2184 – RSM PREGNANT WOMEN

POLICY STATEMENT	RSM Pregnant Women (PgW) provides Medicaid to pregnant women who have Budget Group (BG) income at or below 200% of the FPL and who meet all other eligibility requirements.
BASIC CONSIDERATIONS	For RSM eligibility purposes, pregnancy begins with the month of conception and continues through the 60th day following the termination of pregnancy. Eligibility terminates at the end of the month in which the 60th day falls. Begin the 60-day count on the day of the termination of pregnancy. **NOTE:** Pregnancy termination includes live birth, still birth, spontaneous abortion (miscarriage), therapeutic abortion and elective abortion. RSM is the only COA that considers a woman as pregnant during the 60-day transition period. A pregnant woman who is not eligible as a pregnant woman prior to and/or including the month of pregnancy termination **is** potentially eligible for RSM during the 60-day pregnancy transition period if she meets eligibility requirements during the 60-day period. A pregnant woman who is correctly determined Medicaid eligible remains financially eligible from the effective month of approval through the end of the 60-day 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. **EXCEPTIONS:** • Individuals who receive RSM PgW as Emergency Medical Assistance (EMA) are not required to meet the citizenship or enumeration requirements. Refer to Section 2054, Emergency Medical Assistance. • Individuals who receive RSM PgW are not required to cooperate with CSS and are not required to apply for other benefits. A pregnant woman can be determined eligible for continuous Medicaid coverage based on RSM PgW eligibility in any of the three months prior to the application month. The pregnant woman must meet all RSM financial and non-financial requirements, and must be pregnant in the prior month in which eligibility is being determined.

BASIC CONSIDERATIONS (cont.)	A pregnant woman is budgeted as two individuals (the pregnant woman and the unborn child). If a multiple-fetus pregnancy is medically verified, increase the BG to include the number of verified fetuses. **NOTE:** If a pregnant woman applies for Medicaid for children only, the unborn child cannot be included in the BG.
OTHER CONSIDERATIONS	
Presumptive Eligibility	Certain medical facilities are approved by the Division of Medical Assistance (DMA) and provide an on-site Presumptive Eligibility (PE) Medicaid certification to pregnant women who apply for and are presumed eligible for RSM. 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 application is forwarded to the local DFCS or RSM Outreach Project worker for a regular Medicaid determination, as the PE decision is temporary and only covers services performed on an outpatient basis. Refer to Section 2067, Presumptive Medicaid.
PROCEDURES	Screen for LIM. If the applicant is potentially eligible for LIM, approve RSM pending the disposition of the LIM application. Screen for TANF and assist with the TANF application if the A/R chooses to apply. Follow the steps below to determine Medicaid eligibility for pregnant woman under RSM:
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.

PROCEDURES (cont.)

Step 3 Obtain verification of pregnancy and number of fetuses from a medical provider, either verbally or in writing. If pregnancy is verified verbally from the medical provider, document who verified the information. A pregnancy test performed by the health department or other qualified provider, including the test given at the time of the PE application, is acceptable.

NOTE: If an A/R applies for RSM Pregnant Woman after her pregnancy has terminated, she will need to provide a birth certificate, confirmation of birth or statement from a medical provider as proof that she was pregnant. If the pregnancy terminated in a manner other than a live birth, the A/R should provide a proof of pregnancy as outlined in Step 3.

Step 4 Obtain the estimated date of delivery (EDD) from a medical provider or from the A/R. Written verification of the EDD is not required.

Step 5 Establish all points of basic eligibility. Accept the A/R's statement unless the statement conflicts with information known to the agency, or is deemed questionable. Document in the case record the conflict of information or reason questioned and the verification that is subsequently requested.

Step 6 Accept the A/R's statement of gross income unless questionable.

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

If eligible, approve RSM PgW. If ineligible, complete and document the results of a CMD.

Step 8 Initiate contact with the PgW recipient in the month prior to the month in which the EDD falls. Continue these monthly contacts to establish that the pregnancy continues.

Step 9 If the pregnancy terminates with a live birth, approve the child for Newborn Medicaid if requirements are met. Refer to Section 2174, Newborn Medicaid.

Continue RSM PgW eligibility 60 days following termination of pregnancy. Terminate eligibility at the end of the month in which the 60th day falls. Begin a CMD for the pregnant woman in the month prior to the last month of RSM PgW eligibility.