Managed Care Eligibility for Newborns: What Providers Need to Know

A child born to a woman with full Medicaid coverage on the date of the child's birth is automatically eligible for Medicaid. The newborn is deemed eligible based on the mother's Medicaid coverage. The child's Medicaid eligibility certification period is from the first day of the month of birth through the end of the month the child turns age 1.

A child whose mother is not covered by full Medicaid benefits may be eligible for Medicaid. An application must be submitted for the child and the child must meet all eligibility requirements, including income. The local county department of social services (DSS) determines eligibility the same as for any Medicaid applicant.

All information contained in this document depends on the NC Medicaid status and managed care status of the mother and the newborn. Nothing in this document supersedes the newborn's actual official status according to the records of the NC Department of Health and Human Services (DHHS), Division of Health Benefits.

NEWBORN PLAN ASSIGNMENT*

If on the date she gives birth, the mother is covered by:	…And the newborn is covered by:
NC Medicaid Direct	Standard Plan
Tailored Plan	Standard Plan
Standard Plan	Standard Plan

* Newborns that may be a member of a federally recognized tribe and are considered excluded and will be enrolled in NC Medicaid Direct or Eastern Band of Cherokee Indians (EBCI) Tribal Option, depending on county of residence.

WHAT DATA WILL HEALTH PLANS RECEIVE TO SUPPORT NEWBORN ENROLLMENT AND WHEN WILL THEY RECEIVE IT? WHAT TRANSITION OF CARE SUPPORT IS REQUIRED?

Health plans will receive newborn enrollment information once the local DSS processes the newborn's eligibility in NC FAST. The health plans receive enrollment information daily.

If the newborn moves between Standard Plans, encounter data, open prior authorizations and care planning materials related to the newborn's care will also be transferred. If the newborn is receiving care management, the care manager will contact the receiving health plan care manager and help with the transition.

WHAT WILL A PROVIDER SEE REGARDING A NEWBORN IN NCTRACKS?

Once eligibility has been processed, the provider can verify eligibility and Managed Care enrollment through the NCTracks Recipient Eligibility Verification function in the Provider Portal.

HOW DOES A PROVIDER KNOW WHO TO BILL FOR NEWBORN CARE SERVICES?

The provider should use the NCTracks Recipient Eligibility Verification function in the Provider Portal to verify enrollment information of the newborn and identify the appropriate health plan to bill.

HOW WILL NEWBORN CLAIMS BE HANDLED IF THE ATTENDING PEDIATRICIAN DOES NOT PARTICIPATE IN THE NEWBORN'S HEALTH PLAN?

Health plans will treat all out-of-network providers the same as in-network providers for purposes of prior authorization and will pay out-of-network providers the NC Medicaid Direct rate for services rendered through the earlier of:

1. 90 days from the newborn's birth date, or
2. Date the health plan is engaged and has transitioned the child to an in-network PCP or other provider.

When a child is enrolled in a health plan, that health plan will be visible to providers when they confirm the child's eligibility. Providers should bill the health plan the child is enrolled in, regardless of whether they are in-network or out-of-network.

HOW WILL PAYMENTS BE MADE FOR THE NEWBORN'S NURSERY CARE?

Pediatricians often rotate rounding for hospital newborn nursery care and may see patients who did not end up on their panel. Health plans will treat all out-of-network providers the same as in-network providers for purposes of prior authorization and will pay out-of-network providers the NC Medicaid Direct rate for services rendered through the earlier of:

1. 90 days from the newborn's birth date or
2. Date the health plan is engaged and has transitioned the child to an in-network PCP or other provider.

When a child is enrolled in a health plan, that health plan will be visible to providers when they confirm the child's eligibility. Providers should bill the health plan the child is enrolled in, regardless of whether they are in-network or out-of-network.

WHAT IF THE MOTHER IS ELIGIBLE ONLY FOR EMERGENCY PREGNANCY MEDICAID COVERAGE?

If the mother is authorized as an emergency for labor and delivery as of the newborn's date of birth, the newborn is automatically eligible. Newborn coverage is authorized at the same time as the mother's Medicaid and will be under a Standard Plan.

WHAT IF THE MOTHER IS NOT ELIGIBLE FOR MEDICAID? CAN THE NEWBORN RECEIVE MEDICAID OR NC HEALTH CHOICE?

A newborn whose mother does not qualify for Medicaid may still qualify independently. In this situation, an application for Medicaid coverage must be submitted for the newborn with the appropriate DSS office.

Newborns and children with family income up to 210% of the federal poverty level receive health care coverage through Medicaid. NC Health Choice coverage begins at age 6.

HOW ARE NEWBORNS ASSIGNED TO A MEDICAID MANAGED CARE HEALTH PLAN? WHEN IS COVERAGE FOR ELIGIBLE NEWBORNS EFFECTIVE?

If the mother is enrolled in a Standard Plan, the child will be automatically enrolled in the same Standard Plan as the mother at birth.

If the mother is enrolled in a Tailored Plan, the child will be enrolled in a Standard Plan at birth, until such time the child meets Tailored Plan enrollment criteria. If the child is eligible for the Tailored Plan, the child will be identified and enrolled during the Tailored Plan criteria process through claims and other enrollment criteria.

Enrollment with a health plan will be retroactive to the first day of the month of birth. Health plan assignment will be based on the parent or guardian's choice or the auto-enrollment criteria. If the parent or guardian does not make a health plan selection and is enrolled with a health plan, the newborn will be assigned to the mother's plan at auto-enrollment.

Auto-enrollment is based on:

1. Tailored Plan enrollment criteria
2. Where the beneficiary lives and county that manages the beneficiaries Medicaid case
2. Whether the beneficiary is part of a special population (Tribal/Indian Health Services eligible)
3. Historical provider-beneficiary relationship and preference
4. Health plan assignments of other family members (if enrolled in a Standard Plan)
5. Previous health plan enrollment within the past 12 months
6. Equitable health plan distribution.

If it is determined that the newborn would be better served under a Tailored Plan, the mother will need to select that option.

There are additional options that beneficiaries and providers can take if a need to switch to a Tailored Plan is identified at a later time. The request can be made using one of the following forms:

a. Request to Stay in NC Medicaid Direct and LME-MCO: Beneficiary Form
b. Request to Stay in NC Medicaid Direct and LME-MCO: Provider Form

More information can be found in the Behavioral Health I/DD Tailored Plan Memo on Eligibility and Enrollment Updates.

.

HOW LONG DO FAMILY MEMBERS HAVE TO SWITCH HEALTH PLANS AFTER THE NEWBORN IS ASSIGNED TO THE MOTHER'S OR SIBLING'S PLAN? HOW WILL PROVIDERS BE PAID IF A CHANGE IS MADE?

A health plan is assigned to a newborn retroactive to the first day of the month of birth. The provider is required to file claims using the ID on the newborn's card once the card is issued. The health plan assigned is responsible for covering all costs incurred since birth.

If the newborn is assigned to the mother's (or sibling's) health plan, that family member has 90 days from the effective date of enrollment in the health plan to change their plan. If the newborn's plan is changed, the new health plan would be responsible starting the first of the following month (when the new enrollment is effective).

Health plans will treat all out-of-network providers the same as in-network providers for purposes of prior authorization and will pay out-of-network providers the NC Medicaid Direct rate for services rendered through the earlier of:

1. 90 days from the newborn's birth date or
2. Date the health plan is engaged and has transitioned the child to an in-network PCP or other provider.

When a child is enrolled in a health plan, that health plan will be visible to providers when they confirm the child's eligibility. Providers should bill the health plan the child is enrolled in, regardless of whether they are in-network or out-of-network.

WHAT IF I HAVE QUESTIONS?

For questions about contracting, contact the health plan.

For general inquiries and complaints regarding health plans, a **Provider Ombudsman** to represent the interests of the provider community. The Ombudsman will:

- Provide resources and assist providers with issues through resolution.
- Assist providers with Health Information Exchange (HIE) inquires related to NC HealthConnex connectivity compliance and the HIE Hardship Extension process.

Provider Ombudsman inquiries, concerns or complaints can be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov, or call 919-527-6666. The Provider Ombudsman contact information is also published in each health plan's provider manual.

For questions related to your NCTracks provider information, contact the NCTracks Call Center at 800-688-6696. To update your information, log into the NCTracks Provider Portal to verify your information and submit a MCR or contact the NCTracks Call Center.

For all other questions, contact the NC Medicaid Contact Center at 888-245-0179.