

Managed Care Eligibility for Newborns: What Providers Need to Know

Eligibility Requirements for Newborns

A child born to a woman with health coverage through Medicaid 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 one year of age.

A child whose mother is not covered by Medicaid for the birth of the child 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 is dependent upon the actual 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. None of the below will apply to a Newborn not in Medicaid.

NEWBORN PLAN ASSIGNMENT*

If on the date she gives birth, the mother is covered by...	Newborn is covered by...
NC Medicaid Direct	NC Medicaid Managed Care Health Plan
NC Medicaid Managed Care Health Plan	NC Medicaid Managed Care Health Plan

*There are rare cases where a newborn could be a member of a federally recognized tribe and are considered exempt and will be enrolled in 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?

The county worker keys the newborn coverage within five days of notification. The coverage cannot be keyed until the county is notified of name, date of birth and gender of newborn is reported. Health plans will receive newborn enrollment information once the county DSS office enters the newborn’s eligibility in NC FAST. The health plans receive enrollment information daily.

If the newborn moves between NC Medicaid Managed Care health plans, encounter data, open prior authorizations and care planning materials related to the newborn’s care will be transferred to the new plan. If the newborn member is receiving care management, the care

manager will provide additional assistance through the transition.

WHAT WILL A PROVIDER SEE REGARDING A NEWBORN IN NCTRACKS?

In NCTracks, the provider will be able to verify eligibility and NC Medicaid Managed Care enrollment through the NCTracks Recipient Eligibility Verification function available in the Provider Portal once eligibility has been processed by the county DSS office.

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 bill the appropriate health plan.

HOW WILL NEWBORN CLAIMS BE HANDLED IF THE ATTENDING PHYSICIAN/ADVANCED PRACTICE PROVIDER 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 Medicaid fee-for-service rate for services rendered through the earlier of:

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

* In the above, "engaged" means that the PHP has assigned the newborn to an in-network PCP and the newborn has visited that in-network PCP. Once the newborn visits their in-network PCP, this provision would end, even if that visit occurs prior to 90 days from the newborn's birth date.

This provision covers all medically necessary care provided by any health care provider, not just primary care providers, which includes hospitals and/or facilities.

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. Providers can bill all health plans regardless of contracting status during the first 90 days of a newborn's life. Providers should know they may initially get a denial, but most health plans have an extenuating circumstances review that will allow payment. Providers should work with health plans to ensure payment.

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

Physicians often rotate rounding for hospital newborn nursery care and may see patients who did not end up in their medical home. 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 Medicaid fee-for-service rate for services rendered as described above.

Providers can bill all health plans regardless of contracting status during the first 90 days of a newborn's life. Providers should know they may initially get a denial, but most health plans have an extenuating circumstances review that will allow payment. Providers should work with health plans to ensure payment.

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

If the mother is authorized as 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 Medicaid Managed Care 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 six.

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

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 mother's choice or the auto enrollment algorithm. If the mother does not make a health plan selection and is enrolled with a health plan, the newborn would be assigned to the mother's plan at auto enrollment. If the mother is NC Medicaid Direct, and no choice is made, the newborn would be auto-enrolled to the health plan of the closest family member or, if none, other parameters in the auto enrollment algorithm.

The Auto-enrollment algorithm considers:

1. Where the beneficiary lives
2. Whether he or she is a member of a special population
3. Historical provider-beneficiary relationship and preference
4. Health plan assignments of other family members
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 NC Medicaid Direct, the provider should complete the Request to Stay in Medicaid Direct and LME-MCO form below.

There are additional options that beneficiaries and providers can take if a need to switch to NC Medicaid

Direct 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 [here](#) on the DHHS website.

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 to 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 changed plans, 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 Medicaid fee-for-service rate for services rendered through the earlier of:

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

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WHAT IF I HAVE QUESTIONS?

Additional resources for providers on the transition to managed care can be found in the [NC Medicaid Help Center](#), the [Provider Playbook](#) and on the [Medicaid Transformation website](#).

For general provider inquiries and complaints regarding health plans, contact the **Provider Ombudsman** at Medicaid.ProviderOmbudsman@dhhs.nc.gov, or 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, please contact the NCTracks Call Center at 800-688-6696. To update your information, please log into NCTracks (<https://www.nctracks.nc.gov>) provider portal to verify your information and submit a MCR.

Fact Sheets will be updated periodically with new information. Updated May 2021. For more information, please visit <https://www.ncdhhs.gov/assistance/medicaid-transformation>