

### Medicaid Newborn Coverage at Birth and During the Hospitalization

The following information provides clarification regarding hospital coverage of newborns in managed care.

- Newborns always receive initial coverage from his/her mother's payer {fee-for-service (FFS)/managed care organization (MCO)}.
- If the baby is born to a FFS mother, the baby must receive their own Medicaid ID number before the baby's claim can be submitted for payment.
- If the baby is born to a Medicaid mother covered by a Medicaid MCO, there is a three calendar month guaranteed period of coverage (birth month plus next two months) for the newborn under the mother's MCO. For example, a baby born any day in February will be enrolled with the mother's contracted MCO until April 30. Hospitals will bill the mother's MCO for the three-month guaranteed period of coverage or for the period of time the infant is hospitalized if less than the guaranteed period.
- If a newborn has not received a Medicaid identification number at the end of the guaranteed period of coverage, the newborn will be disenrolled from Medicaid (and the MCO if applicable) at the end of the third calendar month.
- If the newborn continues to be hospitalized beyond the end of the guaranteed period of coverage, the MCO will not have further liability beyond the guaranteed period of coverage if reimbursement is on a per diem payment methodology. If the payment methodology is based on DRG reimbursement, the MCO will have responsibility until the case (hospitalization) is ended.
- Upon receipt of the Medicaid identification number, eligibility will be retroactive back to the date of birth. The hospital will bill the MCO for the first three months and Medicaid FFS for the remainder of the hospitalization, if reimbursed is based on a per diem payment methodology.
- Exception - If a newborn is enrolled with a health plan from the date of birth (also date of admit) and then enrolls in another health plan during the same admission the financial responsibility shall be allocated as follows:
  - a. For *per diem* provider contracts, reimbursement will be shared between the Contractor and either the Department or the new health plan. In the absence of a written agreement otherwise, the Contractor and the Department or the new health plan shall each pay for the period during which the Medicaid member is enrolled with the entity. This also applies to newborns hospitalized at the time of enrollment.

- b. For *DRG* provider contracts, the Contractor is responsible to pay for the full inpatient hospitalization (admission to discharge), including for any Medicaid member actively enrolled in the health plan on the date of admission, regardless of the members' disenrollment from the health plan during the course of the inpatient hospitalization to another health plan.
- Hospitals can help facilitate a newborn getting a Medicaid identification number. Immediately after birth, hospitals should complete the Newborn Eligibility Report (DMAS 213 – Hospital Manual, Chapter 111, Exhibits) and send it to the local department of social services (DSS) office.
- DMAS regulations prohibit newborns continuously hospitalized and in FFS from being enrollee in an MCO. DMAS relies on hospitals reporting those individuals hospitalized on the first of the month. The Managed Care Unit uses these reports to disenroll those individuals moving into an MCO.