	GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES MEDICAID POLICY MANUAL			
	Chapter:	**2100**	**Effective Date:**	**May 2023**
	Policy Title:	**Pregnant Women**		
	Policy Number:	**2184**	**Previous Policy Update:**	**MT 68**

REQUIREMENTS

Pregnant Women provides Medicaid to pregnant women who have Budget Group (BG) income at or below 220% of the Federal Poverty Level (FPL) and who meet all other eligibility requirements.

BASIC CONSIDERATIONS

For eligibility purposes effective November 1, 2022, pregnancy begins with the month of conception and continues through the 12th month following the termination of pregnancy. Eligibility terminates at the end of the month in which the 12th month falls. Begin the 12 month count the month after the termination of pregnancy.

NOTE: Pregnancy termination includes live birth, still birth, spontaneous abortion (miscarriage), therapeutic abortion and elective abortion.

Pregnant Women Medicaid considers a woman as pregnant during the 12-month extended postpartum period. . A pregnant woman who is not receiving Medicaid or is not eligible as a pregnant woman prior to and/or including the month of pregnancy termination is not eligible for Pregnant Women Medicaid during the 12-month extended postpartum period even if she meets eligibility requirements during the 12- month period.

A pregnant woman who is correctly determined Medicaid eligible remains financially eligible from the effective month of approval through the end of the 12-month pregnancy transition period, regardless of changes in the BG income. Refer to Section 2720, Continuous Coverage for a Pregnant Woman.

NOTE: A pregnant woman must continue to meet all non-financial eligibility requirements.

BASIC CONSIDERATIONS (cont.)

12-Month Extended Postpartum Coverage

Individuals may be eligible for the 12-Month Extended Postpartum coverage if:

- While pregnant were eligible for and received coverage under Medicaid or PCK in Georgia. The 12-month extended postpartum coverage will not be extended to individuals who were not enrolled in Medicaid or PCK in the Georgia at some point during pregnancy.

- Applying for Medicaid benefits were pregnant and received Medicaid-covered services in Georgia while pregnant or terminated during a period of retroactive eligibility.

Note: No retroactive coverage in PCK.

Pregnant individuals (including Individuals in their postpartum period) should remain eligible through the last day of the month in which the 12-month extended postpartum period ends regardless of any changes in circumstances that may affect eligibility (ex. income, household composition, gaining SSI or aging out). For PCK individuals in their extended postpartum period, this also includes becoming Medicaid eligible or non-payment of premiums. This list is not all inclusive.

Note: If an individual voluntarily requests closure of their PCK case during their extended postpartum period, the individual would not be eligible for the remainder of the 12-month postpartum period if later approved for a Medicaid COA.

EXCEPTIONS:

- Individuals who receive Pregnant Women Medicaid as Emergency Medical Assistance (EMA) are not required to meet the citizenship/identity or enumeration requirements. Refer to Section 2054, Emergency Medical Assistance.

- Individuals who receive Pregnant Women Medicaid are not required to cooperate with DCSS and are not required to apply for other benefits.

A pregnant woman can be determined eligible for continuous Medicaid coverage based on Pregnant Women Medicaid eligibility in any of the three months prior to the application month. The pregnant woman must meet all financial and non-financial requirements and must be pregnant in the prior month in which eligibility is being determined.

A pregnant woman is budgeted at minimum as two individuals (the pregnant woman and the unborn child). Increase the BG to include the number of fetuses per client statement. If the pregnant woman is included in any Family Medicaid category, ensure the fetus(es) are counted in the BG for the family according to the tax-filer/non-filer rules. .

OTHER CONSIDERATIONS

Presumptive Eligibility

Certain medical facilities including the Department of Public Health (DPH) are approved by the Department of Community Health (DCH) and provide an on-site Presumptive Eligibility (PE) Medicaid certification to pregnant women who apply for and are presumed eligible for Pregnant Women Medicaid.

A Presumptive Eligibility Medicaid application is completed by certified Qualified Providers (QP's) at these facilities. The purpose of the PE is to provide Medicaid coverage for pregnant women to receive immediate prenatal care. After certification, the PE packet is forwarded to the local DFCS or RSM Outreach Project worker for a full Medicaid determination, as the PE decision is temporary and only covers services performed on an outpatient basis.

NOTE: Qualified Providers do not verify citizenship and identity for PE applications. This must be done by the DFCS or RSM Project worker when completing the regular Medicaid determination.

Refer to Section 2067, Presumptive Pregnancy Medicaid.

PROCEDURES

Follow the steps below to determine Medicaid eligibility for Pregnant Woman Medicaid:

Step 1 Review the application and contact the applicant if additional information is needed that is not included in the application.

Step 2 Determine the AU and BG. Refer to Chapter 2600, Family Medicaid Assistance Units and Budget Groups.

NOTE: If an applicant applies for Pregnant Woman Medicaid after her pregnancy has terminated, accept her statement of pregnancy, fetus number, and termination date of pregnancy.

Step 3 Obtain the number of fetuses and estimated date of delivery (EDD) from a medical provider or from the applicant. Written verification of the pregnancy is not required.

Step 4 Establish all points of basic eligibility. Verify applicant's citizenship/qualified immigrant status and identity. Accept the applicant's statement for all other points of basic eligibility unless the statement conflicts with information known to the agency or is deemed questionable. Refer to Section 2215 Citizenship/ Immigration Status/Identity.

Document in the case record the conflict of information or reason questioned and the verification that is subsequently requested.

NOTE: Citizenship/Immigration Status/Identity are not a requirement for Emergency Medical Assistance (EMA). Refer to Section 2054, EMA.

Step 5 Based on tax filer or non-tax filer status, apply the appropriate FPL depending on the BG size, to determine eligibility for the Pregnant Women. Refer to Section 2245, Filer Status/Specified Relative Relationship. Refer to Appendix A2, Financial Limits for Family Medicaid.

Step 6 Verify Modified Adjusted Gross Income (MAGI) income using available electronic data sources. Refer to Section 2051, Verification.

Step 7 Complete the budgeting process. Refer to Section 2669, Budgeting.

PROCEDURES (cont.)

Step 8 If eligible, approve Pregnant Women Medicaid. If ineligible, allow case to cascade to Pregnancy Spend Down Medicaid (or PCK, depending on age of Pregnant Woman and amount of income), complete and document the results of a Continued Medicaid Determination (CMD). Refer to Section 2052, CMD.

When the MAGI income limit is above the PeachCare for Kids® income limit, or the applicant is 19 years of age or older, a system CMD will be completed to the Federally Facilitated Marketplace (FFM).

Step 9 If the application originated as a Presumptive Medicaid, screen in GAMMIS to determine if applicant is actively receiving as a Presumptive Medicaid pregnant woman (aid category 865). If so, link GA Gateway client ID numbers to GAMMIS member ID numbers. This must be done the same day the application is approved.

Step 10 Refer pregnant women to WIC and document the case. Section 2985

Step 11 Initiate contact with the member in the month prior to the month in which the EDD falls. Continue these monthly contacts to establish that the pregnancy continues.

If the pregnancy terminates with a live birth, the child meets the Deemed Newborn requirement and Medicaid must be established for the newborn. Refer to Section 2174, Newborn Medicaid.

Continue Pregnant Women Medicaid eligibility 12 months following termination of pregnancy. Terminate eligibility at the end of the month in which the 12th month falls. Begin a CMD for the pregnant woman in the month prior to the last month of Pregnant Women Medicaid eligibility.