CATEGORICAL FACTORS
PREGNANCY/NEWBORNS

Policy: Pregnant women are eligible for Medicaid, if they meet all other eligibility requirements. Infants under age one (1) or a baby born to a woman in receipt of Medicaid, including FHPlus, FPBP, etc., at the time of birth is automatically eligible for Medicaid until the end of the month the baby turns one (1). (See **CATEGORICAL FACTORS** MEDICAID EXTENSIONS/CONTINUATIONS)

References:

SSL Sect. 366
366-ee

Dept. Reg. 360-3.3(b)(4)
360-3.3(c)(5)

ADMs 10 OHIP/ADM-01
01 OMM/ADM-6
OMM/ADM 97-2
95 ADM-21
90 ADM-9
87 ADM-39
85 ADM-33
85 ADM-13
80 ADM-47

INF 00 OMM/INF-01

GISs 10 MA/011
10 MA/006
09 MA/027
00 MA/024
91 MA042

Interpretation: A pregnant woman applying for health insurance is not eligible for Family Health Plus (FHPlus). A woman who becomes pregnant after enrolling in FHPlus is counseled on her options of either remaining in FHPlus until the end of her pregnancy and the 60 day post-partum period or switching to full Medicaid coverage. The counseling includes providing information on the services available under Medicaid compared to FHPlus, and assisting the woman in determining if her current providers also participate in Medicaid fee-for-service or managed care.

Pregnant women with household income equal to or less than 100% of

CATEGORICAL FACTORS

PREGNANCY/NEWBORNS

the federal poverty level may be eligible for full Medicaid coverage. Pregnant women with household income greater than 100% of the federal poverty level and equal to or less than 200% of the federal poverty level may be eligible for perinatal care and are eligible for enrollment in Medicaid Managed Care. Perinatal care coverage provides most Medicaid covered care and services. (See **OTHER ELIGIBILITY REQUIREMENTS** PREGNANT WOMEN and **REFERENCE** COVERED SERVICES FOR PREGNANT WOMEN)

A woman determined eligible for Medicaid for any day during her pregnancy remains eligible for Medicaid coverage for at least 60 days from the date the pregnancy ends, regardless of any changes in the family's income or household composition. Eligibility continues until the last day of the month in which the 60th day occurs. This eligibility period is granted in all instances where a Medicaid application was made prior to the end of the pregnancy and the pregnant woman was determined eligible for Medicaid. At the end of the 60-day period, the A/R's circumstances are re-evaluated. If the A/R is not found eligible for full Medicaid, the A/R is budgeted under FHP; if ineligible under FHP, eligibility is determined for FPBP, etc.

When to Verify: When an A/R indicates she is pregnant;

When an A/R indicates that she has recently given birth.

Verification: A birth or pregnancy may be verified by:

(a) Information from the New York State Medicaid New Born System.

(b) Notification from a Managed Care Organization, Article 28 Pre-natal Care Providers, or other medical provider is acceptable; notification can be verbal or written. If notification is verbal, an appropriate notation is made in the case record with the name of the person and the organization providing the information and the date.

(c) For a woman who has an established case (whether there is an unborn on the case or not), written or verbal notification of the birth from an immediate family member or medical provider, or, in exceptional circumstances, an alternate reliable individual or agency, is acceptable. If notification is verbal, an appropriate notation is made in the case record with the name

CATEGORICAL FACTORS

PREGNANCY/NEWBORNS

of the person and the organization providing the information and the date.

(d) Any official government, medical or church record continues to be an acceptable form of documentation of birth.

(e) Individuals who are initially eligible for Medicaid as a "deemed" newborn are considered to have provided satisfactory documentation of citizenship and identity, by virtue of being born in the United States, and will not be required to further document citizenship or identity at any subsequent Medicaid eligibility redetermination/renewal.

NOTE: Verification is NOT required for name, date of birth, or social security number in order to provide the one-year extension for the newborn.

Disposition:

The eligibility of a pregnant woman is determined first under the LIF budgeting methodology. If ineligible under LIF budgeting, eligibility is determined using ADC-related budgeting methodology. If ineligible under ADC-related budgeting, the poverty levels are used for the pregnant woman and other children residing with her. This includes two-parent families. (See **CATEGORICAL FACTORS** UN/UNDEREMPLOYED TWO-PARENT HOUSEHOLDS) There is no resource test for pregnant women and newborns. Pregnant women are requested to voluntarily provide their social security number. However, pregnant women cannot be denied Medicaid for failure to provide an SSN.

NOTE: Pregnant women have a right to apply for presumptive eligibility (See **OTHER ELIGIBILITY REQUIREMENTS** PRESUMPTIVE ELIGIBILITY) at the site of a provider.

NOTE: When an LDSS is notified via WMS Report WINR 5225 (Upstate) or WINR 0796 (NYC), or through any other means that a baby has been born with a low birth weight designation (weighing less than 1200 grams at birth), and the mother is in a managed care plan, the LDSS must inform the health plan in writing within 5 days. The 5 day clock begins on the day that the district received such notification. Notification to the plan may be made in electronic form.