ARKANSAS REGISTER

Transmittal Sheet

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Secretary of State
John Thurston
500 Woodlane, Suite 026
Little Rock, Arkansas 72201-1094
(501) 682-5070
www.sos.arkansas.gov

For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of County Operations

Contact Mac E. Golden E-mail Mac.E.Golden@dhs.arkansas.gov Phone 501.320.6383

Statutory Authority for Promulgating Rules Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

Rule Title: Expansion of Pregnant Women Medicaid

Intended Effective Date (Check One)

- ☐ Emergency (ACA 25-15-204)
- ☑ 10 Days After Filing (ACA 25-15-204)
- ☐ Other _____ (Must be more than 10 days after filing date.)

Date	
Legal Notice Published	10/14/2022
Final Date for Public Comment	11/12/2022
Reviewed by Legislative Council	12/16/2022
Adopted by State Agency	01/01/2023

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Chloe Crater	chloe.crater@dhs.arkansas.gov	January 17, 2023
Contact Person	E-mail Address	Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Mary Franklin
Signature

501-244-3944 mary.franklin@dhs.arkansas.gov
Phone Number E-mail Address

Director, Division of County Operations
Title

January 17, 2023
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

122.000 Agencies Responsible for Determining Eligibility 1-1-23

The Department of Human Services (DHS) local county offices or district Social Security offices determine beneficiary eligibility for most Medicaid beneficiaries.

District Social Security offices determine Supplemental Security Income (SSI) eligibility, which automatically confers Medicaid eligibility for SSI beneficiaries.

124.130 Pregnant Women, Infants & Children 1-1-23

The infants and children in the SOBRA (Sixth Omnibus Budget Reconciliation Act of 1986) aid category receive the full range of Medicaid benefits.

Pregnant Women (PW)-eligibility ends on the last day of the month in which the 60th postpartum day occurs.

PW-Unborn Child group (covered through the State Child Health Insurance program, which is authorized by Section 4901 of the Balanced Budget Act of 1997) does not cover sterilization or any other family planning services. Therefore, providers must verify eligibility to determine if the pregnant women is PW-or PW "Unborn Child" (when providers check eligibility, the system will reflect: "PW Unborn CH-no Ster cov" for the Unborn Child group).

Aid Category 61 also includes benefits to unborn children of alien pregnant women who meet the eligibility requirements. The benefits for this eligibility category are:

A. Prenatal services

B. Delivery

C. Postpartum services for 60 days (plus the days remaining in the month in which the 60-day period ends)

D. Services for conditions that may complicate the pregnancy

System eligibility verification will specify "PW unborn ch-no ster cov/FP."

203.500 The Nurse Practitioner's Role in Family Planning Services 1-1-23

Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services provided by nurse practitioners and other providers. Medicaid clients' family planning services are in addition to their other medical benefits. Family planning services do not require PCP referral.

A. Refer to Sections 214.321 through 214.333 of the manual for family planning coverage information.

B. Refer to Sections 252.430 and 252.431 of the manual for family planning services special billing instructions and procedure codes.

214.321 Family Planning Services for Women in Aid Category 61, PW 1-1-23

Women in Aid Category 61, Pregnant Women (PW), are eligible for all Medicaid-covered family planning services through the last day of the month in which the 60th day postpartum falls.

Aid Category 61 PW Unborn Child does not include family planning benefits.

214.600 Obstetrical Services 1-1-23

The Arkansas Medicaid Program covers obstetrical services for Medicaid-eligible clients in *full* coverage aid categories with a medically verified pregnancy.

Aid category 61, PW clients are eligible for full range Medicaid coverage. Aid category 61, PW pregnant women's eligibility ends on the last day of the month in which the 60th postpartum day falls.

292.650 NeuroCybernetic Prosthesis
292.660 Newborn Care
292.670 Obstetrical Care
292.671 Method 1 - “Global” or “All-Inclusive” Rate
292.672 Method 2 - “Itemized Billing”
292.673 Fetal Non-Stress Test and Ultrasound
292.674 External Fetal Monitoring
292.675 Obstetrical Care Without Delivery
292.676 Risk Management for Pregnancy
292.680 Outpatient Hospital Services
292.681 Emergency Services
292.682 Non-Emergency Services
292.683 Therapy and Treatment
292.684 Outpatient Hospital Surgical Procedures
292.690 Pelvic Examinations, Prostatic Massages, Removal of Sutures, Etc.
292.700 Physical and Speech-Language Therapy Services Billing
292.710 Prior Authorization Control Number
292.720 Billing for Professional Component of Services Performed in a Hospital
292.730 Professional and Technical Components
292.740 Counseling Services
292.741 Behavioral Health Screen
292.742 Family/Group Psychotherapy
292.750 Radiation Therapy
292.760 Rural Health Clinic (RHC) Non-Core Services
292.770 Sexual Abuse Examination for Beneficiaries 0 - 20 Years
292.780 Locum Tenens and Substitute Physician Policy
292.790 Surgical Procedures with Certain Diagnosis Ranges
292.801 Cochlear Implant and External Sound Processor Billing Protocol
292.810 Reserved
292.811 Reserved
292.812 Reserved
292.813 Reserved
292.820 Organ Transplant Billing
292.821 Billing for Corneal Transplants
292.822 Billing for Renal (Kidney) Transplants
292.823 Billing for Pancreas/Kidney Transplants - Under Age 21
292.824 Billing for Bone Marrow Transplants
292.825 Billing for Heart Transplants
292.826 Billing for Liver Transplants
292.827 Billing for Liver/Bowel Transplants
292.828 Billing for Lung Transplants
292.829 Reserved
292.830 General Information for Transplants
292.831 Billing for Tissue Typing
292.832 Claim Filing for Living Organ Donors
292.840 Vascular Embolization and Occlusion
292.850 Blood or Blood Components for Transfusions
292.860 Hyperbaric Oxygen Therapy (HBOT) Procedures
292.870 Reserved
292.880 Enterra Therapy for Gastroparesis
292.890 Gastrointestinal Tract Imaging with Endoscopy Capsule
292.900 Tobacco Cessation Counseling Services
292.910 National Drug Codes (NDCs)
292.920 Medication Assisted Treatment (MAT) for Opioid Use Disorder
292.930 Drug Treatment for Pediatric PANS and PANDAS
292.940 Radiopharmaceutical Services
292.950 Injections, Therapeutic and/or Diagnostic Agents

203.140 Physician's Role in Family Planning Services 1-1-23

A. Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services.

1. Medicaid clients' family planning services are in addition to their other medical benefits.
2. Family planning services do not require a PCP referral. PCPs electing not to provide some or all family planning services can use the information in this manual to counsel their Medicaid-eligible patients and help them locate family planning services.
    a. Refer to Sections 221.000 and 221.100 of the manual for family planning services benefit limitations.
    b. Refer to Sections 243.000 through 243.500 of the manual for service descriptions and coverage information.
    c. Refer to Sections 292.550 through 292.553 of the manual for family planning services billing instructions and procedure codes.

B Arkansas Medicaid covers family planning services for women in limited aid categories. Refer to Sections 221.100, and 243.000 through 243.500 for more information on coverage of family planning services for these eligibility categories.

243.200 Family Planning Services for Women in Aid Category 61, PW 1-1-23

Women in Aid Category 61, Pregnant Women (PW), are eligible for all Medicaid-covered family planning services. Clients in aid category 61 Pregnant Women (PW) are eligible for family planning services through the last day of the month in which the 60th day postpartum falls.

247.100 Pregnant Women in the PW Aid Category 1-1-23

Women in Aid Category 61 (PW) receive the full range of Medicaid benefits. Aid Category 61 also includes benefits to unborn children of alien pregnant women who meet the eligibility requirements. The benefits for this eligibility category are:

A. Prenatal services

B. Delivery

C. Postpartum services for 60 days (plus the days remaining in the month in which the 60-day period ends)

D. Services for conditions that may complicate the pregnancy

System eligibility verification will specify "PW unborn ch-no ster cov/FP."

Aid Category 61 PW Unborn Child does not include family planning benefits.

200.110 ARKids First-A and ARKids First-B 1-1-23

Medicaid-eligible children in the SOBRA eligibility category for pregnant women, infants, and children (category 61 PW) and newborn children born to Medicaid-eligible mothers (categories 52 and 63), are known as ARKids First-A clients. Uninsured, non-Medicaid-eligible children that meet additional established eligibility requirements will have health coverage under ARKids First-B, a CHIP separate child health program. All ARKids First clients will receive a program identification card without indication of level of coverage (either ARKids First-A or ARKids First-B).

A Medicaid eligibility verification transaction response either through the provider portal via the web or through the Voice Response System (VRS) will indicate that the individual is either an ARKids First-A client or an ARKids First-B client. The response will also indicate that cost sharing may be required for ARKids First-B clients. Refer to Section I of the Arkansas Medicaid provider manual for automated eligibility verification procedures.

When a child presents as an ARKids First-A eligible client, the provider must refer to the regular Medicaid provider policy manuals. When an ARKids First-B eligible client is identified, the provider must refer to the ARKids First-B Provider Manual for determination of levels of coverage, as well as the associated Medicaid provider policy manuals for the services provided.

216.100 Outpatient Hospital's Role in Family Planning Services 1-1-23

A. Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services.

1. Medicaid clients' family planning services are in addition to their other medical benefits.

2. Family planning services do not require a PCP referral. PCPs electing not to provide some or all family planning services can use the information in this manual to counsel their Medicaid-eligible patients and help them locate family planning services.

a. Refer to Section 216.110 of this manual for family planning services benefit limitations.

b. Refer to Section 216.130 of this manual for service descriptions and coverage information.

c. Refer to Sections 216.515, and 216.540 through 216.550 of this manual for family planning services, billing instructions, and procedure codes.

B Arkansas Medicaid covers family planning services for women in some limited aid categories. Refer to Sections 216.500 through 216.510 for more information on coverage of family planning services for these eligibility categories.

216.510 Family Planning Services for Women in Aid Category 61 (PW) 1-1-23

Women in Aid Category 61, Pregnant Women (PW), are eligible for all Medicaid-covered family planning services.

Clients in Aid Category 61, Pregnant Women (PW) are eligible for family planning services through the last day of the month in which the 60th day postpartum falls.

Aid Category 61 PW Unborn Child does not include family planning benefits.

See Sections 216.100-216.110, 216.130-216.132, 216.500-216.515, and 216.540-216.550 for family planning services, billing, and coverage restrictions.

215.220 Family Planning Services for Women in Aid Category 61, PW 1-1-23

Women eligible in Aid Category 61, Pregnant Women (PW), are eligible for all Medicaid-covered family planning services. Clients in aid category 61 are eligible for family planning services through the last day of the month in which the 60th day postpartum falls.

215.260 Expansion of Medicaid Eligibility for Pregnant Women 1-1-23

A. Arkansas Medicaid provides expanded coverage for pregnant women. Women in Aid Category 61 (PW) receive the full range of Medicaid benefits. Service settings may be both outpatient and inpatient, as appropriate.

Aid Category 61 also includes benefits to unborn children of alien pregnant women who meet the eligibility requirements. The benefits for this eligibility category are:

1. Prenatal services
2. Delivery
3. Postpartum services for 60 days (plus the days remaining in the month in which the 60-day period ends)
4. Services for conditions that may complicate the pregnancy

System eligibility verification will specify "PW unborn ch-no ster cov/FP."

Aid Category 61 PW Unborn Child does not include family planning benefits.

B. When verifying a client's eligibility, please note the "AID CATEGORY CODE" and "AID CAT DESCRIPTION" fields. The "AID CATEGORY CODE" field contains the 2-digit numeric code identifying the client aid category. The "AID CAT DESCRIPTION" field contains an abbreviation of the aid category description, comprising 2 or more characters, usually letters, but sometimes numerals as well as letters.

1. Pregnant Women (PW) eligibility will occasionally overlap with eligibility in another category, such as Aid Category 20, TEA-GR. If a PW-eligible client is seeking services that are not for pregnancy or conditions that may complicate pregnancy and are not family planning services, other eligibility segments may be reviewed on the

transaction response and other available electronic options. The woman may have benefits for the date of service in question under another aid category. If so, the service may be performed and the claim may be filed with Medicaid as usual.

2. Medicaid also provides coverage in Aid Category 61 (PW) to children who are eligible for all Medicaid benefits. The aid category code is the same as those of a pregnant woman.

   Aid Categories 62 (PW-PE), 65 (PW-NG), 66 (PW-EC) and 67 (PW-SD) only cover the pregnant woman. Aid Categories 65, 66 and 67 have lower income limits than those listed above for Aid Category 61. Only Aid Category 61 may include eligible pregnant women and/or children.

A-217 Retroactive Eligibility-Pregnant Woman

MS Manual 01/01/23

Retroactive eligibility for Pregnant Women (PW) is determined according to the guidelines for current PW eligibility determination. The applicant should have alleged medical expenses for the retroactive period. (Refer to the "No Look Back" policy at MS C-205 and I-610).

The begin date of the retroactive period will be entered in the system at certification (when authorized in conjunction with current PW eligibility).

For Full PW, if application for retroactive PW coverage is made after termination of the pregnancy, the retroactive period may not begin more than three (3) months prior to the date of application, and the retroactive period must end no later than the last day of the month of delivery (for example, the applicant will not be eligible for the postpartum coverage). (Refer to MS C-205.)

NOTE: Retroactive coverage for Unborn Pregnant Woman will follow the rules for the type of pregnancy coverage her eligibility falls in, Full Pregnant Woman as stated above.

Procedures for authorizing retroactive eligibility only (for example, "fixed eligibility") are found in (MS A-220).

If application for retroactive PW coverage is made after termination of a pregnancy and coverage after the month of delivery is also requested, a separate applica~~tion~~ must be made in the appropriate category to provide coverage for the month(s) following the expiration of the PW coverage.

C-205 Pregnant Woman (PW) Period of Eligibility

MS Manual 01/01/23

An individual found eligible may receive PW Medicaid coverage only during the period of pregnancy and through the end of the month in which the sixtieth (60th) day postpartum falls. Postpartum coverage will be provided to women who are Health Care certified at the time of delivery and to women who have a Health Care application pending at the time of birth and are later found eligible for PW coverage.

An individual who applies for Pregnant Woman – Full or Medically Needy Medicaid after termination of a pregnancy may be given benefits to the end of the birth month, if eligible, but may not be given postpartum coverage. A pregnant woman who applies after the birth of the child and is found eligible in the birth month for Unborn Child will be given full postpartum coverage.

If the pregnant woman has medical bills in the three (3) months prior to the date of application, retroactive eligibility will be determined. There must have been medical bills incurred to give retroactive coverage. The medical bills must be for the PW. Medical bills for other family members will not qualify the PW for retroactive PW coverage.

If a PW applicant is not income eligible in the month of application or the month in which the forty-fifth (45th) day falls but is income and otherwise eligible in one (1) of the retroactive months, the application will be approved beginning in the earliest month of retroactive eligibility. Eligibility will then continue through the end of the month in which the sixtieth (60th) day postpartum falls, if the applicant is eligible for the postpartum coverage, with disregard of any income changes which occurred after the beginning month of eligibility.

There will be “No Look Back” at later income increases throughout the pregnancy and the postpartum period, even if the applicant is not eligible in the month of application or in the month when the forty-fifth (45th) day of the application falls. Refer to MS I-610.

E-100 Financial Eligibility

MS Manual 10/26/15

Each individual applying for or receiving Medicaid benefits must have a financial eligibility determination made at application and, if eligible, on an on-going annual basis or when a change affecting eligibility occurs. Financial eligibility consists of an income test and if the category requires, a resource or asset test.

Most Medicaid eligibility groups have an income limit which an individual's countable income must fall under in order to be eligible for coverage in that group. Income limits and the manner in which countable income is determined vary by eligibility groups. The groups to which an income limit does not apply, and therefore no income determination is made, are the following:

- Newborns (MS B-220);
- Former Foster Care Adults (MS B-280);
- Workers with Disabilities (MS B-330).

NOTE: For the Workers with Disabilities category, before determining eligibility, the applicant must pass a pre-test screening to ensure his/her unearned income does not exceed the SSI individual benefit plus $20. If the applicant meets this criteria, all income is disregarded in the financial eligibility determination. However, both unearned and earned income will be used to determine cost sharing. See MS A-115.

A resource limit applies to most of the eligibility groups that do not use MAGI methodologies for financial eligibility. For these groups, the value of an individual's countable resources must be determined. There is no resource limit, and therefore no resource determination is made, for the following groups:

- Those using MAGI methodologies (MS E-110);
- Newborns (MS B-220);
- Former Foster Care Adults (MS B-260);
- Workers with Disabilities (MS B-330).

E-110 Income and Resource Limits for MAGI and Non-MAGI Groups

MS Manual 01/01/23

Below are the income and resource limits for all Health Care groups. When the income limit is based on a percentage of the federal poverty level (FPL), the countable household income will

be compared to the FPL for the applicable household size. Refer to Appendices F and S for the specific income level amounts.

Category	Income Limit	Resource Limit
ARKids A	142% of FPL *	No Resource Test
ARKids B	211% of FPL *	No Resource Test
Newborns	No Income Test Eligibility is based on mother's Health Care eligibility at child's birth	No Resource Test
Pregnant Women: Full Pregnant Woman Unborn Child	 209% FPL* 209% of FPL *	 No Resource Test
Parent and Caretaker Relative	1 person: $124.00 2 person: $220.00 3 person: $276.00 4 person: $334.00 5 person: $388.00 See Appendix F for household sizes over 5.	No Resource Test
Adult Expansion Group	133% of FPL *	No Resource Test
Medically Needy: Exceptional (EC) Spend Down (SD)	 EC – may not exceed the monthly income limit SD – may exceed the quarterly income limit See MS O-710 for the monthly and quarterly income limit	 1 person: $2,000 2 person: $3,000 3 person: $3,100
TEFRA	3 times the SSI Payment Standard Appendix S	$2000
Autism	3 times the SSI Payment Standard Appendix S	$2000
Long-Term Services & Supports: Nursing Facility, DDS, ARChoices,	3 times the SSI Payment Standard Appendix S	Individual $2000 Couple $3000

Assisted Living, and PACE		
Medicare Savings: ARSeniors QMB SMB QI-1 QDWI	 Equal to or below 80% FPL 100% FPL Between 100% & 120% FPL 120% but less than 135% FPL 200% FPL Appendix F	 ARSeniors, QMB, SMB & QI-1: Individual $7,730 Couple $11,600 QDWI: Individual $4000 Couple $6000
Workers with Disabilities	Unearned income may not exceed SSI individual benefit plus $20	No resource test
PICKLE	Under the current SSI/SPA level Appendix S	Individual $2000
Widows & Widowers with a Disability (COBRA and OBRA '87)	Under the current SSI/SPA level Appendix S	Individual $2000
Widows & Widowers with a Disability and Surviving Divorced Spouses with a Disability (OBRA '90)	Under the current SSI/SPA level Appendix S	Individual $2000
Disabled Adult Child (DAC)	Under the current SSI/SPA level Appendix S	Individual $2000
***May be eligible for an additional 5% disregard, MS E-268.**		

F-130 Child Support Enforcement Services

MS Manual 03/27/2023

The Office of Child Support Enforcement (OCSE) is mandated to provide services to all Health Care recipients who have assigned their rights to medical support to the State. Each applicant or recipient who is responsible for the care of a dependent child must cooperate with OCSE in establishing legal paternity and obtaining medical support for each child who has a parent absent from the home. (See exception below.)

OCSE must provide all appropriate services to Health Care applicants and recipients without the OCSE application or fee. The OCSE agency is required to petition for medical support when health insurance is available to the absent parent at a reasonable cost. OCSE will also collect child support payments from the absent parent unless OCSE is notified by the recipient in writing that this service is not needed. Child support payments collected on behalf of Health Care recipients are received and distributed to the custodial parent through the OCSE Clearinghouse. However, no recovery cost will be collected.

1. Referrals

   When a child's parent, guardian, or caretaker relative voluntarily requests a referral to be made, or is receiving Health Care, an OCSE referral will be made at initial approval. Refer to Exception and Note below.

   Act 1091 of 1995, amended by Act 1296 of 1997, requires that both parents sign an affidavit acknowledging paternity, or obtain a court order, before the father's name will be added to the birth certificate.

   NOTE: If the father's name is included on the birth certificate of a child born April 10, 1995, or later, paternity has already been established. As paternity establishment is the only service the Office of Child Support Enforcement can offer to a family when both parents are in the home, there is no need to make a referral in these instances.

NOTE: For child-only cases, cooperation with OCSE is voluntary. The only time that a referral to OCSE is necessary is when a parent, guardian, or caretaker relative is eligible in another Health Care eligibility group in which cooperation with OCSE is mandatory. Cooperation with OCSE will be strictly voluntary when a:

- Parent, guardian, or caretaker relative is not receiving Health Care, but the children are receiving Health Care;
- Parent, guardian, or caretaker relative is the only one receiving Health Care and the children are not receiving Health Care; or
- Parent, guardian, or caretaker relative is receiving Health Care in an exempt category.

A parent is considered to be absent for Health Care purposes when the absence is due to divorce, separation, incarceration, institutionalization, participation in a Rehabilitation Service Program away from home, or military service. These considerations are regardless of support, maintenance, physical care, guidance, or frequency of contact.

2. Good Cause

An applicant or recipient may have good cause not to cooperate in the state's efforts to collect child or Medical support. The applicant or recipient may be excused from cooperating if they believe that cooperation would not be in the best interest of the child, and if the applicant or recipient can provide evidence to support this claim.

The following are circumstances under which DCO may determine that the applicant or recipient has good cause for refusing to cooperate:

- Cooperation is anticipated to result in serious physical or emotional harm to the child.
- Cooperation is anticipated to result in physical or emotional harm to the individual that is so serious it reduces the ability to care for the child adequately.
- The child was born as a result of forcible rape or incest.
- Court proceedings are in progress for the adoption of the child.
- The individual is working with an agency helping to decide whether or not to place the child for adoption.

3. Refusal to Cooperate-Sanction

A child's Health Care benefits cannot be denied or terminated due to the refusal of a parent or another legally responsible person to assign rights or cooperate with OCSE in establishing paternity or obtaining medical support. Health Care for the parent or caretaker relative will end after the appropriate notice has expired.

If a parent or another legally responsible person states that they refuse to cooperate with the OCSE referral process during any case action (such as during the initial application or case change), the sanction can be applied by the DHS Eligibility Worker.

Medicaid Eligibility

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0027

Eligibility Groups - Mandatory Coverage
Pregnant Women

S28

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

■ **Pregnant Women -** Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☐ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

◉ Yes ○ No

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ○ No

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

- ○ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ○ 185% FPL

The amount of the maximum income standard is: 209 % FPL

■ Income standard chosen

Indicate the state's income standard used for this eligibility group:

- ○ The minimum income standard
- ◉ The maximum income standard
- ○ Another income standard in-between the minimum and maximum standards allowed.

■ There is no resource test for this eligibility group.

■ Benefits for individuals in this eligibility group consist of the following:

- ◉ All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- ○ Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

■ Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

○ Yes ○ No

PRA Disclosure Statement

V.20160722