



---

# Missing Babies: Best Practices for Ensuring Continuous Enrollment in Medicaid and Access to EPSDT

---

*Despite federal law protections, too many babies—more than 500,000 nationwide—are missing and not counted as continuously eligible during their first year of life. States can take action to close this gap by adopting promising practices identified here and ensuring every baby receives the coverage and services to which they are entitled.*



Johnson Group Consulting, Inc.  
January 2021

---

## Missing Babies: Best Practices for Ensuring Continuous Enrollment in Medicaid and Access to EPSDT

”

*For more than 25 years, federal law has guaranteed automatic enrollment for babies born to Medicaid-enrolled mothers, beginning at birth and continuing uninterrupted through the first year of life.*



---

## OVERVIEW

Approximately half of all babies born in the United States, and in some states as many as three-quarters, have Medicaid financed births. Congress has enacted a series of Medicaid policy changes designed to parallel the way private, employer-based insurance works for families with new babies – a simple notification to add the baby to the coverage. For states to offer this protection and convenience for families has not been simple or uniformly effective.

For more than 25 years, federal law has guaranteed automatic enrollment for babies born to Medicaid-enrolled mothers, beginning at birth and continuing uninterrupted through the first year of life. Policy changes in 2009 further strengthened the law's protections. States have used various strategies for implementing this special automatic newborn enrollment protection, but over the years, Medicaid's increasing operational and technical complexity as a result of changes in care delivery and information exchange have made automatic newborn enrollment more challenging. Today, most state programs enroll nearly all pregnant women, infants, and children in managed care arrangements. As a result, state approaches to implementation varies widely.

This project analyzed state data reported to the Center for Medicare and Medicaid Services (CMS Form 416), reviewed state documents, and interviewed select state agency staff to identify best practices and continuing concerns related to infant enrollment in Medicaid. (See Appendix A for project methods.)

Data reported by states suggest that not all states may be effectively implementing the automatic and continuous infant enrollment policy. Wide state-to-state variation in the percentage of babies in Medicaid who are not enrolled for at least 90-days suggests that lapses can be attributed to state administration rather than variation in births. Too many babies—more than 500,000 nationwide—are missing and are not counted as continuously eligible during their first year of life. States can take action to close this gap by adopting promising practices identified here and ensuring every baby receives the coverage and services to which they are entitled.

---

## POLICY BACKGROUND

Since 1984, federal Medicaid law has required automatic newborn and continuous infant enrollment for most babies whose births are financed by Medicaid. (Section 1902(e)(4) of the Social Security Act/ 42 U.S.C. Sec. 1396a(e)(4)). The purpose of these provisions—passed with bipartisan Congressional support under the Deficit Reduction Act of 1984 (P.L. 98-369)—was to ensure that babies would not experience even a single day’s break in coverage from the date of birth through the first year of life.<sup>1 2</sup> (See Appendix B for legislative history and specific details on statutory and regulatory language.)

Federal law requires so called “deemed” eligibility for infants born to mothers covered by Medicaid (i.e., those having a Medicaid financed birth), from the date of the child’s birth and continuing through the first year following birth.<sup>3</sup> Prior to 2009, the law contained substantial limitations, including that the newborn must remain a member of the woman’s household and that the woman must remain Medicaid-eligible (or would remain Medicaid-eligible if pregnant). Moreover, Congress adopted requirements related to Medicaid citizenship documentation under the Deficit Reduction Act of 2005 (P.L. No. 109-171), and, in 2006, the George W. Bush Administration adopted a rule that said infants born to non-citizen, undocumented immigrant mothers with Medicaid financed births would not be automatically entitled to Medicaid coverage and would be required to provide citizenship documentation.

### Deemed Infant Eligibility and Enrollment Requirements for States

States are required to:

- **Provide Medicaid coverage for newborns born a woman covered by Medicaid for the child’s birth.**
- **Not require separate eligibility application and determination.**
- **Eliminate rules requiring that infants must live with mother or mother remain eligible for Medicaid.**
- **Use the mother’s Medicaid identification number for up to a year and/or issue a separate number/card to the baby for mothers who lack a Medicaid number.**
- **Not require proof of citizenship for the first year of an infant’s life.**
- **Continue infant eligibility until the first birthday unless the child dies, moves out of state, or a family requests voluntary disenrollment.**
- **Conduct a redetermination of eligibility and notify the family prior to a baby’s first birthday.**

Provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. No 101-508) were designed to eliminate most of these conditions and limitations and to assure that babies born to women covered by Medicaid at the time of birth would be automatically enrolled in Medicaid for a full year of continuous coverage. The CHIPRA amendments (which became effective date April 1, 2009) eliminated requirements that the infant must live with the mother and the mother must remain eligible for Medicaid, as well as requirements for newborn citizenship documentation. Removing the link between infant and mother's continued eligibility "effectively . . . means that all newborns born to women covered by Medicaid for the child's birth are now covered as mandatory categorically needy."<sup>4 5 6</sup>

Specifically, the CHIPRA provisions did the following.

- Eliminated the requirement that newborns coming home from the hospital must live with the mother and remain a member of the mother's household, and that the mother remain eligible for Medicaid (or would remain eligible if still pregnant).
- Specified that the mother's Medicaid or CHIP eligibility identification number may be used as the infant's identification number for the first year. All claims are to be submitted and paid for the newborn under the mother's number unless the state issues a separate identification number for the child (except in the case of mothers with emergency coverage at time of birth).
- Removed the newborn citizenship documentation requirements under the Deficit Reduction Act of 2005 (DRA) so that children initially eligible for Medicaid or CHIP as deemed newborns would be considered to have provided satisfactory documentation of citizenship and identity when their eligibility is renewed on their first birthday or other subsequent Medicaid or CHIP eligibility redeterminations.
- Clarified that Medicaid deemed newborn eligibility applies to a child born in the United States to a mother covered by Medicaid for labor and delivery as emergency medical services under section 1903(v). The child receives full Medicaid coverage, and, since the child cannot be covered on a continued basis under the mother's number, the state must immediately issue a separate eligibility identification number to the newborn.
- Extended Medicaid's deemed enrollment protections to infants born to pregnant women insured through CHIP under a state option to use CHIP funding to insure additional "targeted low income" pregnant women. (This state option, part of the Children's Health Insurance Program amendments of 2009, is available to states whose Medicaid programs already cover pregnant women up to 185% of the federal poverty level and children with incomes up to 200% of the federal poverty level.)
- Required that a redetermination process for eligibility must be completed on behalf of the infant around the time of the first birthday.

---

## RESULTS OF ANALYSIS OF INFANT ENROLLMENT DATA

This analysis used the state reported CMS Form 416 data on children enrolled in Medicaid and entitled to EPSDT benefits.\* These data provide insight into the total number of Medicaid enrolled infants enrolled, which can be compared to the number not counted as 90 days continuously eligible for the Federal Fiscal Years (FFY) 2010-2018. (See Appendix A for data sources and methods.)

National and state trends indicate the following.

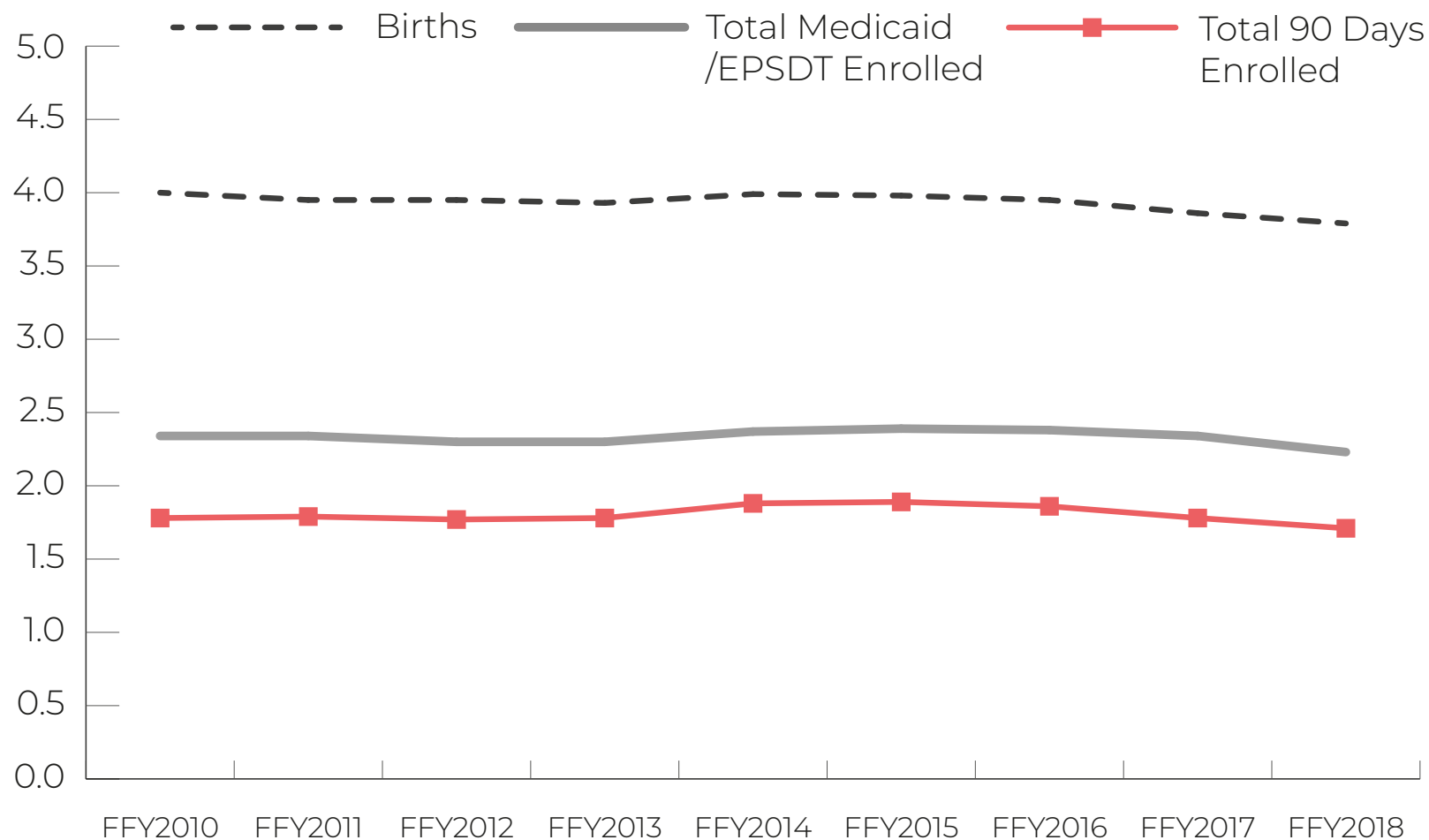
- In each year between FFY 2010-2018, more than 2.3 million infants were counted by states as enrolled in Medicaid and entitled to EPSDT benefits. This is more than half of the total 3.9 million U.S. births per year. (See Figure 1.)
- On average, more than 500,000 babies born in the U.S. each year and enrolled in Medicaid for sometime in the year were nonetheless not counted as enrolled in Medicaid for least 90 days continuously. As shown in Figure 2, no trend in improvement was shown for the nation for FFY 2010-2018.
- Many states show a gap between the number of infants counted as eligible and the number continuously enrolled. The percentage varies substantially by state, ranging from a low of 6% to a high of 41% in FFY 2018. (See Figure 3.)
- While a few states showed substantial improvement in infant enrollment, no state showed consistent improvement.
- Generally, the gap could reflect the number of infants under age 3 months (effectively those born within quarter prior to collection of 416 data or July 1-September 30) who have not yet reached their initial continuous enrollment threshold. A comparison of Medicaid/EPSDT data to birth data did not show consistent correlations by state.
- The variations in data by state suggest that the gap is real – that is, the gap is the result of state plan administration practices related to the actual enrollment process or data reporting, not simply variation attributable to the timing of births in relation to the 90-day continuous enrollment period.

---

\* A very small number of infants are covered under Medicaid waiver programs and state optional medically needed programs that do not include entitlement to EPSDT benefits. Those in medically needy programs that include the EPSDT benefit are counted here.

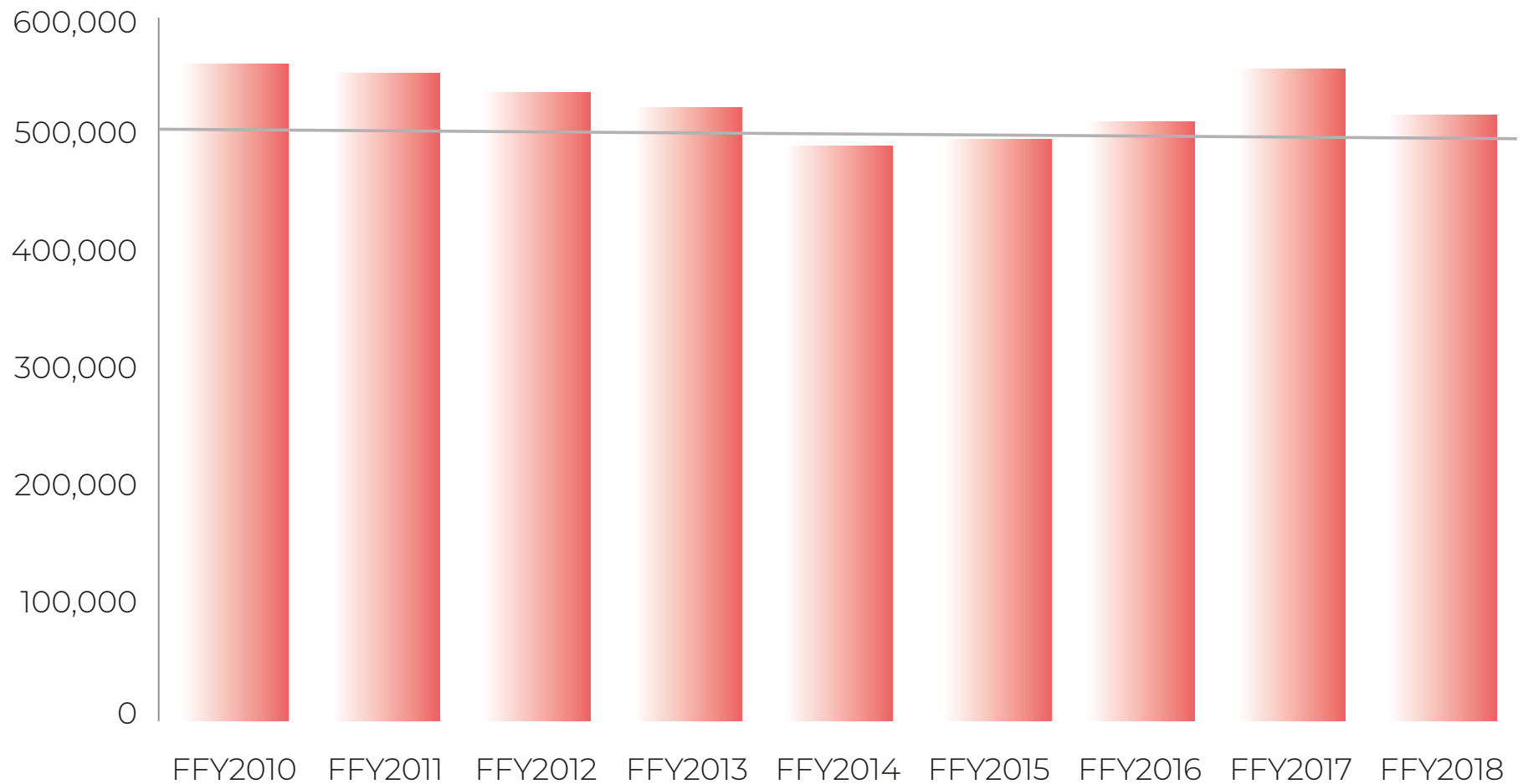
## Figure 1. Total Births, Infants Enrolled in Medicaid, and 90 Days Enrolled, U.S., 2010-2018

(in millions of infants)



Data Source: Centers for Medicare and Medicaid Services (CMS) Form 416 data federal fiscal years; and Centers for Disease Control and Prevention (CDC) birth statistics calendar years. Analysis by Johnson Group.

**Figure 2. Number of Infants Not Enrolled in Medicaid At Least 90 Days Continuously, U.S., FFY 2010-2018**



Data Source: CMS Form 416 data FFY 2010-2018. Analysis by Johnson Group.



---

## RESULTS OF ANALYSIS OF POLICY AND ADMINISTRATIVE PRACTICES

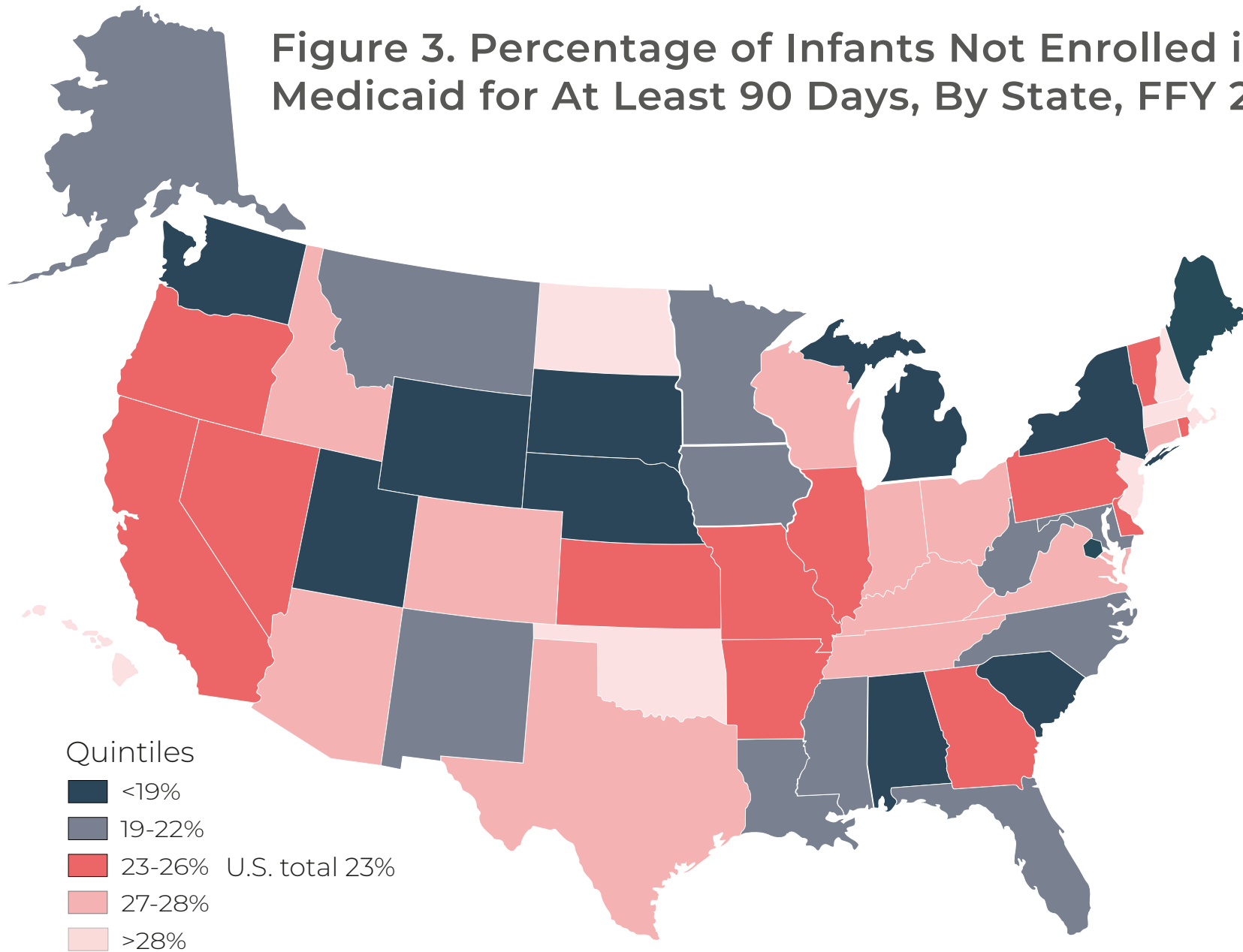
Since 1984, states' administrative practices have varied widely in terms of the implementation of the automatic newborn and continuous infant enrollment provisions. Procedures and processes have included: issuing special cards or numbers, using hospital forms/procedures for notification of birth, designating responsibility to Medicaid managed care organizations (MCOs), and assigning numbers automatically following notice of birth. Larger health system and Medicaid program changes related to information systems, eligibility determination mechanisms, coverage expansions, and managed care arrangements have all added complexity to implementation of this policy. For example, in recent years, most states streamlined eligibility processes (e.g., more online and telephone applications), and many modernized processes through use of electronic data systems.<sup>7</sup>

Moreover, most states enroll nearly all Medicaid beneficiaries who are pregnant women, infants, and children in managed care arrangements.<sup>8</sup> Where newborn enrollment processes have not been incorporated into updated state Medicaid information management systems, managed care operational and reporting systems, or revised application and enrollment processes, infant enrollment gaps may result in not only an

enrollment counting error but in an actual enrollment gap – leaving the family without evidence of coverage for their baby.

This review of state websites and provider manuals conducted found that many states made improvements over the years. (See Appendix C.) In these states, websites and documents indicate concerted effort to have efficient, modern, Internet-based, and family-friendly systems for automatic newborn and continuous infant enrollment. At the same time, however, some states had not yet updated their procedures for ensuring automatic coverage of babies born to Medicaid mothers, nor had they updated their written guidance to align with the 2010 CHIPRA amendments. In addition, the transition to managed care may have led to confusion about how automatic enrollment is supposed to work, to the extent that, in operationalizing managed care, states did not also squarely address alignment of managed care enrollment with automatic newborn enrollment.

Figure 3. Percentage of Infants Not Enrolled in Medicaid for At Least 90 Days, By State, FFY 2018



Data Source: CMS Form 416 data FFY 2018. Analysis by Johnson Group.

# PROMISING PRACTICES IN ADMINISTRATION

## OPPORTUNITIES TO USE TECHNOLOGY

Most states have forms and processes to be used by hospitals or health plans, including electronic eligibility system approaches that facilitate entry of information about newborns. Currently, several states are using highly automated processes that support the respective role of state agency staff, health plans, providers, and families. For example,

- An increasing number of states offer an online system for providers and plans to report to the state.
- Some states offer simple ways for families to confirm that their infant is enrolled, giving options for Internet, telephone, or in-person approaches.
- Some states use automated checks or searches based on maternal information, either in vital statistics and/or in Medicaid claims datasets.<sup>9</sup> Using linked birth and Medicaid records can help to identify gaps in coverage.<sup>10 11 12</sup>
- At least two states use special cards issued during the prenatal period that can be quickly and simply activated by plans and providers following the birth, a process which effectively pre-assigns the infant's Medicaid identification number.
- At least one state conducts a review with follow up at 60 days by a health navigator to help families whose infants are not yet enrolled in their own name.
- Some states do not require any action on the part of the family prior to the transition at the first birthday.
- At least ten states use the eligibility group code for deemed newborns (code 6) as part of their Transformed Medicaid Statistical Information System (T-MSIS) approaches.<sup>13 14 15 16</sup>
- States are pursuing a variety of approaches as part of the redetermination process, with triggers to the agency to complete a renewal process during month of child's first birthday.
- Some states have made substantial advances on automated renewals for Medicaid beneficiaries of all ages, including infants.<sup>17</sup>

---

## PROMISING PRACTICES IN ADMINISTRATION

### LEVERAGING AGENCY AND MCO OPPORTUNITIES

Interagency collaboration is an important concern in some states. Interviews indicate that when different units of government administer Medicaid and process eligibility determinations, automatic newborn and continuous infant enrollment may be affected. Challenges include differences in communication to families, limited data sharing, and/or lack of attention to deemed infants' continuous eligibility. For example, some states interviewed for this project had not reviewed their data on deemed infant enrollment or their CMS Form 416 infant data, often because no one entity had responsibility for reviewing eligibility and enrollment data.

Many states using Medicaid managed care arrangements rely on MCOs to report a birth and use automatic enrollment into the mother's managed care plan, with voluntary changes possible. This can work well for pregnant women whose Medicaid coverage is effectuated through managed care plan membership. At the same time, some states that rely on the Medicaid managed care systems to carry out automatic newborn enrollment reported challenges in their processes for achieving the same thing for births covered through their basic Medicaid fee-for-service system (e.g., under temporary emergency coverage for labor and delivery).

Reaching families during pregnancy with special cards that have a Medicaid identification number for the baby that can be quickly turned on when the birth is reported offers an opportunity for many states to effectuate automatic newborn enrollment and a year of continuous coverage. Making that a "gold card" as they do in Florida or giving it some other special designation fits with the positive spirit of preparing for the birth of a baby.

Some states go farther. Ohio has a clear message on its website and a special form for use by families and MCOs offer incentives and rewards programs. For example, Ohio's CareSource plan also offers a "Babies First" reward program for families who sign up and complete well baby visits. The program provides \$20 for the first newborn visit then \$10 for subsequent visits (up to \$150 total) on a "My CareSource Rewards" card that can be used to purchase items for mothers or babies at many local stores. Parents can call or go online to sign up. They also encourage families to enroll during pregnancy using a "Babies First Registration Form," to get a rewards card loaded for new baby. Other MCOs in Ohio offer rewards to Medicaid beneficiaries as well.

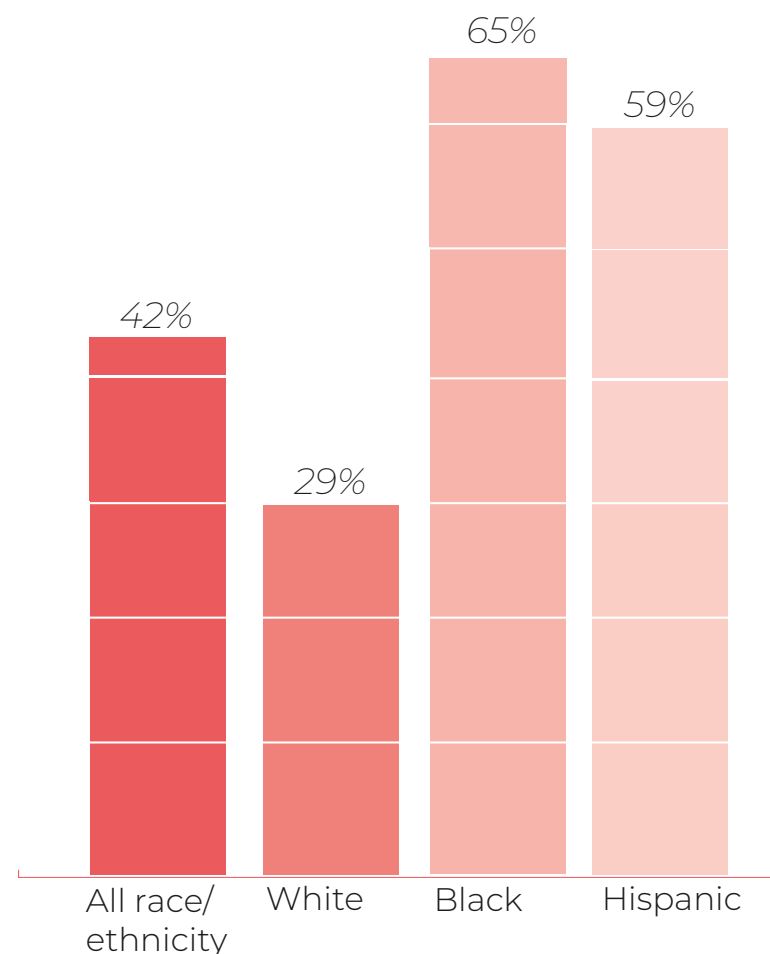
Setting up automated processes to conduct an internal review and redetermination, as well as to give notice to families prior to the first birthday is another important action

## AND CHALLENGES

that states can take. Many states mention this in provider or staff manuals. Where this does not occur, reports from across the country suggest that toddlers are falling through the cracks.<sup>18</sup>

This review also found significant shortcomings in some state practices. Some states had out-of-date information on their websites or in their provider manuals, which appear not to have been updated following policy changes implemented in 2010. While some states require no action by the family, others require the parent to report in person or by telephone within 10, 30, or 45 days for the newborn to be eligible, which appears to directly contravene the federal automatic enrollment standard. A few states specified that parents must reapply for their babies when they reach age 1 rather than conducting the seamless redetermination process required by law for all beneficiaries.<sup>19</sup> When the infant's eligibility comes up for redetermination at age one, a new application must be filed in person in order to establish continued Medicaid eligibility. Again, federal law calls for state action in redetermination and does not call for face-to-face applications.

**Figure 4. Medicaid as Source of Payment for Birth, By Race/Ethnicity of Mother, U.S., 2019**



Source: Martin J et al. Births in the United States, 2019. NCHS Data Brief (No. 387). October, 2020. <https://www.cdc.gov/nchs/products/index.htm>.

# MEDICAID MANAGED CARE

## USING CLEAR CONTRACTS SPECIFICATIONS

More than two-thirds of Medicaid beneficiaries are enrolled in comprehensive managed care plans. Thirty-two states cover 75% or more of low-income adults in eligibility groups covered prior to the Affordable Care Act expansions (e.g., parents, pregnant women) through MCOs. The great majority of children are enrolled in Medicaid managed care in 40 states.<sup>20</sup> A majority of states enroll nearly all Medicaid beneficiary pregnant women, infants, and children in managed care arrangements.

A review of Medicaid managed care contract language for provisions related to deemed infant enrollment found some promising practices. As with other topics in managed care contracts, the provisions related to infant enrollment indicate similarities and variations in how this topic is addressed.<sup>21 22</sup>

This project found that 29 of the 40 states (including the District of Columbia) in the George Washington University managed care contract database (all states that as of 2018 utilized comprehensive Medicaid managed care systems) had provisions related to newborn enrollment.<sup>23</sup> (See Appendix D.) Analysis of these provisions points to opportunities for states using Medicaid managed care arrangements for pregnant women and children to include more complete and effective contract provisions that address the following topics.

- Clear language about eligibility and retroactive nature of coverage to date of birth.
- Obligations for plan action during the prenatal period (e.g., informing the parent, assisting with pre-birth selection of a pediatric provider and pre-assignment of an enrollment identifier).
- A specific description about the process for ensuring that the birth is reported for enrollment purposes.
- Statement of the responsibilities of the MCO (e.g., reporting the birth, covering all medically necessary services, ensuring that a pediatric provider is identified).
- Management of special circumstances (e.g., infants who are placed in foster care or adoption).
- EPSDT coverage requirements, including a statement that all medically necessary services are covered under the EPSDT benefit for children in Medicaid.
- Timeline for action (e.g., deadlines for notice of birth).
- Processes to be followed in the case of infants enrolled in a MCO different from the one that covered the birth.
- Terms under which parents can disenroll an infant from an auto-assigned plan and move to another MCO.

- Roles of enrollment brokers, local human service agency offices, health care navigators, or others that may be involved in this process.
- Terms for payments (e.g., capitation payment begins with the birth, penalties for lack of notification about birth).
- Incentives (e.g., “kick” payment for month of birth to cover related expenses, incentive payments for timely reporting).

This analysis also identified some language that could have negative effects on automatic newborn or continuous infant enrollment. In particular, several states had timelines for MCOs that could result in the infant losing coverage. For example, the Illinois contract states: “If the newborn is added to the case before the newborn is forty-six (46) days old, Contractor shall provide coverage of the newborn Enrollee retroactively to the date of birth.” This provision could lead to confusion over who had responsibility coverage for those first weeks and/or infant disenrollment after 46 days.

In contrast, Kansas’ contract language emphasizes the importance of the timeline for reporting and links it to payments; however, it is clear that families are not responsible for costs, saying: “The CONTRACTOR(S) shall receive a capitation payment for the month of birth and for all subsequent months the child remains enrolled with the CONTRACTOR if the CONTRACTOR provided the newborn information to the State with-

in sixty (60) calendar days of the date of birth. If there is an administrative lag that is not the fault of the Member in enrolling the newborn and costs are incurred during that period, the Member shall be held harmless for those costs.”

Similarly, the Missouri contract language states: “In the case of an administrative lag in enrolling the newborn and costs are incurred during that period, the health plan shall hold the member harmless for those costs. The health plan shall be responsible for the cost of the newborn including medical services provided prior to completion of the State enrollment process.”





## EXAMPLES OF MEDICAID MANAGED CARE CONTRACT LANGUAGE

- “... eligibility for the newborn will be the newborn’s date of birth, and the Contractor is responsible for all covered services to the newborn, whether or not [state] has received notification of the child’s birth.” (Arizona)
- “Babies born to women enrolled in Medicaid (excluding plan XXX) are automatically eligible for Medicaid benefits for one year from the baby’s date of birth.” (Indiana)
- “The Managed Care Plan shall be responsible for newborns of pregnant enrollees from the date of their birth. The Managed Care Plan shall comply with all requirements and procedures set forth by the Agency or its agent related to unborn activation and newborn enrollment.” (Florida)
- “A newborn shall be automatically enrolled from birth in its biological mother’s MCO.... The MCO is responsible for the newborn’s health care from birth until the newborn enrolls into another MCO.” (Maryland)
- “The mother’s health plan shall be responsible for all medically necessary services provided under the comprehensive benefit package to the newborn child of an enrolled mother. The child’s date of birth shall be counted as day one (1). The health plan shall provide services to the child until the child is disenrolled from the health plan. When the newborn is enrolled... and entered into the eligibility system, the health plan shall receive capitation payment for the month of birth and for all subsequent months the child remains enrolled with the health plan.” (Missouri)
- “Medicaid eligible newborns are eligible for a period of thirteen (13) months, starting with the month of birth. The newborn shall be enrolled retroactively to the month of birth with the mother’s MCO.” (New Mexico)
- “Contractor is responsible for: i) Issuing a letter informing parent(s) about newborn child’s enrollment or a member identification card within two (2) business days of the date on which the Contractor becomes aware of the birth.” (New York)
- “[MCO] shall provide notification of the birth to the [state] within five business days of birth or immediately upon learning of the birth. The [MCO] shall provide the mother’s name, social security number, eligibility system case number, 12-digit recipient ID, county of eligibility and the newborn’s name, gender, and date of birth in format designated.” (Ohio)
- “Enrollment of Newborns Up to 250% of FPL - The [MCO] must have written administrative policies and procedures to enroll and provide all Medically Necessary services to newborn infants of Members, effective from the time of birth, without delay, in accordance... The [MCO] must receive advance written approval from the Department regarding these policies and procedures.” (Rhode Island)
- “The obligation of the MCO to cover the MCO Newborn... is not contingent on the mother’s continued enrollment in the MCO; the MCO must cover the MCO Newborn even if the mother does not remain enrolled after the MCO Newborn’s date of birth. The Contractor must ensure that the newborn has a Medicaid ID number before sixty (60) days.... Any medically necessary claims for an MCO Newborn may not be denied by the MCO for any reason... including, but not limited to, lack of service authorizations for newborn services, timely filing issues as a result of delayed or incorrect enrollment of the newborn, medically necessary services received out of MCOs service area, or medically necessary services received from out-of-network providers.” (Virginia)



## PROMISING PRACTICES IN COMMUNICATION

In any state, communication to public agency staff, health plans, providers, and consumers is essential for successful implementation of this policy. The qualitative review of state documents (e.g., policies, provider manuals, websites, consumer brochures, letters to families or providers) and meetings with state agency staff identified several themes related to best and promising practices.

### COMMUNICATION TO AGENCY STAFF

- Clear procedures related to eligibility determination such as specifying acceptable documentation of birth, preparation and mailing of enrollment cards, timelines for determinations, and so on.
- Clear statements about special circumstances (e.g., related to presumptive eligibility of mother, immigration status, medically needy, retroactive coverage, etc.).
- Examples of various eligibility circumstances for the mother or at the time of redetermination near first birthday.
- Focus on the redetermination time when babies turn one (e.g., “The first birthday prompts a review of the infant’s eligibility. The timing, notices, and review process can be confusing for families and cause loss of coverage...”).

### SAMPLE STAFF TRAINING QUESTIONS

**“Was the mother receiving Medicaid at the time of the birth? Y/N”. [Edits in brackets for clarity]**

- **Example 1: Child is born 07/03/18. Mom applies for herself and her newborn child on 08/02/18 and she asks for backdate. Income is at or below the [Medicaid] income limit in July. Both Mom and child are eligible... Answer the question above ‘Yes’.**
- **Example 2: Child is born 07/03/18. Mom applies for herself and her newborn child on 08/02/18 and she asks for backdate. Income is above the income limit in July. Mom and child are NOT eligible for [Medicaid]. The child may be eligible for All Kids [CHIP or other coverage] but would be required to comply with the SSN policy. The Mom may be considered for Family Health Spenddown. Answer the question above ‘No’.**
- **Example 3: Child is born 07/03/18. Mom is receiving [Medicaid]... in the month of July. The baby is automatically eligible for [Medicaid] even though the Department was not aware of the pregnancy. Add the baby as soon as you learn of the baby’s birth; neither an SSN nor signed request is required to add the baby. Answer the question above ‘Yes’.**

## COMMUNICATION TO PROVIDERS

- Clear provider guidance about how to report the birth, including hospitals, obstetric and pediatric providers (e.g., obstetricians, neonatologists, pediatric primary care, nurse practitioners, nurse midwives, family practice physicians), Federally Qualified Health Centers (FQHC), and others.
- Specify terms for provider billing (e.g., no billing prior to issuance of a card/number for infant). Information about provider reimbursement for services at the time of birth and for the infant beyond that date also should include a clear description of when the mother's Medicaid identification number can be used for billing.

## SAMPLE LANGUAGE FOR PROVIDERS

- **“This form is to be used by hospitals, physicians and certified nurse-midwives to report the birth of an infant whose mother is currently certified for Medicaid... It will serve as verification of the birth date of the infant as well as relationship to the mother. It will also verify the eligibility and Medicaid ID number of the infant found eligible by the DHS County Office.” (Arkansas)**
- **“[STATE] has an automated system in place where once the [NEWBORN] information has been sent to Vital Records from the hospital and is in Vital Records... the system will look for a match to the Mother on our enrollment files. Next it will run a process to attempt to create the [NEWBORN] Beneficiary ID#, add a Medicaid benefit plan and add the baby to the Mother's Health plan.” (Michigan)**
- **“Hospitals must notify the Division of Medicaid within 5 calendar days of a newborn's birth using the Newborn Enrollment Form located on the Envision Web Portal. The Division of Medicaid, Office of Eligibility, will notify the provider within 5 business days of the newborn's permanent Medicaid Identification (ID) number... The birthing hospital should also provide the baby's Medicaid ID number to any hospital to which the infant may have been transferred.” (Mississippi)**

## COMMUNICATION WITH FAMILIES

- Provide information through multiple communication channels including websites, mailed enrollment information, brochures to be distributed by providers, telephone warm lines, and others.
- Clearly state that the infant's eligibility begins at birth and continues until the first birthday, regardless of mother's eligibility or immigration status, whether or not the infant lives with the mother, and without other documentation.
- Specify any family responsibility (e.g., notifying and verifying).
- Describe how the family can confirm the baby's enrollment (e.g., via Internet, telephone, or local offices).
- Place the information in visible and logical areas of state websites. This review found that most information about automatic newborn eligibility was contained in sections of websites or documents and not as often in the child health section.
- Use common terms and easy to read text.

Many states currently use complex, legal jargon on websites designed to communicate to families. Studies have shown that caregiver literacy and health literacy are factors in enrollment continuity and gaps for families with children in Medicaid.<sup>24</sup> Maternal knowledge about eligibility criteria for Medicaid and cash assistance has been shown to have strong positive effects on continuity of Medicaid enrollment for infants and toddlers. In one study of African American families living in an urban area, maternal Medicaid disenroll-

ment was associated with more than 10 times increased odds of disenrollment of the infants and toddlers. Other factors significantly associated with continuity of in coverage between birth and age 24 months were: a) maternal knowledge of eligibility criteria, b) maternal health literacy, c) receipt of cash assistance, and d) family housing situation.<sup>25</sup>



### SAMPLE LANGUAGE FOR INFORMING FAMILIES VIA WEBSITES AND DOCUMENTS

- Once your baby is born, he or she is automatically eligible for coverage for the first year of life. Please contact your eligibility worker, go online XXXXX.gov, or call XXX-XXX-XXXX to confirm that your baby is enrolled.
- You can add your baby online or through the mobile app. You also can report the birth of your baby by calling XXX-XXX-XXXX or by contacting your county human/social services office or a Medicaid case worker near you.
- If you are a woman enrolled in Medicaid or CHIP when your baby is born, your baby will then be automatically enrolled until his or her first birthday.
- If you had Medicaid coverage when your baby was born, the baby will have coverage until his or her first birthday – even if the mother's eligibility or family income changes.
- Your baby will automatically be covered by Medicaid for 13 months and be enrolled in your MCO.
- No application or interview is required for approval of a newborn infant's Medicaid eligibility if the mother was covered at the time of birth.
- Automatic newborn coverage includes a baby born to a non-citizen mother eligible for emergency services only.
- Eligibility begins with the birth, regardless of when the STATE agency is notified of the birth.
- Your baby is automatically covered if you had Medicaid coverage on the day of the birth. Coverage will continue through the month of his or her first birthday, as long as your baby lives in STATE.
- Your baby is about to turn one year old. Please contact the XXXXXXXX to renew and continue his or her Medicaid enrollment. Our goal is that your child have no gaps in coverage.
- Parents don't have to file for their babies' separate enrollment right away, but it's good to do this as soon as possible and no later than one year, before first birthday.

# BEST PRACTICES FOR INFANT ENROLLMENT



## Prenatal

- Inform during prenatal visits.
- Preassign number for baby.
- Give cards with preassigned numbers.
- Use outstationed eligibility workers, navigators, home visitors, and others to assist and inform families.



## Birth

- Inform family.
- Set up simple methods for notice of birth.
- Use mother's number until infant number / card is received.
- Provide tools for families and providers to verify enrollment.
- Establish effective methods to auto-enroll whether birth financed by managed care or fee-for-service.



## Infant

- Require no action by family before time of first birthday.
- Use mother's number until infant number / card is received.
- Continue enrollment throughout year.
- Use technology to flag when any infant is disenrolled.
- Develop a data dashboard for deemed infant enrollment.



## First birthday

- Inform and remind family prior to first birthday.
- Conduct re-determination process automatically.
- Offer no wrong door approach (e.g., in-person, online, or e-mail document submission).
- Conduct data quality reviews of CMS 416, T-MSIS, and other data.

Basic elements to support these approaches: policies and procedures aligned with federal law, trained eligibility staff, specific managed care contract provisions, clear communications materials, and effective data and IT systems.

## RECOMMENDATIONS FOR STATE ACTION

Project findings from analysis of data, state procedures, contract language, and communications point to opportunities for states to improve their implementation of automatic newborn and continuous infant eligibility.

Note that the policies and procedures reported here do not reflect changes state may have made during the COVID-19 public health emergency. States' procedures and practices for deemed infant enrollment may have been affected by state action following enactment of the Families First Coronavirus Response Act<sup>26</sup> or other federal policy changes (e.g., continued eligibility beyond end of first year under requirements for no disenrollment).<sup>27 28 29</sup> These recommendations do apply to the general program during and beyond the pandemic.

### ELIGIBILITY RULES AND PROTOCOLS

- Aim to have every baby with a Medicaid/CHIP financed birth leave the birth facility (e.g., hospital, birthing center) with a card or written document that shows the eligibility/identification number to be used for infant care.
- Assure that state rules and regulations are aligned with federal law requirements.
- Set up enrollment procedures and protocols that are streamlined, clear, and have administrative check points around both the time of birth and the time of the first birthday.

- Include clear and specific language regarding automatic newborn and continuous infant enrollment in Medicaid contracts with MCOs, ACOs, and similar entities.
- Develop specific procedures for automatic newborn enrollment of infants born to a mother who has emergency labor and delivery coverage only.
- In states that rely on managed care plans to facilitate reports of birth and automatic enrollment, develop specific procedures for women who are not enrolled in MCOs.
- Use a State Plan Amendment (SPA) to adopt all options for coverage for infants with a CHIP financed birth, and thereby expand automatic newborn coverage.
- Under the Families First Coronavirus Response Act maintenance of effort provisions, do not disenroll children who reach their first birthday who were enrolled as infants as of March 18, 2020 or thereafter during the COVID-19 public health emergency (unless they move out of state or voluntarily disenroll).

### COMMUNICATIONS AND OUTREACH

- Update and clarify communications regarding Medicaid eligibility for infants in materials designed for use with providers and health plans (e.g., rules, guidance, provider manuals, websites, reporting forms, billing procedures, etc.).



- Improve and update communications aimed at informing families about Medicaid eligibility for infants (websites, brochures, benefits booklets, letters, etc.).
- Include information about deemed infants in both communications related to pregnancy and communications related to children, giving the topic of infant coverage its own subheading or section.
- Train and involve health navigators, outstationed eligibility workers, home visitors, staff in WIC programs, and others in the process for automatic and newborn eligibility.

## DATA AND ANALYSIS

- Review CMS Form 416 data annually with the aim of improving data quality, particularly analyzing trends in infant continuous enrollment.
- Use electronic systems for matching data (e.g., vital statistics and Medicaid pregnancy or infant enrollment).
- Link birth and Medicaid data to assess the percentage of covered births, maternal and infant outcomes, and automatic and continuous infant enrollment.
- Take advantage of opportunities in the Transformed Medicaid Statistical Information System (T-MSIS) to support automatic newborn and continuous infant eligibility and utilization of care by the youngest children in Medicaid and CHIP.

## ALIGNING MATERNAL AND INFANT ELIGIBILITY

- Develop prenatal approaches for designating a Medicaid identification number to the infant (e.g., special cards with preassigned numbers), which can be quickly validated at the time the state agency receives notice of the birth.
- Increase prenatal focus on informing parents about the automatic newborn coverage rules and on designation of a pediatric primary care provider.
- Adopt Medicaid policies to extend Medicaid postpartum coverage for 12 months following the end of pregnancy.

---

## CONCLUSION

More than one half million babies per year are not counted by states as continuously eligible for Medicaid and therefore are not continuously entitled to EPSDT well-baby visits and other needed care. This reflects at least data issues and perhaps a much larger and troubling concern about gaps in infant enrollment. The data suggest that the automatic and continuous infant enrollment policy has not been effectively implemented in all states. The distribution of the percentage of missing babies by state indicates challenges in administration of the program, not related to the distribution of births.

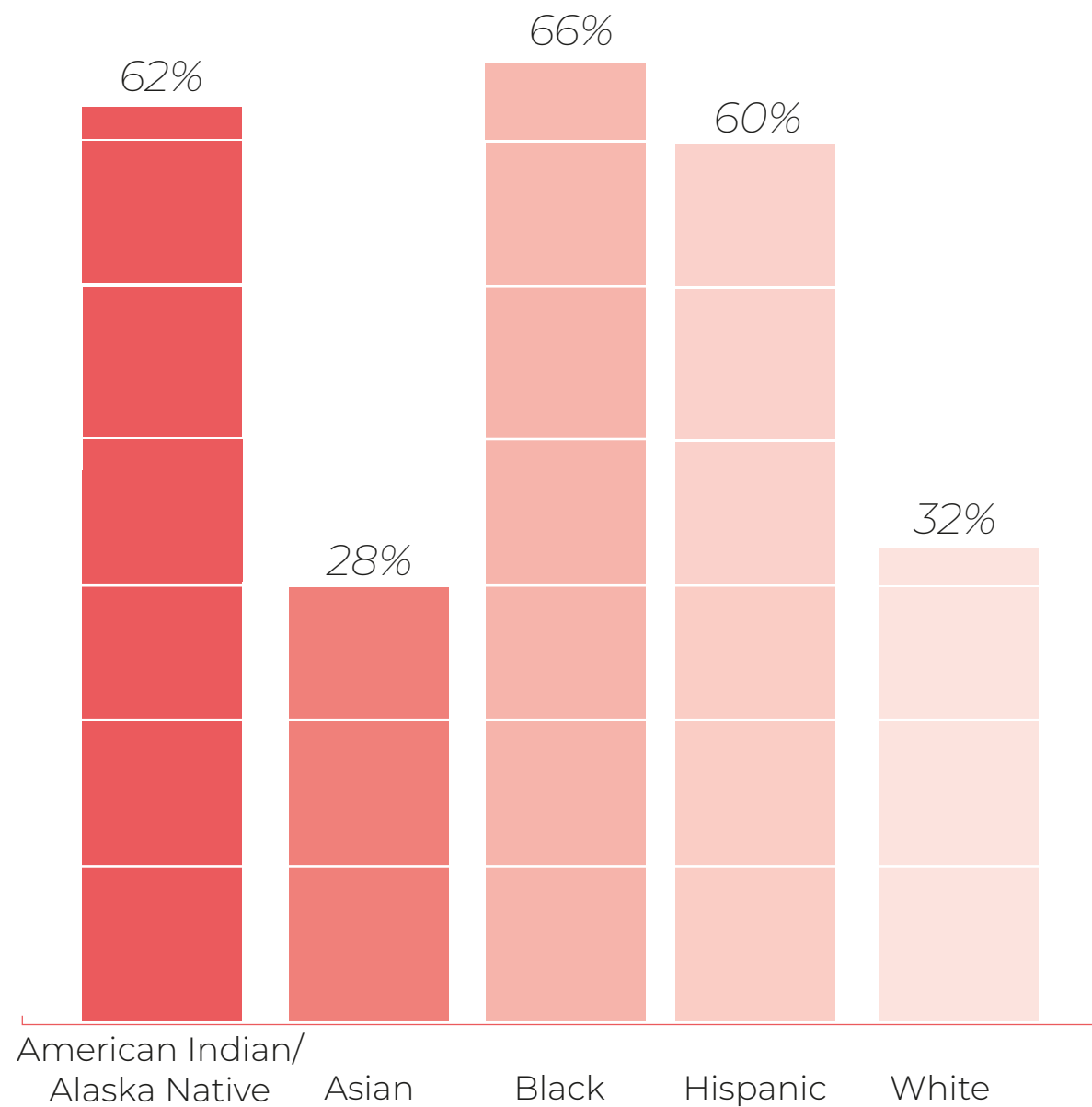
The nation cannot afford to miss the opportunity to provide preventive and other needed health services to 500,000 or more babies. The first year of life sets a foundation for future well-being; a time when both preventive care and early identification and treatment of special health needs are critical for ensuring optimal health and development. Automatic and continuous enrollment is particularly important given that the Bright Futures Guidelines<sup>30 31 32</sup> call for six visits in the first year after an infant leaves the hospital as a newborn (the newborn visit is the seventh visit in the AAP Bright Futures recommended schedule which is followed for EPSDT by most states). Immunizations are due at five of those well-baby visits. Developmental screening is due at the 9-month well-baby visit. Maternal depression screening is also recommended

during well-baby visits and covered by Medicaid in a growing number of states. Moreover, infants are more likely to suffer life threatening conditions than older children. For example, without infant coverage, a child's developmental delays may not be detected at the 9-month visit, a respiratory infection may be left unattended to become critical and life threatening, and services for conditions identified by newborn screening may not be provided. Such serious and life-threatening conditions were one factor that stimulated Congressional action and adoption of the automatic newborn and continuous infant eligibility requirements.

Medicaid and CHIP are key sources of health coverage for approximately half of all births, and the programs are particularly important for families of color having babies. As shown above in Figure 4, births to Black and Hispanic women are more likely to be financed with Medicaid. The Kaiser Family Foundation reports that approximately two-thirds of Black, American Indian/Alaska Native, and Hispanic infants have coverage through Medicaid and CHIP public coverage.<sup>33</sup> (See Figure 5.) We cannot achieve health equity for infants and young children without effective state policies and administrative procedures to ensure they benefit from continuous coverage and access to services financed under Medicaid and CHIP.



**Figure 5. Percentage of Infants Covered by Medicaid and CHIP, By Race/Ethnicity, U.S., 2019**



Source: Henry J. Kaiser Family Foundation. Analysis of 2019 American Community Survey data from U.S. Census Bureau. 2020.

Every state can do much better in implementation of this policy. Improved policy is needed to ensure that our babies get the coverage to which they are entitled and that they have access to services that will optimize their health and development. In tandem, Congressional and state action to provide one-year of postpartum coverage for new mothers is needed to align maternal and infant coverage in Medicaid and CHIP.<sup>34 35 36</sup> Parental loss of Medicaid is associated with discontinuity in child coverage.<sup>37</sup> About one in three people who give birth experience a disruption in coverage. Having both maternal and infant coverage under Medicaid be continuous for one year following a birth is a major step toward ending disparities in maternal and infant mortality and giving our children an equitable start.<sup>38 39</sup>



---

## ACKNOWLEDGEMENTS

This work would not have been possible without a grant from the David and Lucile Packard Foundation. The guidance and support of Katherine “Katie” Beckmann, Program Officer for the Foundation’s Children, Families, and Communities program, was critical to moving from a concern about the issue to a practical policy research project and useful products for the field.

Sara Rosenbaum, Harold and Jane Hirsh Professor of Health Law and Policy, and Morgan Handley, Senior Research Associate in the Department of Health Policy and Management, Milken Institute School of Public Health at George Washington University were formal advisors and consultants for this project. They provided a legal history of federal policy regarding automatic newborn and continuous infant enrollment, extracted related contract language from the George Washington University data base, reviewed drafts of this brief, and co-authored a related blog for Health Affairs. Their legal expertise was essential to the success of this project, and their partnership deeply appreciated.

The author is grateful to the following subject matter experts who participated in interviews that shaped the direction of this project, including: (1) Charles Bruner, InCK Marks;

(2) Elisabeth Burak, Tricia Brooks, and Kelly Whitener at the Georgetown Center for Children and Families; (3) Margaret “Peggy” McManus, National Alliance to Advance Adolescent Health and consultant on EPSDT to the American Academy of Pediatrics; (4) Cindy Mann and Jocelyn Guyer, Manatt Health; (5) Donna Cohen-Ross, independent consultant; (6) Maureen Hensley-Quinn, National Academy for State Health Policy (NASHP); (7) Jane Perkins, National Health Law Program (NHeLP); and (8) Megan Thomas, Harbage Consulting / Aurera Health Group, who formerly worked on EPSDT 416 data at CMS. In addition, a group of 18 individuals from the CMS Center for Medicaid and CHIP Services (CMCS) and Center for Medicare and Medicaid Innovation (CMMI) participated in an informational meeting as federal agency experts.

Last, but not least, appreciation to the 48 state agency staff from nine states who participated in virtual meetings to help identify continuing challenges and best practices, including multiple individuals from: District of Columbia, Louisiana, Michigan, Nevada, New Jersey, Oklahoma, Rhode Island, Virginia, and Washington State. Their knowledge, experience, and leadership is reflected throughout this report.

---

## APPENDIX A: PROJECT METHODS

With the support of a grant from the David and Lucile Packard Foundation, this project studied deemed infant enrollment in the current Medicaid and health care system context. It included both quantitative and qualitative analyses.

A trend analysis for Federal Fiscal Years (FFY) 2010-2018 was conducted with data reported by states to the Centers for Medicare and Medicaid Services (CMS) on Form 416, which offers a source of routinely collected data reported by all states on an annual basis related to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Among other things, states are required to report “the total unduplicated number of individuals enrolled in Medicaid or CHIP Medicaid expansion program determined to be eligible for the EPSDT services, by age and by basis of eligibility as of September 30.” (Form CMS-416 Line 1a).

Since 2010, states also submit the unduplicated number of children eligible and enrolled for 90 continuous days in the Federal Fiscal Year (October 1 to September 30) report. (Form CMS-416 Line 1b). CMS 416 instructions for line 1b say: “Enter the total unduplicated number of individuals... who have been continuously enrolled in Medicaid or a CHIP Medicaid expansion program for at least 90 continuous days in the federal fiscal year...” This gives states an adjusted number of continuously eligible children, which they use to calculate perfor-

mance rates. This analysis looked at the gap between the total number of infants enrolled and the number counted at least 90 days continuously eligible and enrolled. Those infants in the gap are identified here as “missing babies.”

Using the EPSDT CMS 416 data helps overcome some measurement challenges. First, while the 416 data system has weaknesses for measuring the total number of well-child visits received, it offers the best routinely available data for counting the number of Medicaid-enrolled and participating children. While it does not count every child in Medicaid, it does include those enrolled as categorically needy, medically needy, and CHIP-Medicaid who are entitled to EPSDT. It does not include the small number of children covered as medically needy, in Section 1115 waivers, children in separate CHIP programs, or other special coverage for whom a few states do not extend EPSDT benefits. Second, while some national survey estimates based on parent reports of child coverage under Medicaid and CHIP likely include some children not in the CMS 416 data, these are administrative records data and do not depend on parental recall. Third, measuring the enrollment and participation of infants using claims data is complicated by the fact that in many states, the birth or the entire first year of services may be billed under the mother’s Medicaid recipient number. The 416 data on enrollment do not

have this methodological weakness. Fourth, the 416 data report is made based on the age the child was on September 30. Thus, the numbers likely underestimate how many infants were enrolled (e.g., a baby who had a first birthday in August would be counted in the 1-2 age group of toddlers).

Monthly birth statistics from the Centers for Disease Control and Prevention, National Center for Health Statistics were used to compare the number and percent of babies not counted 90 days continuously eligible to the number of births for the three months prior to CMS 416 reporting (i.e., July, August, September). The percentages were correlated in only 17 states.

To identify best practices, an analysis was conducted of publicly available state information related to deemed infant enrollment. This included collection and qualitative analysis of website content, provider manuals, consumer brochures, and so forth. Based on Internet searches and website reviews (completed in September 2019 and updated in November 2020), most states had at least some specific content related to deemed infant eligibility included in this analysis. (See Appendix C for a list of states.)

A separate analysis of Medicaid managed care contract provisions was completed with assistance from health policy and legal researchers at the George Washington University, Milken Institute School of Public Health. The George Washington University researchers used their database of managed care contract provisions to extract provisions related to deemed infant enrollment. They also prepared a legislative history which is contained in Appendix B.

Based on the review of state data and documents, 18 states were invited to participate in meetings designed to enhance understanding of best and promising practices. Many Medicaid agencies were in the process of making changes to their enrollment systems and decided not to participate at that time. The nine states participating in virtual meetings to discuss their data and their newborn enrollment processes included: District of Columbia, Louisiana, Michigan, Nevada, New Jersey, Oklahoma, Rhode Island, Virginia, and Washington State. These meetings with state agency staff—conducted prior to the COVID-19 public health emergency—provided more in-depth knowledge regarding how states administer and implement this aspect of Medicaid law, as well as the process for EPSDT reporting. Additional interviews were conducted with subject matter experts to gather information about best practices and program trends.

This project was on pause during the early phase of the COVID-19 pandemic. While the scan of state information available on the Internet was repeated in November 2020, the data and processes described here do not reflect changes states may have made during the COVID-19 public health emergency. Notably, this report does not describe any practices for deemed infant enrollment that may have been affected by maintenance of effort requirements under the Families First Coronavirus Response Act or other federal law changes.

## APPENDIX B: LEGISLATIVE HISTORY

### INFANT ENROLLMENT LEGISLATION - STATUTE

#### Deficit Reduction Act of 1984, P.L. No. 98-369

##### CLARIFICATION OF MEDICAID ENTITLEMENT FOR CERTAIN NEWBORNS

SEC. 2362. (a) Section 1902(e) of the Social Security Act is amended 42 use by adding at the end the following new paragraph:

“(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child’s birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year so long as the child is a member of the woman’s household and the woman remains eligible for such assistance.”

(b) The amendment made by subsection (a) shall apply to children born on or after October 1, 1984.

#### Omnibus Budget Reconciliation Act of 1987, P.L. No. 100-203

SEC. 4101 MEDICAID BENEFITS FOR POOR CHILDREN AND PREGNANT WOMEN. (a) MEDICAID OPTIONAL COVERAGE FOR ADDITIONAL LOW-INCOME PREGNANT WOMEN AND CHILDREN...

(2) Section 1902(e)(4) of such Act (42 U.S.C. 1396a(e)(4)) is amended by adding at the end the following new sentence: “During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance eligibility identification number of the mother shall also serve as the identi-

fication number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).”

(3) The amendments made by this subsection shall apply to medical assistance furnished on or after July 1, 1988.

#### Omnibus Budget Reconciliation Act of 1990, P.L. No. 101-508

SEC. 4603. MANDATORY CONTINUATION OF BENEFITS THROUGHOUT PREGNANCY OR FIRST YEAR OF LIFE. (a) IN GENERAL.—Section 1902(e) (42 U.S.C. 1396a(e)) is amended— (1) in the first sentence of paragraph (4), by inserting “(or would remain if pregnant)” after “remains”; ...

(b) EFFECTIVE DATE — (1) INFANTS.—The amendment made by subsection (a) shall apply to individuals born on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date. ...

#### Children’s Health Insurance Program Reauthorization Act of 2009, P.L. No. 111-3

SEC. 113. ELIMINATION OF COUNTING MEDICAID CHILD PRESUMPTIVE ELIGIBILITY COSTS AGAINST TITLE XXI ALLOTMENT.

(b) AMENDMENTS TO MEDICAID.— (1) ELIGIBILITY OF A NEWBORN.—Section 1902(e)(4) (42 U.S.C. 1396a(e)(4)) is amended in the first sentence by striking “so long as the child is a member of the woman’s household and the woman remains (or would remain if pregnant) eligible for such assistance.”

## Changes Related to Proof of Citizenship for Infants

### Deficit Reduction Act of 2005, P.L. No. 109-171

#### SEC. 6036. IMPROVED ENFORCEMENT OF DOCUMENTATION REQUIREMENTS.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396(b)) is amended—

... (2) by adding at the end the following new subsection: “(x)(1) For purposes of subsection (i)(23), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual. (2) The requirement of paragraph (1) shall not apply to an alien who is eligible for medical assistance under this title— “(A) and is entitled to or enrolled for benefits under any part of title XVIII; (B) on the basis of receiving supplemental security income benefits under title XVI; or (C) on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented.

(3)(A) For purposes of this subsection, the term ‘satisfactory documentary evidence of citizenship or nationality’ means—

- (i) any document described in subparagraph (B); or
- (ii) a document described in subparagraph (C) and a document described in subparagraph (D).

(B) The following are documents described in this subparagraph:

- (i) A United States passport.
- (ii) Form N-550 or N-570 (Certificate of Naturalization).
- (iii) Form N-560 or N-561 (Certificate of United States Citizenship).

(iv) A valid State-issued driver’s license or other identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act...

‘(v) Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

### Tax Relief and Health Care Act of 2006, P.L. No. 109-432

#### SEC. 405. CERTAIN MEDICAID DRA TECHNICAL CORRECTIONS.

(c) ADDITIONAL MISCELLANEOUS TECHNICAL CORRECTIONS.—  
(1) DOCUMENTATION (SECTION 6036).—

(A) IN GENERAL.—Effective as if included in the amendment made by section 6036(a)(2) of the Deficit Reduction Act of 2005, section 1903(x) of the Social Security Act (42 U.S.C. 1396b(x)), as inserted by such section 6036(a)(2), is amended— (i) in paragraph (1), by striking “(i)(23)” and inserting “(i)(22)”; (ii) in paragraph (2)— (I) in the matter preceding subparagraph (A), by striking “alien” and inserting “individual declaring to be a citizen or national of the United States”; (II) by striking subparagraph (B) and inserting the following: “(B) and is receiving— “(i) disability insurance benefits under section 223 or monthly insurance benefits under section 202 based on such individual’s disability (as defined in section 223(d)); or “(ii) supplemental security income benefits under title XVI;”; (III) in subparagraph (C)— (aa) by striking “other”; and (bb) by striking “had” and inserting “has”; (IV) by redesignating subparagraph (C) as subparagraph (D); and (V) by inserting after subparagraph (B) the following new subparagraph: “(C) and with respect to whom— “(i) child welfare services are made available under part B of title IV on the basis of being a child in foster care; or “(ii) adoption or foster care assistance is made available under part E of title IV; or”; and (iii) in paragraph (3)(C)(iii), by striking “I-97” and inserting “I-197”.



## Children's Health Insurance Program Reauthorization Act of 2009, P.L. No. 111-13

(3) CHILDREN BORN IN THE UNITED STATES TO MOTHERS ELIGIBLE FOR MEDICAID.—

(A) CLARIFICATION OF RULES.—Section 1903(x) (42 U.S.C. 1396b(x)), as amended by paragraph (2), is amended—(i) in paragraph (2)— (I) in subparagraph (C), by striking “or” at the end; (II) by redesignating subparagraph (D) as subparagraph (E); and (III) by inserting after subparagraph (C) the following new subparagraph: “(D) pursuant to the application of section 1902(e)(4) (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis); or”; and (ii) by adding at the end the following new paragraph: “(5) Nothing in subparagraph (A) or (B) of section 1902(a)(46), the preceding paragraphs of this subsection, or the Deficit Reduction Act of 2005, including section 6036 of such Act, shall be construed as changing the requirement of section 1902(e)(4) that a child born in the United States to an alien mother for whom medical assistance for the delivery of such child is available as treatment of an emergency medical condition pursuant to subsection (v) shall be deemed eligible for medical assistance during the first year of such child's life.”

(B) STATE REQUIREMENT TO ISSUE SEPARATE IDENTIFICATION NUMBER. — Section 1902(e)(4) (42 U.S.C. 1396a(e)(4)) is amended by adding at the end the following new sentence: “Notwithstanding the preceding sentence, in the case of a child who is born in the United States to an alien mother for whom medical assistance for the delivery of the child is made available pursuant to section 1903(v), the State immediately shall issue a separate identification number for the child upon notification by the facility at which such delivery occurred of the child's birth.”

## INFANT ENROLLMENT REGULATIONS

**52 FR 42063 (1987)**

### **§ 435.117 Newborn children.**

(a) The agency must provide categorically needy Medicaid eligibility to a child born to a woman who is eligible as categorically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible as categorically needy for one year so long as the woman remains eligible as categorically needy and the child is a member of the woman's household. If the mother's basis of eligibility changes to medically needy, the child is eligible as medically needy under § 435.301(b)(1)(iii).

(b) The requirements under paragraph (a) of this section apply to children born on or after October 1, 1984.

### **78 FR 38662 (2007) § 435.117 Newborn children.**

(a) The agency must provide Medicaid eligibility to a child born to a woman who has applied for, has been determined eligible and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains (or would remain if pregnant) eligible and the child is a member of the woman's household. This provision applies in instances where the labor and delivery services were furnished prior to the date of application and covered by Medicaid based on retroactive eligibility.

(b) The agency must provide Medicaid eligibility in the same manner described in paragraph (a) of this section to a child born to an otherwise eligible qualified alien woman subject to the 5-year bar so long as the woman has filed a complete Medicaid application, including but not limited to meeting residency, income and resource requirements, has been determined eligible, is receiving Medicaid on the date of the child's birth, and remains (or would remain if pregnant) Medicaid eligible. All standard Medicaid application procedures apply, including timely determination of eligibility and adequate notice of the agency's decision concerning el-



eligibility. A 5-year bar qualified alien receiving emergency medical services only under § 435.139 is considered to be Medicaid-eligible and receiving Medicaid for purposes of this provision. With respect to whether the mother remains (or would remain if pregnant) eligible for Medicaid after the birth of the child, the State must determine whether a 5-year bar qualified alien would remain eligible for emergency services under § 435.139. In determining whether the woman would remain eligible for these services, the State must consider whether the woman would remain eligible if pregnant. This provision applies in instances where the labor and delivery services were furnished prior to the date of application and covered by Medicaid based on retroactive eligibility.

(c) The agency must provide Medicaid eligibility in the same manner described in paragraph (a) of this section to a child born to an otherwise-eligible nonqualified alien woman so long as the woman has filed a complete Medicaid application (other than providing a social security number or demonstrating immigration status), including but not limited to meeting residency, income and resource requirements, has been determined eligible, is receiving Medicaid on the date of the child's birth, and remains (or would remain if pregnant) Medicaid eligible. All standard Medicaid application procedures apply, including timely determination of eligibility and adequate notice of the agency's decision concerning eligibility. A non-qualified alien receiving emergency medical services only under § 435.139 is considered to be Medicaid-eligible and receiving Medicaid for purposes of this provision. With respect to whether the mother remains (or would remain if pregnant) eligible for Medicaid after the birth of the child, the State must determine whether a non-qualified alien would remain eligible for emergency services under § 435.139. In determining whether the woman would remain eligible for these services, the State must consider whether the woman would remain eligible if pregnant. This provision applies in instances where the labor and delivery services were furnished prior to the date of application and covered by Medicaid based on retroactive eligibility.

(d) A redetermination of eligibility must be completed on behalf of the children described in this provision in accordance with the

procedures at § 435.916. At that time, the State must collect documentary evidence of citizenship and identity as required under § 435.406.

**88 FR 38662 (2016) § 435.117 Deemed newborn children.**

(a) Basis. This section implements sections 1902(e)(4) and 2112(e) of the Act.

(b) Eligibility.

(1) The agency must provide Medicaid to children from birth until the child's first birthday without application if, for the date of the child's birth, the child's mother was eligible for and received covered services under—

(i) The Medicaid State plan (including during a period of retroactive eligibility under § 435.915) regardless of whether payment for services for the mother is limited to services necessary to treat an emergency medical condition, as defined in section 1903(v)(3) of the Act; or

(ii) The CHIP State plan as a targeted low-income pregnant woman in accordance with section 2112 of the Act, with household income at or below the income standard established by the agency under § 435.118 for infants under age 1.

(2) The agency may provide coverage under this section to children from birth until the child's first birthday without application who are not described in (b)(1) of this section if, for the date of the child's birth, the child's mother was eligible for and received covered services under—

(i) The Medicaid State plan of any State (including during a period of retroactive eligibility under § 435.915); or

(ii) Any of the following, provided that household income of the child's mother at the time of the child's birth is at or below the income standard established by the agency under § 435.118 for infants under age 1:

(A) The State's separate CHIP State plan as a targeted low-income child;

(B) The CHIP State plan of any State as a targeted low-income pregnant woman or child; or

(C) A Medicaid or CHIP demonstration project authorized under section 1115 of the Act.

(3) The child is deemed to have applied and been determined eligible under the Medicaid State plan effective as of the date of birth, and remains eligible regardless of changes in circumstances until the child's first birthday, unless the child dies or ceases to be a resident of the State or the child's representative requests a voluntary termination of eligibility.

(c) Medicaid identification number.

(1) The Medicaid identification number of the mother serves as the child's identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until the State issues the child a separate identification number.

(2) The State must issue a separate Medicaid identification number for the child prior to the effective date of any termination of the mother's eligibility or prior to the date of the child's first birthday, whichever is sooner, except that the State must issue a separate Medicaid identification number in the case of a child born to a mother:

(i) Whose coverage is limited to services necessary for the treatment of an emergency medical condition, consistent with § 435.139 or § 435.350;

(ii) Covered under the State's separate CHIP; or

(iii) Who received Medicaid in another State on the date of birth.

(d) Renewal of eligibility. \* \* \*



## APPENDIX C: STATES WITH WEBSITES AND DOCUMENTS REVIEWED

State Name		Kentucky		North Dakota	No
Alabama	Yes	Louisiana	Yes	Ohio	Yes
Alaska	Yes	Maine	Yes	Oklahoma	Yes
Arizona	No	Maryland	Yes	Oregon	Yes
Arkansas	Yes	Massachusetts	Yes	Pennsylvania	Yes
California	Yes	Michigan	Yes	Rhode Island	Yes
Connecticut	Yes	Minnesota	Yes	South Carolina	Yes
Delaware	Yes	Mississippi	Yes	South Dakota	Yes
District of Columbia	Yes	Missouri	Yes	Tennessee	Yes
Florida	Yes	Montana	No	Texas	Yes
Georgia	Yes	Nebraska	Yes	Utah	Yes
Hawaii	Yes	Nevada	Yes	Vermont	No
Idaho	No	New Hampshire	No	Virginia	Yes
Illinois	Yes	New Jersey	Yes	Washington	Yes
Indiana	Yes	New Mexico	Yes	West Virginia	Yes
Iowa	Yes	New York	Yes	Wisconsin	Yes
Kansas	Yes	North Carolina	Yes	Wyoming	Yes

## APPENDIX D: INFANT ENROLLMENT IN MCO CONTRACTS

Based on a scan of the database of 39 state Medicaid managed care contracts effective in January 1 to October 1, 2019. Research was conducted for this project by Sara Rosenbaum, Maria Velasquez, Morgan Handley, et al., Milken Institute School of Public Health at the George Washington University. Learn more about their larger and more comprehensive Medicaid managed care contracts project and the database of contract provisions at: <https://www.common-wealthfund.org/publications/issue-briefs/2020/jul/how-states-are-using-comprehensive-medicaid-managed-care>

### Arizona

Newborns: The Contractor is responsible for notifying AHCCCS of a child's birth to an enrolled member even though the newborn may not be under the custody of the Contractor.

For newborns eligible for CMDP: Capitation for the newborn will be retroactive to the date of birth if notification is received no later than one day from the date of birth. In all other circumstances, capitation for the newborn will begin on the date notification is received by AHCCCS. The effective date of AHCCCS eligibility for the newborn will be the newborn's date of birth, and the Contractor is responsible for all covered services to the newborn, whether or not AHCCCS has received notification of the child's birth. AHCCCS is available to receive notification 24 hours a day, seven days a week via the AHCCCS website. If the newborn meets statutory requirements for CMDP coverage as set forth in A.R.S. §8-512, CMDP shall remain the newborn's health plan.

For newborns ineligible for CMDP: Newborns who do not meet statutory requirements for CMDP coverage are auto-assigned to an AHCCCS Complete Care Contractor. Mothers of these newborns are sent a Choice Notice advising them of their right to choose a different Contractor for their child, which allows them 90 days to make a choice. See ACOM Policy 401. In the event the mother chooses a different Contractor, AHCCCS will recoup all capitation paid to the originally assigned Contractor and the baby will be enrolled retroactive to the date of birth with the second Contractor. The second Contractor will receive prior period capitation from the date of birth to the day before assignment and prospective capitation from the date of assignment forward. The second Contractor will be responsible for all covered services to the newborn from date of birth. (p. 43).

### District of Columbia

C.5.19 Responsibility for Medicaid Coverage of Newborns and Assignment/Selection of PCP

C.5.19.1 Contractor shall report to DHCF, ESA, and the Enrollment Broker any Enrollees who are pregnant.

C.5.19.2 Within ten (10) business days of the birth of an infant to a woman enrolled in Contractor's Plan, Contractor shall notify DHCF's Division of Managed Care by completing all fields in the Deemed Newborn forms and log and submit to designated staff at DHCF and ESA within ten (10) business days to ensure Newborns are enrolled timely. All fields on the forms must be completed including

the Newborn's full name to enroll the child into Medicaid and assign a Medicaid ID Number.

C.5.19.3 The Contractor shall submit to the Enrollment Broker Deemed Newborn information via the readable specified format established by the Enrollment Broker. If Contractor fails to adhere to DHCF and its designee's time processing requirements and notification and submission procedures, DHCF will not reimburse the Contractor for services rendered.

C.5.19.4 The Newborn shall remain enrolled with the birth mother's MCO from the time of birth and shall remain an Enrollee of Contractor until a separate Medicaid number is assigned and a parent, subsequent to the assignment of a number, makes a decision to enroll the Newborn in a different MCO. Contractor shall explain to the parent that the Newborn must remain enrolled in Contractor's plan until the date on which a parent is notified of the Newborn's DC-issued Medicaid ID number.

C.5.19.5 If the Newborn is abandoned, the Newborn shall remain in the birth mother's MCO. Contractor shall immediately notify DHCF if the Newborn is abandoned. Contractor shall ensure that the Newborn has a Medicaid number before the transfer for alternative medical care. If the Newborn is placed for adoption the Newborn shall remain in the birth mother's MCO until alternative medical care is determined. Contractor shall ensure the Newborn has a Medicaid number before the transfer of the Newborn for alternative medical care.

C.5.19.5.1 If the Newborn is born a Premature Birth or Low Birth Weight for gestational age and meets the Social Security Administration's (SSA) criteria for presumptive Social Security Income (SSI) benefits, the Newborn shall not be automatically enrolled in the MCO of the birth mother. The MCO shall assist the mother in the SSI process. The Newborn shall remain eligible for FFS Medicaid for a period of ninety (90) days from date of birth, while pending SSI approval. If Newborn does not establish SSI eligibility within 90 days, the Newborn shall be enrolled in the MCO of birth, effective the first day of the following month, after the 90 days allotted timeframe has expired.

C.5.19.5.2 If the Newborn is of fetal demise or stillborn at twenty (20) weeks gestational age or more, the MCO must report this information to DHCF within ten (10) business days of notification via the Add Newborn Log (see Attachment J.20) and Death Notification Form, in order to receive a Kick-Payment for the mother's labor and delivery.

C.5.19.6 Contractor shall ensure that prior to discharge the mother has designated a PCP for the Newborn, the PCP is available, and the PCP has registered the Newborn as a patient and scheduled the first appointment. If there is no selection by the mother, the Contractor shall auto-assign a PCP.

C.5.19.7 Contractor shall submit the following Quarterly reports in accordance with Section C.5.36: C.5.19.7.1 Newborn Births and date of first Newborn outpatient visit report; and C.5.19.7.2 High Risk Newborn Report, including date of discharge and date of home visit. (p. 64-65).

#### Delaware

##### 3.2.2.7 Newborns

3.2.2.7.1 Newborns born to mothers who are DSHP or DSHP Plus members at the time of the child's birth will be Enrolled in their mother's MCO. If the mother is not Enrolled with an MCO but the child is eligible for Medicaid or CHIP, the birth is covered by fee-for-service Medicaid or CHIP, and the child and the mother will be Enrolled in the same MCO.

3.2.2.7.2 The Contractor shall provide Covered Services for eligible newborns retroactive to the date of birth.

3.2.2.7.3 The newborn's mother or guardian may request the newborn's Transfer without cause within the first 90 calendar days (see Section 3.2.6.2 of this Contract) and for good cause at any time in accordance with Section 3.2.7.4.4 of this Contract. (p. 41).

#### Florida

##### 1. Notification of Enrollee Pregnancy

a. The Managed Care Plan shall be responsible for newborns of

pregnant enrollees from the date of their birth. The Managed Care Plan shall comply with all requirements and procedures set forth by the Agency or its agent related to unborn activation and newborn enrollment.

b. Failure to comply with the procedures, set forth by the Agency or its agent, related to the unborn activation and newborn enrollment process as specified by the Agency, may result in sanctions as described in Section XI, Sanctions.

c. Newborns are enrolled in the Managed Care Plan of the mother unless the mother chooses another plan or the newborn does not meet the enrollment criteria of the mother's plan. When a newborn does not meet the criteria of the mother's plan, the newborn will be enrolled in a plan in accordance with Attachment II, Core Provisions, Section III, Eligibility and Enrollment, Item B., of this Contract. (p. 3-4).

### Georgia

2.3.13 In accordance with current operations, DCH or its Agent will issue a Medicaid number to a newborn upon notification from the hospital, or other authorized Medicaid Provider.

2.3.14 DCH will notify Contractor that a Member is an expectant mother based on the pregnancy Category of Service. Upon notification from DCH, the CMO shall mail a newborn enrollment packet to the expectant mother. This packet shall include information that the newborn will be Auto-Assigned to the mother's CMO and that she may, if she wants, select a PCP for her newborn prior to the birth by contacting her CMO. The mother shall have ninety (90) Calendar Days from the day a Medicaid number was assigned to her newborn to choose a different CMO. (p. 49).

#### 4.1.4 Newborn Enrollment

4.1.4.1 All newborns shall be Auto-Assigned by DCH or its Agent to the mother's CMO. The Contractor shall notify DCH or its Agent of newborns born to enrolled Members who do not appear on the monthly roster.

4.1.4.2 The Contractor shall provide assistance to any Member who is an expectant mother who contacts them wishing to make a PCP

selection for her newborn and record that selection.

4.1.4.3 Within twenty-four (24) hours of the birth, the Contractor shall ensure the submission of a newborn notification form to DCH or its Agent. If the mother has not made a PCP selection, the Contractor shall Auto-Assign the newborn to a PCP within thirty (30) Calendar Days of the birth. Auto-Assignment shall be made using the algorithm described in Section 4.1.2.4. Notice of the PCP Auto-Assignment shall be mailed to the mother within twenty-four (24) hours of assignment. (p. 60).

### Hawaii

#### E) Enrollment for Newborns

1. The Health Plan shall notify DHS of a member's birth of a newborn on form DHS 1179 when the Health Plan has access to the first name of the newborn or within thirty (30) days of birth, whichever is sooner. If the Health Plan submits the first name of the newborn as Baby Boy or Baby Girl at thirty (30) days, the Health Plan shall submit the first name of the child to DHS on form DHS 1179 as soon as they receive it. The change will be submitted electronically to the extent feasible in a format specified by DHS. (p. 452-53).

### Illinois

#### 4.6 Enrollment of Newborns, Infants, and Children

Enrollment of Newborns, infants and children who are added to the case of the mother whose RIN is on the IES transaction who is enrolled with the Contractor, are enrolled automatically as follows:

4.6.1 If the newborn is added to the case before the newborn is forty six (46) days old, Contractor shall provide coverage of the newborn Enrollee retroactively to the date of birth.

4.6.2 Enrollment of newborns, infants, and children who are added to the case of the mother whose RIN is on the IES transaction and who is enrolled with the Contractor, are enrolled automatically as follows: is an infant is added to the case after the age of forty-five (45) says and up to but not including one (1) year old, Contractor shall provide coverage of the infant Enrollee prospectively as provided in section 4.7.



4.6.3 Children under the age of nineteen (19), excluding newborns and infants, who are added to the case of a sibling, mother, or head of household and whose RIN is on the IES transaction and who is enrolled with the Contractor, are enrolled automatically. Contractor shall provide coverage of the child Enrollee prospectively as provided in section 4.7.

4.6.4 Contractor shall permit inpatient hospital claims for newborns to be billed under the baby's name and mother's RIN or the mother's Contractor-assigned enrollee ID number. Contractor shall not require prior authorization for inpatient newborn claims. (p. 51-52).

## Indiana

### 3.4 Enrollment of Newborns

Babies born to women enrolled in Medicaid (excluding Package C) are automatically eligible for Medicaid benefits for one year from the baby's date of birth.

If the woman is enrolled in an MCE on the newborn's date of birth, the baby is assigned to the woman's MCE, retroactive to the baby's date of birth, assuming the availability of an appropriate PMP for the newborn. The MCE will receive the newborn's monthly capitation rate retroactively from the newborn's date of birth once eligibility for the newborn is established and the baby is enrolled with the MCE. The State fiscal agent will notify the mother in writing of the auto assignment of the newborn.

If the newborn is not assigned to the mother's MCE due to the lack of pediatric panels slots in the mother's MCE, the newborn will remain in fee-for-service until the effective date of an assignment to another MCE. In these cases, claims for services from the baby's date of birth until assignment to an MCE will be the responsibility of the State fiscal agent on a fee-for-service basis.

The Hoosier Healthwise program encourages all pregnant women to select a PMP for their child prior to the birth of their baby. A mother must choose a PMP for her unborn child from the MCE in which she is enrolled.

Newborns of women in Package C are not automatically eligible for the benefits. If a woman who is enrolled in Package C becomes pregnant, she must submit an application for Health Coverage for her newborn. FSSA must determine if the newborn is eligible for Medicaid or CHIP. If eligible for Hoosier Healthwise Package C (CHIP), the member must pay the Hoosier Healthwise Package C (CHIP) premium before the newborn is enrolled in the program. Once the State receives the first Hoosier Healthwise Package C (CHIP) premium payment, the newborn is eligible for benefits. The State will assign the newborn prospectively to an MCE either by selection or auto-assignment.

The Hoosier Healthwise MCE Policies and Procedures Manual provides more information regarding the Pre-Birth Selection and MCE selection and change process. (p. 379).

## Kansas

c. Beneficiaries eligible to enroll with a CONTRACTOR(S) may be eligible beginning the first (1st) day of the application month with the exception of newborns who are eligible beginning with their date of birth.

d. Newborns of eligible mothers who were enrolled at the time of the child's birth shall be covered under the mother's CONTRACTOR. The CONTRACTOR(S) shall receive a capitation payment for the month of birth and for all subsequent months the child remains enrolled with the CONTRACTOR if the CONTRACTOR provided the newborn information to the State within sixty (60) calendar days of the date of birth. If there is an administrative lag that is not the fault of the Member in enrolling the newborn and costs are incurred during that period, the Member shall be held harmless for those costs. (p. 19).

H. CONTRACTOR(S) must have written policies and procedures for providing all medically necessary services required under the benefit package to newborn children of program Members effective at the time of birth. (p. 22).

## Kentucky

### 27.9 Newborn Infants

Newborn infants of non-presumptive eligible Enrollees shall be deemed eligible for Medicaid and automatically enrolled with the Contractor as individual Enrollees for sixty (60) days. The hospital shall request enrollment of a newborn at the time of birth, as set forth by the Department. Deemed eligible newborns are auto enrolled in Medicaid and enrollment is coordinated within the Cabinet. The delivery hospital is required to enter the birth record in the birth record system called KY CHILD (Kentucky's Certificate of Live Birth, Hearing, Immunization, and Lab data). That information is used to auto enroll the deemed eligible newborn within twenty-four (24) hours of birth. The Contractor is required to use the newborn's Medicaid ID for any costs associated with child. (p. 78).

## Louisiana

### 2.4.12.4 Newborn Enrollment

2.4.12.4.1 The Contractor shall contact enrollees who are expectant mothers at least sixty (60) calendar days prior to the expected date of delivery to encourage the mothers to choose a PCP for their newborns. In the event that the pregnant enrollee does not select a PCP, the Contractor shall provide the enrollee with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.

2.4.12.4.2 Medicaid deemed eligible newborns and their mothers, to the extent that the mother is eligible for Medicaid, shall be enrolled in the same MCO with the exception of newborns placed for adoption, newborns who are born out of state and are not Louisiana residents at the time of birth, and newborns and mothers eligible for Medicaid after the month of birth.

2.4.12.4.3 If LDH discovers that a newborn was incorrectly enrolled in an MCO different than its mother for the month of birth, LDH shall immediately:

2.4.12.4.3.1 Disenroll the newborn from the incorrect MCO;

2.4.12.4.3.2 Enroll the newborn in the correct MCO with the same effective date as when the newborn was enrolled in the incorrect MCO;

2.4.12.4.3.3 Recoup any payments made to the incorrect MCO for the newborn; and

2.4.12.4.3.4 Make payments only to the correct MCO for the period of coverage.

2.4.12.4.4 If the Contractor discovers that a newborn was incorrectly enrolled in an MCO different than its mother for the month of birth, the Contractor shall notify LDH immediately.

2.4.12.4.5 The MCO in which the newborn is correctly enrolled shall be responsible for the coverage and payment of MCO covered services provided to the newborn for the full period of eligibility. The MCO in which the newborn was incorrectly enrolled shall have no liability for the coverage or payment of any services during the period of incorrect MCO enrollment. LDH shall only be liable for the capitation payment to the correct MCO and may recoup the capitation payment from the MCO in which the newborn was incorrectly enrolled.

2.4.12.4.6 For newborns disenrolled, the MCO in which the newborn was incorrectly enrolled shall not recover claim payments from the provider. The MCO in which the newborn is incorrectly enrolled shall seek such claim payments from the MCO in which the newborn should have been enrolled on the dates of service.

2.4.12.4.7 The Contractor shall be responsible for ensuring that hospitals report the births of newborns within twenty-four (24) hours of birth for enrollees in accordance with the process outlined in the MCO Manual. Enrollment of deemed eligible newborns who are Louisiana residents at the time of birth and who are not surrendered prior to hospital discharge shall be retroactive to the date of the birth. (p. 68-69).



## Maryland

### E. Children.

(1) A newborn shall be automatically enrolled from birth in its biological mother's MCO.

(2) The MCO is responsible for the newborn's health care from birth until the newborn enrolls into another MCO.

(3) A newborn, automatically assigned to its biological mother's MCO, is not eligible to change MCOs for family unity as described in COMAR 10.09.63.06 A(1)(b) and (c) during the first 90 days of enrollment. (p. 112).

## Massachusetts

### C. Notification of Birth and Coverage of Newborns

The Contractor shall:

1. Provide MCO Covered Services, and all other services required to be provided to Enrollees under this Contract, to all newborns of Enrollees beginning with the date of birth of the newborn, provided that the newborn's mother is an Enrollee of the Contractor's Plan on the newborn's date of birth. Such services shall be covered when provided by Network Providers and when provided by non-Network Providers prior to notification by EOHHS of retroactive enrollment of the newborn pursuant to Section 3.3.B. In addition, the Contractor shall cover services provided, even if prior authorization was not obtained, or if claims were filed outside of the Contractor's claims filing limits, if the service was provided prior to notification by EOHHS of retroactive enrollment of the newborn pursuant to Section 3.3.B;

2. Include language in its Provider Contracts that it is the Provider's contractual responsibility to submit the Notification of Birth (NOB) form for all births to Enrollees to EOHHS's MassHealth Enrollment Center within 30 calendar days of the newborn's date of birth;

3. Collaborate with EOHHS to establish a smooth and efficient process for reporting all newborns to be covered by the Contractor's Plan; and

4. Require the Contractor's Network hospitals to notify the Contractor of the birth of each Enrollee's newborn in order to meet the

requirements of this Section. (p. 63).

## Michigan

### D. Newborn Enrollment

1. Newborns will be automatically enrolled with the mother's Contractor at the time of birth.

2. Contractors will receive a full Capitation Payment for the month of birth.

3. Contractor must reconcile their birth records with the enrollment information supplied by MDHHS.

4. Contractors must submit a newborn service request to MDHHS no later than six months following the month for which the Contractor has a record of birth if:

a. MDDHS has not notified the Contractor of an Enrollee birth for two months or more following the month for which the Contractor has a record of birth.

b. The child is born outside Michigan. (p. 27).

## Minnesota

### 3.3.3 Newborns.

3.3.3.1 Mother Enrolled with the MCO under this Contract. Eligible newborns born to mothers enrolled in the MCO under this Contract will be enrolled in the same MCO as the mother for the birth month in accordance with STATE policies and procedures, unless the newborn at the time of enrollment meets one of the exclusion reasons listed in section 3.1.3.

3.3.3.2 Mother Enrolled with the MCO under MSHO, MSC+ or SNBC and the MCO has a Program Covered by this Contract in the Same Service Area. If an eligible newborn is born to a mother who is enrolled with the MCO under MSHO, MSC+ or SNBC and the MCO has a program covered by this Contract in that same Service Area, the newborn will be enrolled in the MCO under this Contract in that service area for the birth month in accordance with STATE policies and procedures, unless the newborn at the time of enrollment meets one of the exclusion reasons listed in section 3.1.3.

3.3.3.3 Mother Enrolled with the MCO under MSHO, MSC+ or SNBC and the MCO does not have a Program Covered by this Contract in the Same Service Area. If an eligible newborn is born to a mother enrolled with the MCO under MSHO, MSC+ or SNBC but the MCO does not have a program covered by this Contract in that same Service Area, the newborn will be enrolled in accordance with STATE policies and procedures.

3.3.3.4 Enrollment within Ninety Days. If a request to enroll a newborn (described in 3.3.3.1 or 3.3.3.2 above) in the MCO is received within ninety (90) days of the birth, the MCO will receive a capitation payment for the birth month and the succeeding months as long as the newborn remains eligible, does not meet an exclusion from enrollment, and there is not a request to change to another MCO. If a request to enroll a newborn described in section (3.3.3.1 or 3.3.3.2 above) in the MCO is not received within ninety (90) days of the birth, the MCO will receive a capitation payment for the birth month only, and the newborn will be enrolled in the MCO for the next available month unless a change of MCOs is requested. (p. 35).

#### Missouri

2.12.11 Newborn Enrollment: The health plan shall have and implement written policies and procedures for enrolling the newborn children of members effective to the date of birth. Newborns of members enrolled at the time of the child's birth shall be automatically enrolled with the mother's health plan. The health plan shall have a procedure in place to refer newborns to the FSD to initiate eligibility determinations. A mother of a newborn may choose a different health plan for her child. However, unless a different health plan is requested, the child shall remain with the mother's health plan.

a. The mother's health plan shall be responsible for all medically necessary services provided under the comprehensive benefit package to the newborn child of an enrolled mother. The child's date of birth shall be counted as day one (1). The health plan shall provide services to the child until the child is disenrolled from the health plan. When the newborn is enrolled by the FSD and entered into the eligibility system, the health plan shall receive capitation payment for the month of birth and for all subsequent

months the child remains enrolled with the health plan.

b. In the case of an administrative lag in enrolling the newborn and costs are incurred during that period, the health plan shall hold the member harmless for those costs. The health plan shall be responsible for the cost of the newborn including medical services provided prior to completion of the State enrollment process. (p. 78).

#### New Hampshire

6.2.15 For each live birth, DHHS will make a one-time newborn kick payment to the MCO with whom the mother is enrolled on the DOB. This payment is a global fee to cover all newborn expenses incurred in the first two (2) full or partial calendar months of life, including all hospital, professional, pharmacy, and other services. For example, the newborn kick payment will cover all services provided in July 2019 and August 2019 for a baby born any time in July 2019. Enrolled babies will be covered under the MCO capitated rates thereafter. (p. 313).

#### New Jersey

3. The system shall be able to identify newborns from the date of birth, submit the proper eligibility form to the State, and link the newborn record to the NJ FamilyCare/Medicaid eligibility and enrollment data when these data are received back from the State. (Art. 3, p. 5).

d. Newborn infants.

The Contractor shall notify DMAHS of a birth immediately to facilitate HMO enrollment of the newborn before the 60-day maternity payment period ends. (See Section B.5.1 of the Appendices, for the applicable Notification of Newborns form and amendments thereto). Coverage of newborn infants shall be the responsibility of the Contractor that covered the mother on the date of birth from the date of birth and for a minimum of 60 days after the birth, through the period ending at the end of the month in which the 60th day falls, unless the baby is determined eligible beyond that point. Any baby that is hospitalized during the first 60 days of life shall remain the Contractor's responsibility until discharge as well as for any hospital readmissions within forty-eight (48) hours of

discharge for the same diagnosis (other than “liveborn infant”). DMAHS will take action with the appropriate CWA to have the infant accreted to the eligibility file and subsequently the enrollment roster of the Contractor. The mother’s MCO shall be responsible for the hospital stay for the newborn following delivery and for subsequent services based on enrollment in the Contractor’s plan. See Article 8 for reimbursement provisions.

i. SSI. Newborns born to an SSI mother who never applies for or may not be eligible for AFDC/TANF remain the responsibility of the mother’s MCO from the date of birth and for a minimum of 60 days after the birth, through the period ending at the end of the month in which the 60th day falls, unless the baby is determined eligible beyond that point. Any baby that is hospitalized during the first 60 days of life shall remain the Contractor’s responsibility until discharge as well as for any hospital readmission within forty-eight (48) hours of discharge for the same diagnosis (other than “liveborn infant”).

ii. DCP&P/DCF. Newborns who are placed under the jurisdiction of the Division of Child Protection and Permanency (DCP&P) are the responsibility of the MCO that covered the mother on the date of birth for medically necessary newborn care.

iii. NJ FamilyCare. Newborn infants born to NJ FamilyCare B, C, and D mothers shall be the responsibility of the MCO that covered the mother on the date of birth for a minimum of 60 days after the birth through the period ending at the end of the month in which the 60th day falls unless the child is determined eligible beyond this time period. The Contractor shall notify DMAHS of the birth immediately in order to assure payment for this period. (Art. 5, p. 7).

### New Mexico

#### 4.2.5 Newborns

4.2.5.1 When a child is born to a mother enrolled in Centennial Care, the hospital or other provider shall complete a Notification of Birth, MAD Form 313, or its successor, prior to or at the time of discharge. HSD shall ensure that upon receipt of the MAD Form 313 the eligibility process is immediately commenced and that upon completion of the eligibility process the newborn is enrolled

into his or her mother’s MCO.

4.2.5.2 Medicaid eligible newborns are eligible for a period of thirteen (13) months, starting with the month of birth. The newborn shall be enrolled retroactively to the month of birth with the mother’s MCO.

4.2.5.3 When a Medicaid-eligible child is born to a mother on the New Mexico Health Insurance Exchange and the mother’s Qualified Health Plan is also a Centennial Care MCO, the newborn shall be enrolled retroactively to the month of birth with that Centennial Care MCO.

4.2.5.4 When a Medicaid-eligible child is born to a mother on the New Mexico Health Insurance Exchange and the mother’s Qualified Health Plan is not a Centennial Care MCO, the newborn shall be auto assigned and enrolled in a Centennial Care MCO (in accordance with Section 4.2.4 of this Agreement) retroactively to the month of birth. The mother shall have one (1) opportunity anytime during the ninety (90) Calendar Days from the effective date of enrollment to change the newborn’s MCO assignment.

4.2.5.5 Newborns are not considered part of the retroactive reconciliation period if the mother of the newborn is enrolled in Centennial Care at the time of delivery. (p. 43-44).

### New York

#### 6.7 Newborn Enrollment

All newborn children not Excluded from Enrollment in the MMC Program pursuant to Appendix H of this Agreement, shall be enrolled in the MCO in which the newborn’s mother is an Enrollee, effective from the first day of the child’s month of birth, unless the MCO in which the mother is enrolled does not offer a MMC product in the mother’s county of fiscal responsibility.

In addition to the responsibilities set forth in Appendix H of this Agreement, the Contractor is responsible for coordinating with the LDSS the efforts to ensure that all newborns are enrolled in the Contractor’s MMC product, if applicable.

The SDOH, NYSoH and LDSS shall be responsible for ensuring that timely Medicaid eligibility determination and Enrollment of the newborns is effected consistent with state laws, regulations, and

policy and with the newborn Enrollment requirements set forth in Appendix H of this Agreement.

Applicable to HIV SNP Program Only:

In addition to the responsibilities set forth above and in Appendix H, the Contractor is responsible for:

- i) Issuing a letter informing parent(s) about newborn child's enrollment or a member identification card within two (2) business days of the date on which the Contractor becomes aware of the birth. The child may be disenrolled at any time at the mother's request;
- ii) Assuring that enrolled pregnant women select a PCP for an infant prior to birth and the mother to make an appointment with the PCP immediately upon birth; and
- iii) Linking the newborn with a PCP within two (2) days of the HIV SNP's notification of the birth. (p. 6-3).

## Ohio

### k. Newborn Notifications.

MCP membership for newborns will be in accordance with OAC rule 5160-26-02, unless otherwise notified by ODM. In order to encourage the timely addition of newborns, authorization for Medicaid and enrollment in the MCP, the MCP shall provide notification of the birth to the CDJFS within five business days of birth or immediately upon learning of the birth. The MCP shall provide the mother's name, social security number, eligibility system case number, 12 digit recipient ID, county of eligibility and the newborn's name, gender, and date of birth in format designated by ODM. The information shall be sent to the CDJFS again at 60 calendar days from the date of birth if the MCP has not received confirmation by ODM of a newborn's MCP membership via the membership roster. If no newborn information is provided by the county within two weeks after the 60 day submission, the MCP shall follow established reconciliation procedures. (p. 36).

## Pennsylvania

### 7. Enrollment of Newborns

The PH-MCO must have written administrative policies and procedures to enroll and provide all Medically Necessary services to newborn infants of Members, effective from the time of birth, without delay, in accordance with Section V.F.12, Services for New Members, and Exhibit BB, PH-MCO Recipient Coverage Document. The PH-MCO must receive advance written approval from the Department regarding these policies and procedures.

The PH-MCO must notify the Department if there are errors or inconsistencies in the newborn's MA or PH-MCO eligibility dates per the established procedures found on the HealthChoices Intranet.

For pregnant members, the PH-MCO must make every effort to identify what PCP/pediatrician the mother chooses to use for the newborn prior to the birth, so that this chosen Provider can be assigned to the newborn on the date of birth.

The PH-MCO is not responsible for the payment of newborn metabolic screenings. (p. 70-71).

## Rhode Island

### 2.05.02.01 Enrollment of Newborns Up to 250% of FPL

The Contractor agrees to have written policies and procedures for enrolling the newborn children of Rite Care and Rhody Health Partners Expansion members effective to the time of birth to conform to Section 0348.75. 10 of the Department of Human Services Manual.

The Contractor will supply EOHHS with all necessary files in order to enroll newborns of the adult expansion population members.

Upon notification from the Contractor of a newborn, EOHHS will make a reasonable effort to: Enter each newborn into EOHHS's eligibility and MMIS systems, in a timely manner; and Pay capitation retroactive to date of birth, in a timely manner. (p. 58).

## South Carolina

### 3.7. Special Rules for Enrollment of Newborns

To ensure Continuity of Care in the first months of the Newborn's life, every effort shall be made by the Department to expedite Enrollment of Newborns into the same CONTRACTOR Health Plan as the mother. See the Managed Care Policy and Procedure Guide for additional information concerning Enrollment policy.

3.7.1. The CONTRACTOR shall comply with S. C. Code Ann. §38-71-140 pertaining to coverage for Newborns and children for whom adoption proceedings have been instituted or completed. The Department will be responsible for paying the required Capitation Payment only for children who are Medicaid Eligible.

3.7.2. The CONTRACTOR shall reimburse the Department for any Claims that the Department pays for Core Benefits rendered to Newborns during any month that the CONTRACTOR received a capitation payment for the Newborn. (p. 30).

## Tennessee

### A.2.4.9 Enrollment of Newborns

2.4.9.1 TennCare-eligible newborns and their mothers, to the extent that the mother is eligible for TennCare, should be enrolled in the same MCO with the exception of newborns that are SSI eligible at birth. Newborns that are SSI eligible at birth shall be assigned to TennCare Select but may opt out and enroll in another MCO.

2.4.9.2 A newborn may be inadvertently enrolled in an MCO different than its mother. When such cases are identified by the CONTRACTOR, the CONTRACTOR shall immediately report to TENNCARE, in accordance with written procedures provided by TENNCARE, that a newborn has been incorrectly enrolled in an MCO different than its mother.

2.4.9.3 Upon receipt of notice from the CONTRACTOR or discovery by TENNCARE that a newborn has been incorrectly enrolled in an MCO different than its mother, TENNCARE shall immediately:

2.4.9.3.1 Disenroll the newborn from the incorrect MCO;

2.4.9.3.2 Enroll the newborn in the same MCO as its mother with the

same effective date as when the newborn was enrolled in the incorrect MCO;

2.4.9.3.3 Recoup any payments made to the incorrect MCO for the newborn; and

2.4.9.3.4 Make payments only to the correct MCO for the period of coverage.

2.4.9.4 The MCO in which the newborn is correctly enrolled shall be responsible for the coverage and payment of covered services provided to the newborn for the full period of eligibility. Except as provided below, the MCO in which the newborn was incorrectly enrolled shall have no liability for the coverage or payment of any services during the period of incorrect MCO assignment. TENNCARE shall only be liable for the capitation payment to the correct MCO.

2.4.9.5 There are circumstances in which a newborn's mother may not be eligible for participation in the TennCare program. The CONTRACTOR shall be required to process claims received for services provided to newborns within the time frames specified in Section A.2.22.4 of this Contract. A CONTRACTOR shall not utilize any blanket policy which results in the automatic denial of claims for services provided to a TennCare-eligible newborn, during any period of enrollment in the CONTRACTOR's MCO, because the newborn's mother is not a member of the CONTRACTOR's MCO. However, it is recognized that in complying with the claims processing time frames specified in Section A.2.22.4 of this Contract, a CONTRACTOR may make payment for services provided to a TennCare-eligible newborn enrolled in the CONTRACTOR's MCO at the time of payment but the newborn's eligibility may subsequently be moved to another MCO. In such event, the MCO in which the newborn is first enrolled (first MCO) may submit supporting documentation to the MCO in which the newborn is moved (second MCO) and the second MCO shall reimburse the first MCO within thirty (30) calendar days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the newborn prior to the newborn's eligibility having been moved to the second MCO. Such reimbursement shall be the actual amount expended by the first MCO. The second MCO agrees that should the second MCO fail to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly docu-



mented request for payment, TENNCARE is authorized to deduct the amount owed from any funds due the second MCO and to reimburse the first MCO. In the event that the CONTRACTOR fails to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE may assess liquidated damages as specified in Section E.29.2. Should it become necessary for TENNCARE to intervene in such cases, both the second MCO and the first MCO agree that TENNCARE shall be held harmless by both MCOs for actions taken by TENNCARE to resolve the dispute.

### Texas

Section 5.03 STAR enrollment for pregnant women and infants.

(a) The HHSC Administrative Services Contractor will retroactively enroll some pregnant Members in a Medicaid MCO based on their date of eligibility.

(b) The HHSC Administrative Services Contractor will enroll newborns born to Medicaid eligible mothers who are enrolled in a STAR MCO in the same MCO for at least 90 days following the date of birth, unless the mother requests a plan change as a special exception. The HHSC Administrative Service Contractor will consider such requests on a case-by-case basis. The HHSC Administrative Services Contractor will retroactively, to date of birth, enroll newborns in the applicable STAR MCO.

Section 5.03.1 Enrollment for infants born to pregnant women in STAR+PLUS.

If a newborn is born to a Medicaid-eligible mother enrolled in a STAR+PLUS MCO, the HHSC Administrative Service Contractor will enroll the newborn into that MCO's STAR MCO product, if one (1) exists. All rules related to STAR newborn enrollment will apply to the newborn. If the STAR+PLUS MCO does not have a STAR product but the newborn is eligible for STAR, the newborn will be enrolled in traditional Fee-for-Service Medicaid, and given the opportunity to select a STAR MCO.

Section 5.05 CHIP Perinatal eligibility, enrollment, and disenrollment

(a) HHSC or the HHSC Administrative Contractor will electronically transmit to the MCO new CHIP Perinate Member information based

on the appropriate CHIP Perinate or CHIP Perinate Newborn Rate Cell. There is no waiting period for CHIP Perinatal Program Members.

(b) Once born, a CHIP Perinate who lives in a family with an income at or below the Medicaid eligibility threshold will be deemed eligible for 12 months of continuous Medicaid coverage (beginning on the date of birth). A CHIP Perinate will continue to receive coverage through the CHIP Perinatal Program as a "CHIP Perinate Newborn" after birth if the child's family income is above the Medicaid eligibility threshold. A CHIP Perinate Newborn is eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal MCO.

(c) Once a CHIP Perinate Newborn Member's coverage expires, the child will be added to his or her siblings' active CHIP program case. If there is no active CHIP program case, then in the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Program Members' information. (p. 29-30).

### Virginia

#### 6.4.A Newborns

The Contractor is responsible for the entire birth month plus two (2) additional consecutive months for all MCO Newborns regardless of whether the newborn receives a Medicaid ID number, unless the MCO Newborn's enrollment is changed during the "birth month plus two (2)" period by the parent or legal guardian electing to change health plans. In such cases, the former MCO is not responsible once the MCO Newborn is enrolled into the MCO selected by the parent or legal guardian. This requirement applies to all Medicaid and FAMIS members.

The obligation of the MCO to cover the MCO Newborn for the "birth month plus two (2)" period is not contingent on the mother's continued enrollment in the MCO; the MCO must cover the MCO Newborn even if the mother does not remain enrolled after

the MCO Newborn's date of birth. The Contractor must ensure that the newborn has a Medicaid ID number before sixty (60) days.

If this Contract is terminated in whole or in part by the Contractor, the Contractor shall continue coverage for the MCO Newborn until the child is enrolled with another MCO in the Department's MMIS, or until the end of the "birth month plus two" period, whichever is earlier.

Any medically necessary claims for an MCO Newborn may not be denied by the MCO for any reason during the "birth month plus two (2)" period, including- but not limited to, lack of service authorizations for newborn services, timely filing issues as a result of delayed or incorrect enrollment of the newborn, medically necessary services received out of MCOs service area, or medically necessary services received from out-of-network providers.

The Contractor is required to reimburse provider(s) if treating the MCO Newborn in the hospital and/or performing follow-up appointments during the "birth month plus two (2)" period, even if that provider is not in the MCO network. In the absence of a provider agreement otherwise, an MCO must reimburse the non-network provider at the Medicaid rate in place at the time the services were rendered.

The Department shall reimburse the Contractor appropriate capitation payment for MCO Newborns for the entire "birth month plus two (2)" period. Any payment for MCO Newborns that is not reflected on the Contractor's 820 Payment Report shall be handled via the reconciliation process as outlined in Section 12 and the Managed Care Technical Manual. All charges for MCO Newborns are the responsibility of the Contractor in all cases.

The Contractor is responsible for advising the parent or guardian of the newborn that Medicaid eligibility rules ensure continuous eligibility for the child up to twelve (12) months following birth; however, to receive coverage, the parent or guardian should contact the Cover Virginia Call center at 1-855-242-8282 or their local DSS office to enroll their newborn. The Contractor shall have written policies and procedures governing the identification of MCO Newborns by their network providers. The Contractor should also encourage contracted hospitals to submit newborns via the streamlined online enrollment process through the Medicaid provider web portal at <https://www.virginiamedicaid.dmas.virginia.gov/>.

The Contractor must report all live births monthly to the Department monthly using the specified format and parameters as documented in the Managed Care Technical Manual. (p. 108-109).

### Washington

#### 4.10 Newborns Effective Date of Enrollment

Newborns whose mothers are Enrollees on the date of birth shall be deemed Enrollees and enrolled in the same plan as the mother as follows:

4.10.1 Retrospectively for the month(s) in which the first twenty-one (21) days of life occur, effective when the newborn is reported to the HCA.

4.10.2 If the newborn does not receive a separate client identifier from HCA, the newborn enrollment will be only available through the end of the month in which the first twenty-one (21) days of life occur.

4.10.3 If the mother's enrollment is ended before the newborn receives a separate client identifier from HCA, the newborn's enrollment shall end the last day of the month in which the twenty-first (21) day of life occurs or when the mother's enrollment ends, whichever is sooner, except as provided in the provisions of Subsection 16.7, Enrollee in Facility at Termination of Enrollment of this Contract.

4.10.4 A newborn whose mother is not covered by Apple Health or any comparable coverage, and the newborn is deemed eligible for Apple Health Medicaid prior to discharge from their initial birth hospitalization shall be enrolled according to HCA enrollment rules. The Contractor will be responsible for hospital costs for the newborn starting from the month of enrollment. (p. 80-81).

### West Virginia

#### 3.2.1.4 Enrollment of Program Newborns

The MCO must have written policies and procedures for enrolling newborn children of Medicaid enrollees retroactively effective to the time of birth. These enrollment procedures must include transfer of newborn information to both BMS and the enrollment broker and must provide for processing completion within thirty (30) calendar days of the date of birth. Newborns of program-eligible mothers who



are enrolled at the time of the child's birth will be enrolled in the mother's MCO.

The MCO is responsible for all Medically Necessary covered services provided under the standard benefit package to the newborn child or an enrolled mother for the first sixty (60) to ninety (90) calendar days of life based upon the cut-off date for MCO enrollment with the enrollment broker. The child's date of birth will be counted as day one. BMS will pay a full month's capitation for all newborns. The MCO will receive capitation payments for all subsequent months that the child remains enrolled with the MCO. The MCO must submit newborn enrollment forms to the enrollment broker within sixty (60) calendar days of the date of delivery or as soon thereafter as the MCO becomes aware of the delivery.

### Wisconsin

#### 8. Newborn Enrollment

If the mother is enrolled in a BadgerCare Plus HMO at the time of birth, and the child is reported to the certifying agency within 100 days of birth, the newborn will be enrolled in the same HMO as the mother back to the infant's date of birth.

If the mother is not enrolled in a BadgerCare Plus HMO on the date of birth, or the child is not reported to the certifying agency within 100 days, then the newborn will be enrolled following the normal ADD methodology for HMO enrollment if applicable. The newborn will be enrolled the next available enrollment month.

Infants weighing less than 1200 grams will be exempt from enrollment if the data submitted to the fiscal agent by the HMO or the provider supports the infant's low birth weight. If an infant weighs less than 1200 grams, the HMO or provider should check the box on the BadgerCare Plus Newborn Report. (p. 34).



# REFERENCES

- 1 Quotation by Sara Rosenbaum. Pear R. U.S. Tightens Medicaid Rules for Babies of Illegal Immigrants. **New York Times**. November 2, 2006.
- 2 U.S. Senate Finance Committee. Statement of Senator Grassley. March 5, 2007. Available at: <https://www.finance.senate.gov/ranking-memb-ers-news/grassley-works-to-make-sure-medicaid-law-works-for-newborn-babies>
- 3 Medicaid and CHIP Payment and Access Commission (MACPAC). Federal Requirements and State Options: Eligibility. Available at: <https://www.macpac.gov/subtopic/low-income-children/>
- 4 Deemed Newborn Eligibility (CFR Sections 435.117 and 457.360). Available at: <https://www.federalregister.gov/d/2016-27844/p-383>
- 5 Centers for Medicare and Medicaid Services. CMS SHO #09-009; CHIPRA #5. Available at: <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO083109b.pdf>
- 6 P. L 111-3 § 111.
- 7 Brooks T, Roygardner L, & Artiga S. Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey. Henry J. Kaiser Family Foundation. March, 2020. Available at: <https://www.kff.org/report-section/medicaid-and-chip-eligibility-enroll-ment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey-executive-summary/>
- 8 Rosenbaum S, Valasquez M, Somodevilla A, Gray E, Morris R, Handley M, & Beckerman JZ. How States are Using Comprehensive Medicaid Managed Care to Strengthen and Improve Primary Health Care. Commonwealth Fund Blog. July 30, 2020. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/how-states-are-using-comprehensive-medicaid-managed-care>
- 9 Cantrell C. Electronic Enrollment of Newborns into Medicaid: Insights from Oklahoma. National Academy for State Health Policy. June, 2010.
- 10 Mathematica. Strategies for Using Vital Records to Measure Quality of Care in Medicaid and CHIP Programs. Technical Assistance Brief. January, 2014. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/using-vital-records.pdf>
- 11 Lloyd PC, Driscoll AK, Simon AE, & Parker JD. Using of the National Health Interview Survey Linked to Medicaid Analytic eXtract Data to Identify Children with Medicaid-Covered Births. **National Health Statistics Reports**. 2018;109. National Center for Health Statistics, Centers for Disease Control and Prevention. US Department of Health and Human Services. Available at: <https://www.cdc.gov/nchs/data/nhsr/nhsr109.pdf>
- 12 Centers for Medicare and Medicaid Services. Data and Measurement: Data Linkage. (Website). <https://www.medicaid.gov/medicaid/quali-ty-of-care/improvement-initiatives/maternal-infant-health/data-and-measurement/index.html>
- 13 Centers for Medicare and Medicaid Services. Transformed Medicaid Statistical Information System (T-MSIS). (Website). <https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html>
- 14 Centers for Medicare and Medicaid Services. Missing Eligibility Group Codes in 2017. TAF DQ Brief No. 4142. 2019. Available at: <https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html>
- 15 Bouchery E. Utilization of Well-Child Care Among Medicaid-Enrolled Children. Mathematica Policy Research. Brief No. 10. 2012. Available at: [https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaiddatasourcesgeninfo/downloads/max\\_ib10\\_wellchild.pdf](https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaiddatasourcesgeninfo/downloads/max_ib10_wellchild.pdf)
- 16 Kuncaitis S, Montebello PM, & Hodges M. Best Practices for Linking Medicaid and Separate CHIP Eligibility Records. Mathematica Policy Research. Brief No. 13. 2012. Available at: [https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MAX\\_IB13\\_LinkingMedicaid.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MAX_IB13_LinkingMedicaid.pdf)
- 17 Wishner, J, Hill I, Marks J, & Thornburgh S. Medicaid Real-Time Eligibility Determinations and Automated Renewals: Lessons for Medi-Cal from Colorado and Washington. Urban Institute. August, 2018. Available at: [https://www.urban.org/sites/default/files/publication/98904/medicaid\\_real-time-eligibility-determinations\\_and\\_automated\\_renewals\\_2.pdf](https://www.urban.org/sites/default/files/publication/98904/medicaid_real-time-eligibility-determinations_and_automated_renewals_2.pdf)
- 18 Andrews M. Many Toddlers Fail to Get Necessary Medicaid Renewal at Their First Birthday. Kaiser Health News. July 12, 2016.
- 19 42 U.S.C. §435.916.
- 20 Hinton E, Rudowitz R, Stolyar L, & Singer N. 10 Things to Know about Medicaid Managed Care. Henry J. Kaiser Family Foundation. October, 2020. Available at: <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>

- 21 Centers for Medicare and Medicaid Services. Medicaid Managed Care Enrollment and Program Characteristics, 2018. Mathematica. Winter 2020.
- 22 Rosenbaum S, Valasquez M, Somodevilla A, Gray E, Morris R, Handley M, & Beckerman JZ. How States are Using Comprehensive Medicaid Managed Care to Strengthen and Improve Primary Health Care. Issue Brief. Commonwealth Fund. July, 2020. Available at: [https://www.commonwealthfund.org/sites/default/files/2020-07/Rosenbaum\\_States MMC\\_ib.pdf](https://www.commonwealthfund.org/sites/default/files/2020-07/Rosenbaum_States MMC_ib.pdf)
- 23 Commonwealth Fund and George Washington University. Medicaid Managed Care Contract Analysis Database. (Website). <https://www.commonwealthfund.org/medicaid-managed-care-database/#/>
- 24 Lee JY, Divaris K, DeWalt DA, et al. Caregivers Health Literacy and Gaps in Children's Medicaid Enrollment: Findings from the Carolina Oral Health Literacy Study. *PLOS One*. 2014;9(10):e110178. doi:10.1371/journal.pone.0110178.
- 25 Pati S, Calixte R, Wong A, Huang J, Baba Z, Luan X, & Canaan A. Maternal and Child Patterns of Medicaid Retention: A Prospective Cohort Study. *BMC Pediatrics*. 2018;18(1):275. doi:10.1186/s12887-018-1242-4.
- 26 Pub. L. 116-127.
- 27 Brooks T & Schneider A. Families First Coronavirus Response Act Medicaid and CHIP Provisions Explained. Georgetown Center for Children and Families. March, 2020. Available at: <https://ccf.georgetown.edu/2020/03/22/families-first-coronavirus-response-act-medicare-and-chip-provisions-explained/>
- 28 National Academy for State Health Policy State Medicaid and CHIP Strategies to Protect Coverage during COVID-19. November, 2020. Available at: <https://www.nashp.org/state-medicare-and-chip-strategies-to-protect-coverage-during-covid-19/>
- 29 Centers for Medicare and Medicaid Services. FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation. June 23, 2020. Available at: <https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf>
- 30 American Academy of Pediatrics, Bright Futures Periodicity Schedule Workgroup. 2020 Recommendations for Preventive Pediatric Health Care. *Pediatrics*. 2020;145(3):e20200013. doi:10.1542/peds.2020-0013.
- 31 American Academy of Pediatrics. Periodicity Schedule. (Website). <https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx>
- 32 Hagan J, Shaw J, & Duncan P. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. (4th Edition). Elk Grove, IL: American Academy of Pediatrics. 2018. Available at: <https://brightfutures.aap.org/Pages/default.asp>
- 33 Artiga S, Pham O, Ranji U, & Orgera K. Medicaid Initiatives to Improve Maternal and Infant Health and Address Racial Disparities. Henry J. Kaiser Family Foundation. November, 2020. Available at: <https://www.kff.org/racial-equity-and-health-policy/issue-brief/medicaid-initiatives-improve-maternal-infant-health-address-racial-disparities/>
- 34 Eckert E. Despite Many States Doing What They Can, The Federal Government Must Act Now to Extend Postpartum Medicaid Coverage. *Health Affairs* (Blog). December 9, 2020. doi:10.1377/hblog20201207.582148
- 35 Clark M. Medicaid and CHIP Coverage for Pregnant Women: Federal Requirements, State Options. Georgetown Center for Children and Families. November, 2020. Available at: <https://ccf.georgetown.edu/2020/11/05/medicaid-and-chip-coverage-for-pregnant-women-federal-requirements-state-options/>
- 36 Johnston EM, McMorro S, Thomas TW, & Kenney GM. ACA Medicaid Expansion and Insurance Coverage Among New Mothers Living in Poverty. *Pediatrics*. 2020;145(5):e20193178. doi:10.1542/peds.2019-3178.
- 37 DeVoe JE, Krois L, Edlund T, Smith J, & Carlson NE. Uninsurance Among Children Whose Parents are Losing Medicaid Coverage: Results from a Statewide Survey of Oregon Families. *Health Services Research*. 2008;43(1 Pt 2):401-18. doi:10.1111/j.1475-6773.2007.00764.x
- 38 Allen EH & Benatar S. Maternity Care Financing: Challenges and Opportunities Highlighted by the COVID-19 Pandemic. Urban Institute. October, 2020. Available at: <https://www.urban.org/research/publication/maternal-care-financing-challenges-and-opportunities-highlighted-covid-19-pandemic>
- 39 Johnson K, Rosenbaum S, & Handley M. The Next Steps to Advance Maternal and Child Health in Medicaid: Filling Gaps in Postpartum Coverage and Newborn Enrollment. *Health Affairs* (Blog). January 9, 2020. doi:10.1377/hblog20191230.967912. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20191230.967912/full/>



Suggested citation: Johnson K. Missing Babies:  
Best Practices for Ensuring Continuous Enrollment  
in Medicaid and Access to EPSDT. Johnson Group  
Consulting, Inc. January, 2021.



<https://www.johnsongci.com>