Policy:	FF.2004
Title:	**Financial Responsibility for Newborn Coverage**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 04/04/2024*
Effective Date:	10/27/1995
Revised Date:	04/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy clarifies the financial responsibility for Covered Services provided to a Newborn, if the mother is eligible for Medi-Cal and enrolled in CalOptima Health Direct or a Health Network.

II. POLICY

A. If a mother of Newborn is a CalOptima Health Direct Member, CalOptima Health Direct shall be financially responsible for Covered Services provided to the Newborn as follows:

1. California Children's Services (CCS) Neonatal Intensive Care Unit (NICU) or Pediatric Intensive Care Unit (PICU) eligible Newborns: Through the second (2nd) month of life, on a fee-for-service basis.

2. Newborns not receiving CCS NICU or PICU Services: Until the Newborn receives a Client Index Number (CIN) from the Social Services Agency (SSA), or through the second (2nd) month of life, whichever is earlier, on a fee-for-service basis, for Non-CCS NICU or PICU services.

B. Capitation Payments made to a Health Network for Covered Services to the mother represent payment in full for Covered Services provided to the Newborn.

C. If a mother of a Newborn is a Health Network Member, the Health Network shall be financially responsible for Covered Services provided to the Newborn as follows:

1. CCS NICU or PICU eligible Newborns: Through the second (2nd) month of life.

2. Newborns not receiving CCS NICU or PICU Services: Until the Newborn receives a CIN from SSA or through the second (2nd) month of life, whichever is earlier.

D. If a Newborn does not have a CIN after the second (2nd) month of life, CalOptima Health or a Health Network shall not be responsible for Covered Services provided to the Newborn.

E. CalOptima Health shall enroll the Newborn in a Health Network upon receipt of a CIN from the SSA, in accordance with CalOptima Health Policies DD.2008: Health Network and CalOptima Health Community Network Selection Process and AA.1207a: CalOptima Health Auto-Assignment.

III. PROCEDURE

A. If a mother of Newborn is a CalOptima Health Direct Member, a Provider or Practitioner shall bill for Covered Services provided to a Newborn as follows:

1. CCS NICU or PICU eligible Newborns: Using the mother's CIN for the first two (2) months of life.

2. Newborns not receiving CCS NICU or PICU Services: Using the mother's CIN for the first two (2) months of life, or until the Newborn is issued their own CIN.

B. If a mother of a Newborn is a Health Network Member, a Provider or Practitioner shall bill for Covered Services provided to a Newborn as follows:

1. CCS NICU or PICU eligible Newborns: Using the mother's CIN for the first two (2) months of life.

2. Newborns not receiving CCS NICU or PICU Services: Using the mother's CIN for the first two (2) months of life, or until the Newborn is issued their own CIN.

C. After the first two (2) months of life, a Provider or Practitioner shall not bill for Covered Services provided to a Newborn under the mother's CIN.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment
D. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-034 (revised): California Children's Whole Child Model Program (supersedes APL 21-005)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/22/2022	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
05/05/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/27/1995	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	11/01/1997	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	05/01/2007	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	11/01/2016	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	05/01/2018	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	05/01/2019	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	08/01/2020	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	05/05/2022	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	03/01/2023	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal
Revised	04/01/2024	FF.2004	Financial Responsibility for Newborn Coverage	Medi-Cal

IX. GLOSSARY

Term	Definition
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima Health for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Client Index Number (CIN)	For the purposes of this policy, refers to the unique 9-digit number assigned to eligible Members enrolled in the Medi-Cal program.
Covered Services	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, this Contract, and APLs that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than 21 years of age. Contractor is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, Contractor is responsible for all Covered

Term	Definition
	Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, Contractor is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with APL 22-012.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Newborn	Means a child under the age of one (1) who was born to a Member during her membership or the month prior to her membership.

Term	Definition
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Licensed Midwife (LM) Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.