHT Program

Georgia pursued and was awarded federal funding under CMS's new 5-year RHT Program.[48] In FY2026 Georgia will receive a total of $218,862,170 with a certain portion supporting maternal health focused initiatives.[49] Funding will be used to organize 29 strategies across five initiatives: care delivery, continuum of care, access, and connection to care, workforce, and technology. Maternal-health-specific elements include expanding rural maternity care access and models of care, building the perinatal workforce (e.g., midwives and doulas), and using telehealth/remote monitoring and better data systems for prenatal/postpartum care coordination.

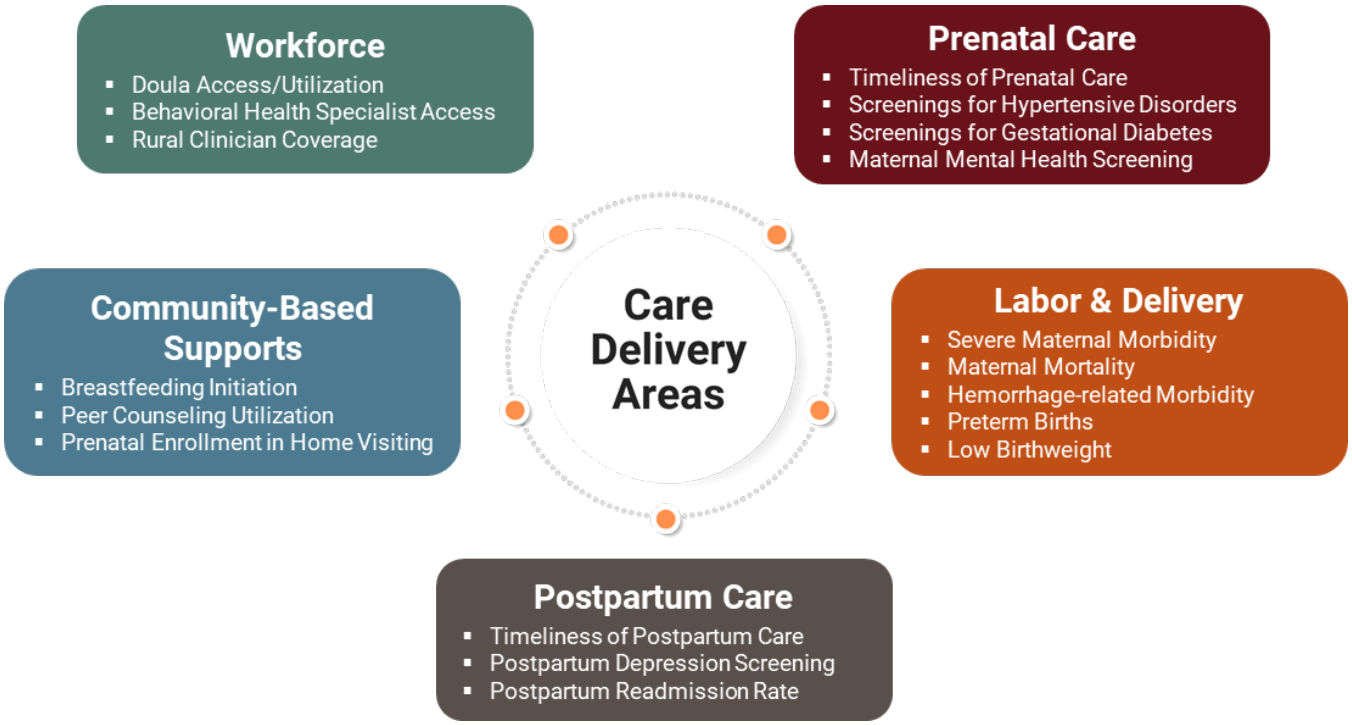
Care Delivery Areas and Outcomes

Georgia's maternal health investments concentrate on five care delivery areas that aim to move care access and quality outcomes (see **Figure 9**). These areas are:

- Prenatal care
- Labor and delivery
- Postpartum care
- Community-based supports
- Workforce

Georgia is leveraging significant state and federal investments to help mothers enter prenatal care earlier, ensure postpartum care is timely and comprehensive, connect families to community-based navigation and social-needs referrals, and strengthen hospital teams and birth support to make delivery safer. Programs achieve these goals through practical tools, such as clinical safety bundles, home visiting supports, and cross-sector data sharing, so more mothers receive the right care, at the right time, in the right setting.

Figure 9. Maternal Health Investments' Care Delivery Areas of Focus in Georgia



Prenatal Care

Primary Funders

Medicaid remains the primary source of funding for prenatal care in Georgia. CMOs under Medicaid offer care coordination and education during pregnancy, helping patients navigate the healthcare system and access needed services.[50] Additional funding comes from the Title V MCH Services Block Grant, which support organizations delivering prenatal education and screenings.[51,52] Nonprofit organizations and local health agencies often leverage these funds to address gaps in access for underserved populations.

> **"There's a lot of room for improvement to make sure that mothers are receiving timely prenatal care, have access to that care, and utilize the care after they're home with their babies to ensure they're being healthy and have a healthy interval between their next pregnancy."**
>
> **— Key Informant Interviewee**

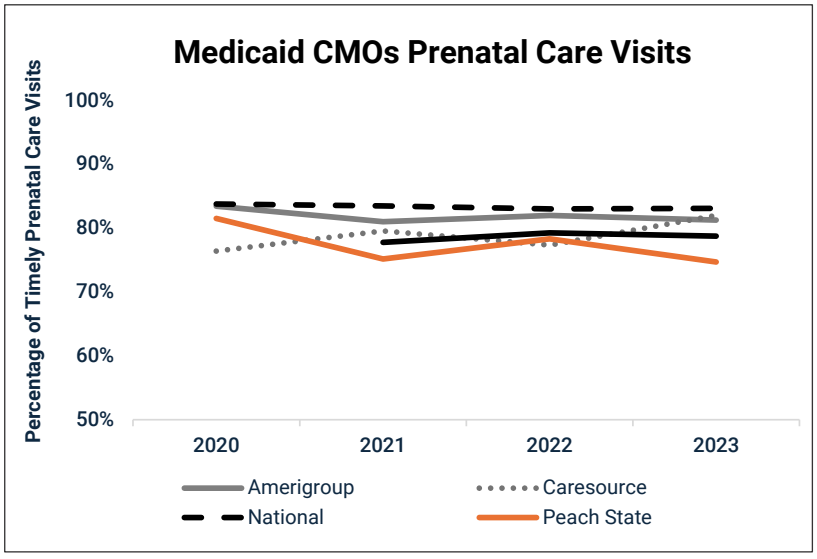
Major Investments

Funders have invested in innovative models to improve prenatal care access and quality, supported by a combination of federal grants, state funding, and Medicaid reimbursement. Programs such as Centering Pregnancy (funded by a March of Dimes grant),[53] offer patient-centered group prenatal care that expands access for low-income women, especially in Southwest Georgia.[54] Telemedicine initiatives also support high-risk pregnancies, particularly in rural areas where access to MCH specialists during the prenatal period is limited.[55]

Performance Outcomes

Despite these statewide and CMO-led investments, recent performance data show that timely entry into prenatal care remains a challenge. Georgia's Medicaid CMOs (Amerigroup, Peach State, and CareSource) use the Healthcare Effectiveness Data and Information Set (HEDIS) Timeliness of Prenatal Care measure to track and improve early entry to care.[56] Performance is compared to national Medicaid benchmarks,[v] where the 50th percentile represents the median performance across all plans nationwide.[57]

Figure 10. GA Medicaid CMO Timeliness of Prenatal Care



Source: National Committee for Quality Assurance (NCQA) Prenatal Care (HEDIS PPC – Timeliness of Prenatal Care).

In 2023, all three plans, as well as the GF statewide average,[vi] performed under the national Medicaid benchmarks (**Figure 10**). Additionally, all plans and the GF Average fell below the 50th percentile for timely prenatal care, underscoring a persistent opportunity to improve pregnant women's access to timely care.

In 2024, DCH required that each plan launch Performance Improvement Projects (PIPs) in hopes of improving prenatal care rates and engaging at-risk pregnant mothers in case management. DCH is exploring a process improvement effort to assign pregnant members to CMOs earlier in the perinatal period.[58] These efforts aim to and may serve to improve perinatal care outcomes.

Labor and Delivery

Primary Funders

Medicaid covers almost half of all births in Georgia, with coverage rising to nearly 60% in rural areas.[59] Most deliveries occur in traditional hospital settings, rather than alternative sites like freestanding birthing centers. Rural areas are particularly affected by workforce shortages, including but not limited to OB-GYNs, which force pregnant individuals to travel long distances for labor and delivery.[60]

> **"The needs in different areas of the state are so vastly different… Closures of labor and delivery units change the landscape."**
>
> **— Key Informant Interviewee**

To address rural access challenges, Georgia has implemented and proposed Medicaid reimbursement strategies for labor and delivery. Recent strategies include the introduction of a $1,000 managed care Medicaid reimbursement for deliveries in counties with populations under 35,000.[61]

Building on this, proposed 2026 state plan amendments (SPAs) include:

- Amendment 1: Adds $1,500 per delivery for counties with populations between 35,001 and 50,000.[61]

[v] Georgia DCH's public Medicaid Health Quality Measures compares each plan's PPC performance to the "National Median" (i.e., the NCQA national Medicaid HEDIS median), including Prenatal and Postpartum Care: Timeliness of Prenatal Care.
[vi] Georgia Families (GF) Average: The statewide, weighted composite performance across all Georgia Medicaid managed care plans.

- Amendment 2: Increases the existing $1,000 add-on to $3,000 per delivery for counties with populations under 35,000.[50]

At present, H.R. 1 does not directly prevent Georgia from pursuing these SPAs, though approvals are at CMS discretion. Based on recent analysis, H.R. 1's provisions are expected to substantially reduce overall federal Medicaid spending—by an estimated $5.4 billion over 2025-2034—which will place new fiscal pressure on the state to either increase its own Medicaid spending or scale back benefits, provider payments, and/or coverage. These financing implications could weaken hospital and community-based health infrastructure statewide, with safety-net and maternity providers facing higher uncompensated care burdens and potential service reductions that disproportionately affect perinatal populations reliant on Medicaid for prenatal, labor and delivery, and postpartum care.[62,63] Similarly, rural hospitals may be disproportionately affected by cuts, as they rely more heavily on Medicaid revenue and supplemental payments to remain financially viable.

Additional funding comes from HRSA grants, which support hospital-based quality improvement initiatives such as Alliance for Innovation on Maternal Health (AIM) safety bundles.[64]

Major Investments

Georgia's labor and delivery improvements build on statewide maternal health investments described in the preceding *Maternal Health Financing Landscape* section. Key strategies include:

- AIM safety bundles implemented through the **Georgia Perinatal Quality Collaborative (GaPQC)** to address obstetric hemorrhage, severe hypertension, and cardiac conditions.
- Projects like the **Doula Integration and Awareness Project (DIAAP)**[65] which complement community-based doula programs discussed under *Postpartum Care*.
- The **Regional Perinatal Center Commission**, which was recently established to assess and strengthen Georgia's six regional centers and address rural disparities.[66]
- Programs such as **HOPE for Georgia Moms**, which align clinical and community partners to implement MMRC recommendations.[67]

These investments are designed to improve hospital readiness, ensure consistent adherence to evidence-based practices, and strengthen labor and delivery systems across the state.

Performance Outcomes

Georgia's maternal health investments are targeting safer, healthier births by focusing activities and targeting performance monitoring on key labor and delivery outcomes such as preterm birth, severe maternal morbidity (SMM), maternal mortality (MM), and low-risk cesarean deliveries. The collective goal is to ensure full-term, complication-free births and to reduce preventable deaths and unnecessary cesarean sections (C-sections). State and community partners are aligning hospital safety practices, prenatal and postpartum follow-up, and community support to make sure families receive the right care at the right time.

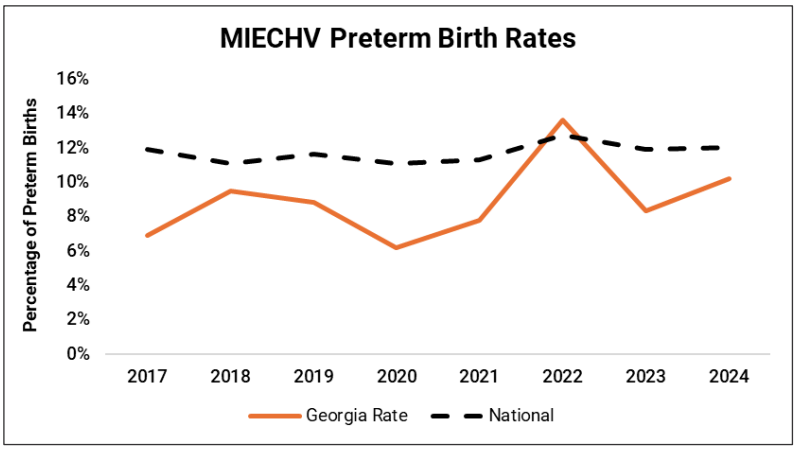
"Over half of birthing facilities have participated in an active way [in the GaPQC] … Reporting data, engaging in trainings, ongoing meetings."

- Key Informant Interviewee

Preterm Birth Outcomes. Georgia's MIECHV tracks the percentage of infants born preterm among families enrolled prenatally in home visiting. Because preterm birth is a systems outcome, shaped by access to prenatal care, medical/obstetric risk, and social determinants, these results provide context, not proof of the effect of the MIECHV program.

Figure 11. Preterm Births Among Individuals Enrolled in the MIECHV Program

*The MIECHV program show Georgia's preterm birth rates among enrolled families **remained below** the national average, suggesting the program is **helping to meet its objective of reducing avoidable preterm birth**.*



Source: HRSA MIECHV – Preterm Birth Performance Measure.

SMM and MM Outcomes. Reducing SMM and MM remain central focus areas across Georgia's maternal health initiatives. While organizations such as the GaPQC, DPH's Maternal Health Extension for Community Healthcare Outcomes (ECHO), and HOPE for Georgia Moms have not publicly released outcome data, each identifies SMM and MM reduction as key performance targets (**Figure 12**). These initiatives reflect Georgia's progress in implementing MMRC recommendations, as highlighted in NORC and the Georgia Health Initiative's Progress Towards Vitality: A 10-Year Retrospective Analysis of Systems-Focused Efforts to Improve Maternal Health in Georgia.

Figure 12. Georgia Initiatives Responding to MMRC Recommendations to Improve Maternal Outcomes

GaPQC (AIM Safety Bundles)	Standardizes readiness, recognition, and rapid response for leading causes of maternal mortality, such as severe hypertension and cardiac conditions, through AIM bundles in hospitals.
DPH Maternal Health ECHO	Translates MMRC findings into frontline practice by bringing clinicians together for monthly, case-based learning on MMRC-prioritized risks such as hypertension, cardiomyopathy, mental-health crises, and care coordination failures.
HOPE for Georgia Moms (Maternal Health Innovation)	Addresses systemic gaps identified by MMRC, including maternal cardiac disease, mental health, respectful care, and access barriers like doula support, through statewide collaboration.

Low Risk C-Section Delivery Outcomes. Funding investments continue to target reductions in preventable delivery-related complications by focusing on the safe reduction of unnecessary primary cesarean births. Through the GaPQC, hospitals are implementing evidence-based practices that promote safer, more equitable birth outcomes.

Overview. The AIM Safe Reduction of Primary Cesarean Birth bundle standardizes labor management and strengthens continuous labor support to reduce avoidable cesarean deliveries among low-risk, first-time mothers.

Target Outcomes. The initiative aims to safely decrease the low-risk (Nulliparous, Term, Singleton, Vertex (NTSV)) cesarean rate, thereby reducing maternal complications associated with surgical delivery—such as hemorrhage, infection, and longer recovery times—and improving newborn health outcomes. It also promotes respectful, patient-centered care, ensuring that every individual is supported through shared decision-making and equitable labor practices. By aligning hospital protocols

statewide, the program seeks to make cesarean reduction a quality and safety improvement goal, not a volume target.

Measures Tracked. Participating hospitals track both process and outcome indicators, including the NTSV cesarean rate, adherence to standardized labor dystocia and fetal heart rate management criteria, and the use of continuous labor support. Hospitals also monitor timely documentation, shared decision-making practices, and equity-focused measures to ensure safe, patient-driven reductions across all populations. These metrics help GaPQC and its partners evaluate progress toward lowering severe maternal morbidity and improving overall birth safety.

Postpartum Care

Primary Funders

Postpartum care in Georgia is supported through a mix of federal, state, and private sources. As the largest payer of postpartum services in the state, Medicaid helps reduce financial barriers and strengthens access to essential clinical and community-based care. Through Georgia's 12-month postpartum extension, Medicaid ensures continuity of care for conditions such as hypertension, mental health needs, and complications that emerge after birth. Beyond clinical services, Medicaid also funds care management programs, supports provider networks, and covers services delivered through community-based organizations that address social drivers of health.

Private and philanthropic funders complement Medicaid's role by supporting postpartum-focused quality improvement (QI) initiatives. Organizations such as CareSource Foundation, Elevance Health Foundation, and Arthur M. Blank Family Foundation invest in community-based models that extend into the postpartum period and address disparities in care. While many of these initiatives begin during pregnancy, their postpartum impact includes funding for doula care, technology-enabled follow-up and outreach, and culturally tailored education to support maternal health outcomes during the critical post-delivery period.[68,69,70]

Major Investments

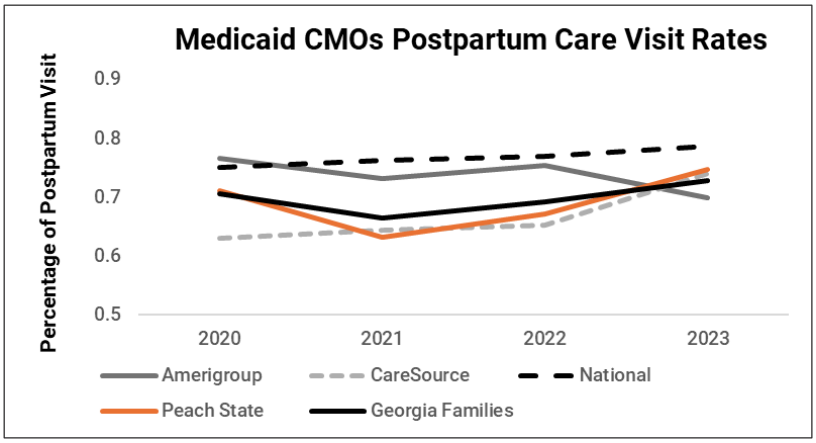
As referenced in our *Maternal Health Financing* section, investments include HOPE for Georgia Moms, funded by HRSA, which addresses gaps identified by the MMRC including mental health integration, respectful maternity care, and doula workforce development. The Perinatal Home Visiting Expansion also provides additional state and federal resources to strengthen home visiting programs (e.g., MIECHV), which offer maternal-infant clinical assessment, depression screening, intimate partner violence screening, safe sleep/nutrition education, breastfeeding help, well-woman care linkage, family planning, and connection to community resources during the postpartum period.

Performance Outcomes

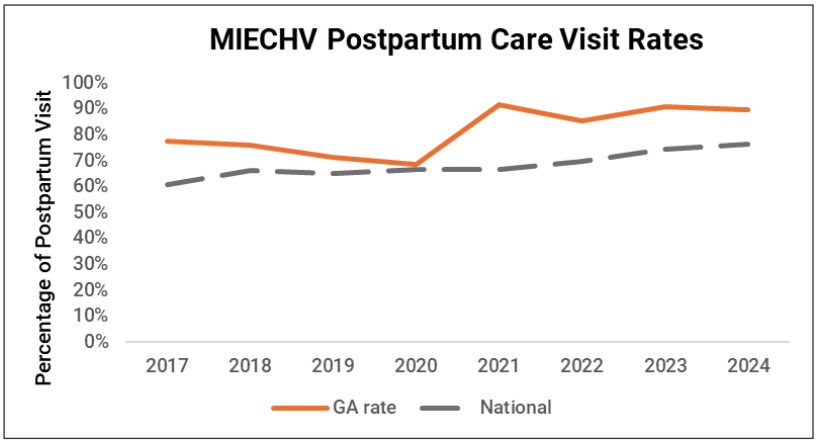
Postpartum care is a top priority because the weeks after birth carry the highest risks for moms.[71] Maternal health investments in Georgia currently track whether individuals receive timely postpartum care (i.e., within 7–84 days postpartum) and whether key care is delivered during the visit (e.g., blood-pressure monitoring, depression screening, contraception counseling, lactation support). Georgia CMOs publicly report and continue to lag behind national averages with respect to rates of timely postpartum care (**Figure 13**), though each CMO has launched PIPs to boost scheduling and follow-up, especially for members with gestational or chronic hypertension. Additionally, the state is exploring billing changes to remove barriers to care. In home visiting, the MIECHV program monitors and publicly reports the share of enrolled families receiving a postpartum visit within 56 days, and Georgia's rate has generally outpaced the national MIECHV average.[72]

Figure 13. Timeliness of Postpartum Care

*As with prenatal care, **performance has lagged**: all three CMOs and the GF statewide average were **below the 50th percentile from 2021–2023**, and all **trailed national Medicaid benchmarks**, pointing to persistent gaps in timely postpartum follow-up.*



*Pregnant women enrolled in GA's MIECHV home visiting program **continue to see higher rates** in postpartum care visits, **compared to MIECHV national rates.***



Source: HRSA MIECHV – Postpartum Care Visit Performance Measure.

Community-Based Supports

Primary Funders

Funding for Georgia's community-based maternal health programs comes primarily from a mix of federal initiatives, state appropriations, and philanthropic grants. HRSA's Healthy Start[73] program, for example, provides critical resources for high-risk communities, while MIECHV supports evidence-based home visiting models. Building on this federal foundation, Georgia has invested state resources to expand home visiting through the Georgia Home Visiting Program Pilot. In addition, foundations and private donors contribute to maternal health programs, such as the Community Innovation Fund[74] and partnerships with CMOs like CareSource.[75]

"Some of the access and quality issues are related to transportation… Having more community health workers to help people navigate the system and understand what their options are and where they can go for particular things, helping to set up and make people feel comfortable with telehealth services."

– Key Informant Interviewee

Major Investments

Maternal health investments in Georgia aim to address disparities in community-based care and supports among underserved populations. Major investments

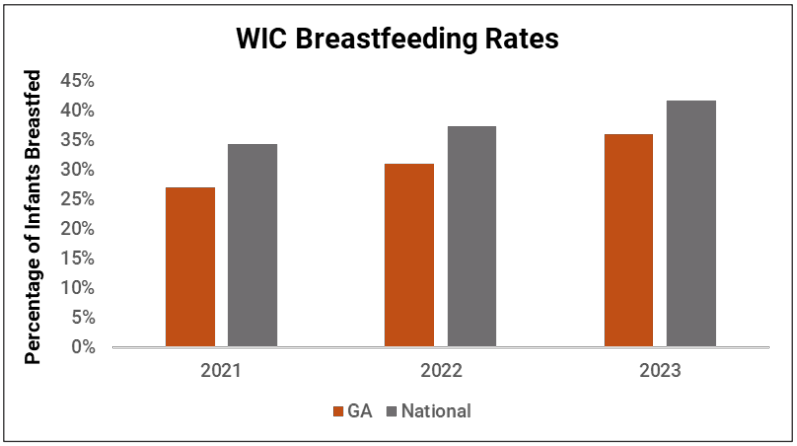
such as the *Black Birthing Initiative*[76] and *Embrace Refugee Birth Support*[77] aim to improve receipt of wraparound supports such as culturally tailored education, transportation, interpretation, and peer support and advocacy. These programs aim to reduce systemic barriers by offering holistic care that addresses social determinants of health and access challenges.

Performance Outcomes

Investments in community-based programming are helping families build healthier starts by targeting and tracking progress in provision of sustained wraparound support to families with respect to infant feeding and maternal well-being. The WIC program, for example, tracks and publicly reports breastfeeding rates among its enrollees and has shown steady year-over-year increases reflecting the impact of peer counseling, lactation services, breast pump access, and practical education offered through local agencies. Similarly, the MIECHV program monitors and shares data on rates of breastfeeding at six months among families enrolled prenatally. While outcomes are influenced by broader system factors, such as workplace supports, clinical lactation care, and community norms, these measures provide important context for how coordinated supports contribute to improved maternal and infant health in Georgia.

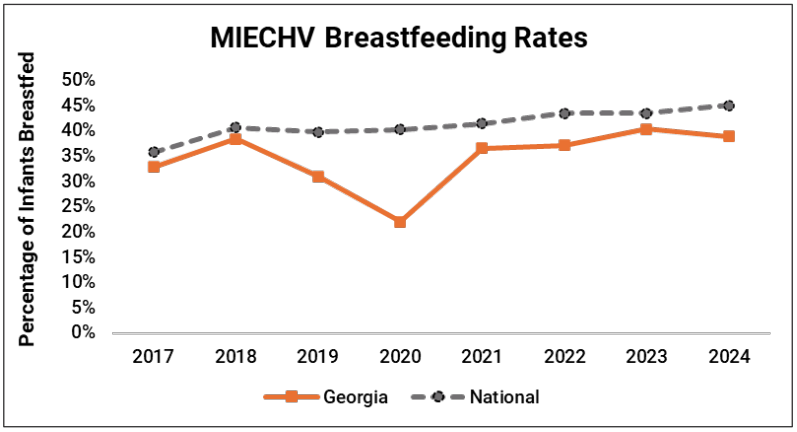
Figure 14. Breastfeeding Outcomes Among WIC and MIECHV Programs

*Georgia's WIC breastfeeding rates **have risen year over year**, mirroring steady gains nationally, though **national rates remain higher** than Georgia's.*



Source: USDA FNS. WIC - Breastfeeding Performance Measure by State.

*Breastfeeding rates among Georgians enrolled in MIECHV are **lower than the national** MIECHV average but have increased in recent years.*



Source: HRSA MIECHV - Breastfeeding Performance Measure.

Maternal Health Workforce

Primary Funders

Federal, state, and philanthropic funders continue to target investments in strengthening the maternal health workforce through a mix of clinical and community-based initiatives. These efforts include programs aimed at addressing workforce shortfalls by reducing barriers to workforce entry (e.g., the Georgia Center for Obstetrics Re-Entry Program), increasing reimbursement rates (e.g., enhanced payments under the Low-Income Medicaid [LIM] and Aged, Blind and Disabled [ABD] programs). Additional initiatives include strengthening workforce capacity and skills (e.g., one-time start-up funding for OB-GYN service expansion and a pediatric rural training track) and addressing care gaps in at-risk and rural communities (e.g., expanded coverage for home visiting services to improve birth outcomes and reduce infant and maternal mortality).[78]

Ongoing discussions emphasize the need to broaden workforce funding to enhance recruitment and improve retention rates. Interviewees echoed this sentiment, noting that expanding loan forgiveness, and offering incentive programs for maternal health providers (including those encouraging providers to seek residency or otherwise serve historically underserved areas) could help address workforce shortages.

Major Investments

Recent investments reflect a commitment to strengthening the maternal health workforce, including but not limited to efforts to incentivize providers to work in and serve historically underserved areas within the state (e.g., the Physicians for Rural Areas Assistance Program, and the Advanced Practice Registered Nurse Loan Repayment Program), and broad the types of providers eligible to bill for select material health services during the perinatal period (e.g., the Doula Medicaid Reimbursement Pilot).

Performance Outcomes

Pilot programs will track utilization rates among Medicaid beneficiaries and evaluate the effectiveness of reimbursement reforms. Workforce incentive programs such as the Physicians for Rural Areas Assistance Program and the Advanced Practice Registered Nurse Loan Repayment Program track basic participation and service-obligation metrics for administrative purposes, but do not routinely publish detailed workforce or utilization outcome measures. **NORC and Georgia Health Initiative's 10-Year Retrospective Analysis Report** found that community-based models incorporating midwives and doulas were associated with improved maternal health outcomes, including reductions in severe maternal morbidity and higher patient satisfaction.[79]

Successes for Georgia's Maternal Health Financing

From this research, several promising attributes of Georgia's maternal health financing landscape have emerged. Across examples of successes is an underlying theme of flexible funding paired with partnerships, which together support progress through innovation, scaling successful models, and advancing systems change efforts. Identified areas of success include:

Securing Supplemental Federal and Private Grants. Georgia historically has had success securing supplemental, discretionary funding from federal agencies and private foundations. Unlike mandatory formula funding, these competitive awards have enabled the state to pursue targeted innovations. For example, HRSA and CMS grants have supported telehealth expansion and mental health integration, while private foundations (Kaiser Permanente, Elevance Health Foundation, Arthur M. Blank Family Foundation) have funded community-based education and workforce development. In addition, the

leveraging of dollars across funding streams has supported implementation of certain MMRC recommendations and the scaling of innovative programs. The success of these efforts underscores the critical role supplemental grants play in financing and sustaining the maternal health system.

Funding Pilot Programs to Spur on Innovation. Targeted, yet flexible, funding streams have supported the initiation of innovative pilot programs addressing maternal health. One example is a program supporting doula services for Medicaid members. This pilot has shown improved birth outcomes, increased breastfeeding rates, and enhanced patient satisfaction. In addition, initiatives like the Black Birthing Initiative Hub leverage private foundation support to offer culturally responsive, community-led care models.[80]

Community Partnership as a Catalyst for Fiscal Policy Shifts. Systems change efforts led by community organizations, academic institutions, and legislative champions have influenced how maternal health services are structured and financed. For example, a coalition of multi-sector community organizations led by 9to5 Georgia worked to establish three weeks of paid leave for all state employees following the birth of a child.[81] Building on this initial success, subsequent state legislation doubled paid parental leave to six weeks.[82] Current efforts continue to gain traction, including proposals to expand doula reimbursement, midwifery licensure, and more expansive telehealth infrastructure.

A central theme in these successes is the strategic integration of quantitative data and personal narratives. While stakeholders emphasize the importance of evidence and data to guide fiscal allocation, they also recognize the unique power of personal narratives in illuminating policy-related conversations.

Changes in State Policy. Specific state policy changes have contributed to improvements in the maternal health financing infrastructure. For instance, in 2021 Georgia extended its postpartum Medicaid coverage from 60 days to six months and then again to 12 months effective November 1, 2022. This extension has expanded access to care, strengthened the financing infrastructure, and is addressing a gap in care and supports care continuity during a critical period.

Ongoing Challenges for Georgia's Maternal Health Financing

In addition to successes, our research also reveals persistent challenges in Georgia's maternal health financing and service delivery landscape, which include:

> **"Funding happens in cycles that aren't amenable to real-world relationships. Episodic funding makes it hard to sustain partnerships with community organizations."**
>
> **— Key Informant Interviewee**

Funding Instability. As previously noted, federal funding includes entitlement dollars that flow automatically to states based on need and participation and supplemental funds that provide time-limited or targeted resources to strengthen infrastructure, support innovation, and address gaps not fully met by entitlement programs. Together, these mechanisms create a layered financing structure that relies on the stability of entitlement dollars and the flexibility of supplemental funds. Because supplemental funding is discretionary and entitlement programs are shaped by federal policy decisions, shifts in federal priorities or regulations can introduce uncertainty, disrupt planning, and limit states' ability to sustain consistent maternal and child health services.

In Georgia, success in securing supplemental federal funds also creates a strategic vulnerability. Maternal health programs rely heavily on federal grants, including awards from HRSA and Title V, which makes the state susceptible to federal policy shifts and related budgetary constraints. This

dependence complicates long-term sustainability and may hinder the ability to scale effective initiatives. Uncertainty around future federal funding also clouds the state's long-term fiscal landscape.

When federal policy changes alter the structure or availability of entitlement or supplemental funding, Georgia's financing environment can shift rapidly. Reductions in Medicaid funding or changes to allowable reimbursement methods can constrain resources for core services, potentially leading to coverage losses and diminishing revenue for programs that depend on Medicaid reimbursement and safety-net support. At the same time, new federal initiatives may introduce short-term grants intended to address emerging priorities or support innovation. Although these funds provide timely assistance, their temporary nature limits the state's ability to build sustained infrastructure or maintain community-based programs once the funding period ends. Short-term grants often encourage pilot projects without offering viable pathways for scale or long-term operation, leaving successful models without the ongoing support needed to persist.

As a result, Georgia must simultaneously manage the impact of potential long-term funding reductions while attempting to leverage episodic federal investments that, by design, do not provide a stable foundation for sustainable maternal health financing.

Limited Transparency Around Financing. While not specific just to Georgia, transparency around both funding and outcomes in maternal health is limited. Funding data are fragmented by virtue of the various sources of funding and their different respective practices around reporting. While federal agencies such as HRSA, CDC, and USDA publish clear grant amounts, private and nonprofit funders rarely provide Georgia-specific investment details beyond potential press releases or Form 990 filings. This makes it difficult to understand the full landscape of maternal health investments and/or assess how philanthropic and state dollars align with community needs. Because most maternal health investments are tied to outcome-oriented goals, performance measures are important for context. That said, publicly available outcome data often lagged or are incomplete. In addition, certain programs use the capture of indicators for purposes of internal quality improvement rather than for public reporting, which limits ability to directly link funding to impact.

Disproportionate Impact in Rural Areas. Thirty-five percent of counties in Georgia are defined as maternity care deserts, lacking labor and delivery units.[83] Rural areas in particular face provider shortages, especially OB-GYNs, midwives, and doulas.

Compared to other states, Georgia maintains some of the most restrictive regulations for midwives, including requirements for physician supervision and limited licensure pathways. In addition, current laws limit billing and reimbursement options for midwives, restricting workforce expansion, and reducing cost-effective care alternatives.[84] These realities, along with an aging workforce and difficulties recruiting and retaining clinicians in rural areas, contribute to Georgia's systemic workforce challenges, which include a critical shortage of OB-GYNs, Maternal-Fetal Medicine specialists, and CNMs.[85] Financing gaps including low reimbursement rates, limited loan forgiveness programs, and lack of targeted workforce incentives also make it difficult to attract new providers.[86]

"No amount of money [can] make someone agree to be on call 24/7 in a rural hospital. We've lost OB programs because we can't staff them."
— Key Informant Interviewee

The closure of labor and delivery units in rural Georgia in particular has significantly reduced access to care, particularly for lower-income populations. The absence of infrastructure in these counties can increase difficulty in attracting and allocating funding, whether through grants or other financial mechanisms, limiting opportunities for investment in essential maternal health services.

Administrative Burden. From the standpoint of maternal health programs or entities receiving funding, budgetary documentation requirements (i.e., how and where money has been spent) can be particularly cumbersome, depending on the funding source. For instance, some federal, state, and private funders impose substantial operational requirements tied to receipt of funds. Administrative complexity can make it challenging to both pursue and maintain funding opportunities in light of the burden imposed by substantial reporting obligations. There needs to be a balance between capturing data to support transparency, evaluation, and learning and the burden it places on organizations, especially with more limited administrative capacity.

> **"With the federal funding, it's been the whole 'defend the spend'... We have to provide documentation down to the penny. It's exhausting and makes me not want to [pursue it]."**
>
> **— Key Informant Interviewee**

Key Considerations

This section outlines key considerations for improving and strengthening Georgia's maternal health financing landscape based on the research conducted. It begins with a summary of the unique attributes of each type of funding source, accompanied by opportunities to strengthen its contribution to the shared funding ecosystem. It then concludes with considerations for what maximal coordination across these sources could look like to multiply the impact of maternal health financing with the shared goal of improving maternal health outcomes in Georgia.

Federal Investments

Unique Attributes of Federal Investments

Federal funding provides substantial support and critical infrastructure to finance maternal health initiatives and other priorities that shape the health and well-being of Georgians. These federal dollars sustain preventive and community-based programs and supply resources that flow through state agencies for implementation at the state level. Multi-year federal entitlement funding which are often awarded at significant funding levels, form a dependable fiscal foundation for Georgia that ensures the continuity of programs that require stable, predictable investment. This is reflected in the proportion of Georgia's annual state budget that is consistently composed of federal funds each fiscal year, underscoring the enduring role of federal support in the state's public health financing.

Georgia also relies on supplemental funding mechanisms that enhance and extend the impact of these federal dollars. Supplemental funds are structured to maximize federal reimbursements, which in the case of maternal health occurs most prominently through Medicaid, and to ensure that the state can fully draw down available federal matching funds. These mechanisms help Georgia leverage limited state resources while expanding service capacity, supporting program sustainability, and filling operational gaps that federal grants alone cannot meet. As a result, supplemental funding serves as an essential complement to federal infrastructure funding, ensuring that Georgia can make the most effective and efficient use of every federal dollar dedicated to maternal health and related public health priorities.

Opportunities to Maximize Federal Investments

As reflected throughout this report, episodic and shorter-term funding contributes to instability for programs and providers. **Long-term commitments in resourcing** maternal health programming can improve sustainability of effective programs and approaches and continuity of care. Ensuring and providing longer-term federal investments in maternal health would also provide more time for assessment and evaluation of outcomes, allowing stakeholders to identify what works well and replicate and/or enhance the scale of effective models.

In addition, **clear and timely regulatory guidance** and other forms of education following passage and implementation of federal policy changes is an area for improvement. As a recent example, passage of H.R.1 contributed to confusion and differences in understanding regarding its implication on funding and public program design in Georgia. Improved provision of guidance from federal decisionmakers to state decisionmakers can strengthen channels of communication, coordination, and assist in shorter- and longer-term planning around maternal health financing.

Building on these opportunities to strengthen federal support and improve long-term planning, additional financing strategies can further enhance the state's ability to advance maternal health priorities. **Targeted rural investments** can be advanced by aligning federal Rural Maternity and Obstetrics Management Strategies (Rural MOMS) with state plans to strengthen obstetric units and support workforce retention in areas experiencing significant gaps in maternity care access. **Data and monitoring support** can be enhanced by expanding federal grants that improve state data systems and public dashboards, enabling more evidence-driven allocation and evaluation of maternal health resources.

State Investments

Unique Attributes of State Investments

State appropriations serve both a complementary and independent function in shoring up maternal health financing in Georgia. For instance, state dollars are used to draw down federal match funds for critical public programs such as Georgia's Medicaid, with the federal government paying $0.66 of every $1 Georgia spends on Medicaid services delivery.

Beyond drawing down federal match dollars within the context of maternal health financing, state funds appropriated are critical to support programs and advance the health priorities as identified by state leaders, which currently includes addressing maternal health. State funding decisions are particularly impactful as state leaders, when compared with federal leaders, often are better informed in financing Georgia-specific solutions to address Georgia-specific problems. Within the context of maternal health, state leaders have closer touchpoints to local academic institutions and community-serving entities to which funds can be distributed. Importantly, these entities can also serve as key partners to state leaders in informing how best to apply resources to address real maternal health needs of Georgians.

Opportunities to Maximize State Investments

Within the context of federal matching rates, Georgia leaders can assess ways to **enhance the percentage of federal dollars drawn down** to support maternal and other health issues. One of the policy successes noted in this report was the expansion of postpartum Medicaid coverage from 60 days to 12 months. Beyond the postpartum Medicaid time frame, Georgia's Pathways to Coverage™ (Pathways) launched in 2023, provides a Medicaid option to certain uninsured, low-income adults who meet certain qualifying activities (including caregiving of a child under age six) and fulfill reporting requirements. Pathways is currently operating under a temporary program extension up through the end of December 2026, after which it will need to come in compliance with H.R.1, which includes revising the caregiving provision to reflect caregiving of a child under age 13. Come January 1, 2027, continuing to operate under the current income eligibility for Pathways established at 100% of the federal poverty level will result in the state continuing to fund about 34% of health care costs for Georgians covered under Pathways with federal funds covering the rest. Should the state increase the income eligibility for Pathways to 138% of the federal poverty level on January 1, 2027, the state would shift to funding about 10% of the health care costs for Pathways members with federal funds covering the rest.

Another consideration for state leaders is within the context of the **onboarding of incoming CMOs** for Georgia's Medicaid program. As detailed earlier in this report, CMOs play a critical role in administering benefits, coordinating care, and running value-based maternal health initiatives to support Medicaid members. Georgia's latest CMO procurement cycle in 2023 resulted in a notice of intent to award to

three new CMOs, retaining only one incumbent CMO. Implementation of these new CMO contracts is scheduled for July 2027, providing an opportunity to enhance the ways in which CMOs are structured to support maternal health.

A final consideration is to **explore innovative financing mechanisms** to support Georgia's stated priorities, including at the intersection of improving maternal health outcomes and shoring up the state's health care workforce. Opportunities include implementing workforce incentives, such as state credits or loan repayment for maternal health care providers (e.g., OB-GYNs, midwives, doulas, etc.), especially in rural and other underserved areas of the state. Strategic budget allocation can further strengthen this approach by prioritizing maternal health in state budget planning and leveraging Title V funds to address persistent differences in access and outcomes across communities. Additionally, creating rapid-response funding mechanisms for needs identified by the Maternal Mortality Review Committee and communities would enable the state to deploy resources quickly where emerging challenges are most acute.

Philanthropic Investments

Unique Attributes of Philanthropic Investments

Philanthropy plays a critical role in complementing both federal and state public dollars. In particular, philanthropic investments help to spur on innovation, systems-building, and support for equity-focused interventions. By their nature, philanthropic funds are much nimbler than government dollars, providing enhanced flexibility in how they are structured and the scopes of work for which they can be deployed. In addition to funding innovative projects and practices, philanthropic entities themselves are exploring innovative ways to support work with and across their sector peers, including through the use of pooled funds.

Opportunities to Maximize Philanthropic Investments

There are several opportunities for philanthropies to leverage their inherent flexibility in financing maternal health vitality in Georgia. Similar to federal grants, **multi-year funding** can strengthen organizational infrastructure, workforce stability, and evaluation efforts. In addition, **unrestricted dollars** or other means of flexible funding can support both stabilization and innovation.

Philanthropic entities can pursue innovative strategies, such as the above-mentioned **pooled fund** mechanism. This would create a shared investment vehicle allowing for contribution of funds from various philanthropic entities that would reduce fragmentation in efforts and enhance risk-sharing. In addition, a pooled fund provides an opportunity for centering shared philanthropic priorities, including equity-centered grantmaking as well as investments in place-based systems change.

Maximizing Coordination Across Federal, State, and Philanthropic Investments

Taken as individual funding sources, federal, state, and philanthropic investments are critical to the maternal health financing ecosystem. However, when these investments are intentionally leveraged and coordinated, they mutually build upon their respective reach and effectiveness to more broadly contribute to enhanced systems support towards improved maternal health outcomes. Cross-cutting considerations to support coordination include:

- **Strengthening Strategy Collaboration with CMOs.** As Medicaid covers nearly half of all births in Georgia, CMOs are indispensable partners in the maternal health financing landscape. As discussed earlier in the report, CMOs' role in the funding landscape for maternal health is often viewed through the lens of their charitable giving. While this is a vital contribution that has seeded many successful local programs, to achieve long-term systems change, there is an opportunity to evolve this partnership from a philanthropic model to a contractual and clinical

integration model. By aligning CMO quality-incentive structures with community-led initiatives, Georgia can ensure that core maternal health services are sustained through predictable reimbursement rather than temporary grants. This shift supports CMOs in meeting their state-mandated performance goals while ensuring that limited philanthropic "risk capital" remains available for high-level innovation and pilot programs.

- **Aligning maternal health priorities** to ensure funding is directed toward shared goals and to prevent duplication of activities, parallel investments, or efforts that compete rather than complement each other. Clear alignment supports more efficient use of resources and helps ensure that providers and community organizations are not burdened by overlapping or conflicting program requirements. Potential evaluation for coordination in this area may involve tracking the development of jointly endorsed plans and the reduction of duplicative or parallel efforts across initiatives. Evidence of effective alignment should also include the use of coordinated timelines and processes amongst more nimble funders that simplify planning for implementing partners and help ensure resources flow to the highest-value activities.
- **Jointly identifying approaches for assessing and evaluating effectiveness** of funded initiatives to support continuous improvement and strengthen the evidence base. Coordinated evaluation strategies spanning both process and outcome measures can increase understanding of how financing streams work together, pinpoint gaps, and identify models with the strongest potential for replication or expansion. Progress indicators may be reflected in the use of shared evaluation frameworks, harmonized indicators, and streamlined reporting that reduces burden on program implementers. Regular joint learning sessions can allow partners to interpret results collectively, incorporate findings into future investment decisions, and build a more cohesive understanding of which approaches most meaningfully improve maternal health.
- **Establishing parameters for testing and scaling innovative pilots** so that promising strategies can move beyond small, time-limited demonstrations. Clarifying roles, expectations, and criteria for scale helps ensure pilot programs are positioned for long-term sustainability and that successful innovations reach communities where needs are most acute. Evaluation of coordination in this area to be considered may include tracking the number of co-funded pilots, the proportion that meet agreed-upon scalability criteria, and the timeliness of decisions to expand or adapt models showing early success. Attention to how pilot learnings are documented, shared, and used to inform larger-scale investments can further indicate whether innovation is being strategically nurtured across the funding landscape.
- **Strengthening data-driven operations and accountability** across funding streams to support more informed decision-making. Integrating or better connecting data systems, where feasible, can reduce reporting burdens for partners on the ground, improve visibility into resource flows and outcomes, and enhance the ability to track progress toward state and federal maternal health goals. Metrics to assess progress may include the development of new or expanded data-sharing agreements, increased adoption of standardized reporting indicators, and improvements in the completeness, interoperability, and timeliness of data submitted across funders. These advancements can help clarify how investments are performing collectively and support more transparent accountability for maternal health outcomes.
- **Establishing a Maternal Health Financing Task Force**. An innovative strategy to sustain and monitor the maternal health financing landscape is the establishment of a Maternal Health Financing Task Force. This standing body would be driven by systems-level leaders in direct collaboration with state agencies and CMOs. By creating a transparent, “single-source” view of the state’s fiscal environment, the Task Force can identify where service gaps persist and coordinate transition of successful pilots into sustainable, CMO-reimbursed service lines. The Task Force would track progress using practical indicators of system health, such as timeliness of “graduation” of programs from philanthropic seed funding to more permanent

funding structures, the reduction of administrative burden on providers, and the effective braiding of funds across public and private sources. This practitioner-informed structure would ensure that all partners are working in concert to institutionalize successful models, thereby strengthening fiscal accountability, and positioning Georgia's maternal health initiatives for long-term, scalable success.

Conclusion

Findings from this research point to the value of establishing a holistic maternal health financing framework that aligns multi-source funds with shared goals and accountability mechanisms to help drive systems change in Georgia. Future opportunities for funding present a critical opportunity to drive innovation, foster collaboration, and ensure long-term sustainability to advance maternal health vitality.

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Appendix A. Acronym List

Below is a list of acronyms used in our report in alphabetical order.

Acronym	Term
ABD	Aged, Blind and Disabled
AIM	Alliance for Innovation on Maternal Health
CBWW	Center for Black Women's Wellness
CDC	Centers for Disease Control and Prevention
CMO	Care Management Organization
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
CORAL	Center to Advance Reproductive Justice and Behavioral Health among Black Pregnant or Postpartum Women and Birthing People
CHIP	Children's Health Insurance Program
DCH	Georgia Department of Community Health
DIAAP	Doula Integration and Awareness Project
DPH	Georgia Department of Public Health
ECHO	Extension for Community Healthcare Outcomes
FMAP	Federal Medical Assistance Percentage
FY	Fiscal Year
GaPQC	Georgia Perinatal Quality Collaborative
GF	Georgia Families
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HMHBGA	Healthy Mothers, Healthy Babies Coalition of Georgia
HOPE for Georgia Moms	Healthy Outcomes and Positive Experiences for Georgia Moms
HRSA	Health Resources and Services Administration
HRSA MCHB	Health Resources and Services Administration's Maternal and Child Health Bureau
LiM	Low-income Medicaid
MHVTT	Maternal Health Vitality Think Tank
MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program
MM	Maternal Mortality

Acronym	Term
MMRC	Maternal Mortality Review Committee
NIH	National Institutes of Health
NSA	Nutrition Services and Administration
NORC	NORC at the University of Chicago
NTS	Nulliparous, Term, Singleton, Vertex
OB-GYN	Obstetrician-Gynecologist
P4HB	Planning for Healthy Babies
PCK	PeachCare for Kids®
PCTE-CPMH	Primary Care Training and Enhancement – Community Prevention and Maternal Health
PIPS	Performance Improvement Projects
PRAMS	Pregnancy Risk Assessment Monitoring Systems
QI	Quality Improvement
RHT	CMS's Rural Health Transformation Program
RPC	Regional Perinatal Center
Rural MOMS	Rural Maternity and Obstetrics Management Strategies
SMM	Severe Maternal Mortality
SPA	State Plan Amendment
USDA	United States Department of Agriculture
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

Appendix B. Research Methodology

Research Questions

1. What are the current sources of maternal health funding in GA at the federal, state, and private level?
2. What pooling and purchasing mechanisms are currently used to allocate such funding?
3. What are the primary models of care used to deliver maternal healthcare in GA?
4. To what extent do these models of care align with current funding streams?

Environmental Scan and Literature Review

NORC conducted a rapid and targeted literature review of maternal health financing in GA. The purpose of the review was to identify public and private funding sources for maternal health programs in GA, pooling and purchasing mechanisms within the state, models of maternal care and their relationship to funding, and barriers and opportunities to align and strengthen the current financing system. We reviewed peer-reviewed journal articles and grey literature as well as a targeted search of information posted on organizational websites (e.g., GA Department of Public Health, Association of Maternal & Child Health Programs). NORC collaborated with the Initiative to establish a set of research questions and key search terms and parameters for the literature review based on the project's objectives.

Key Informant Interviews

NORC conducted 14[vii] informant interviews with individuals and organizations who offer a range of perspectives on maternal health financing in GA. The purpose of the interviews was to identify maternal health funding mechanisms, facilitators, and barriers to aligning funding streams and processes, identify opportunities to strengthen the maternal health financing system, and contextualize findings from other data sources. NORC collaborated with the Initiative to identify interview topics, develop interview guides, and other supporting materials, and identify key informants with varying perspectives. Interviews were held virtually via Zoom and led by a trained interviewer. NORC obtained approval on the interview instrument and protocol from our Institutional Review Board before beginning the interviews.

Quantitative Data Scan

NORC identified and accessed quantitative data sources capturing federal, state, local or private funding sources for maternal health initiatives in Georgia and outcomes currently tracked by maternal health programs with respect to access, quality, efficiency, and equity of maternal health in the state. We prioritized data sources that are publicly available and reflect the primary payer for Georgia births (i.e., Medicaid). We conducted a quantitative analysis to descriptively assess maternal health funding sources, resources, and outcomes across the state, generating summary statistics for key funding sources (e.g., distribution of federal, state, and private funding) and outcomes (e.g., severe maternal morbidity), focusing on the most recently available for each source.

[vii] This count includes one interview where we analyzed feedback where relevant from another NORC study with the Georgia Health Initiative on maternal health.

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