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POLICY

This policy applies to The Johns Hopkins Health System (JHHS) and the following entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center (JHBMC), and Howard County General Hospital (HCGH).

PURPOSE

To ensure that JHHS and its affiliated entities provide Medicaid-eligible services to all potentially eligible inpatients in a consistent and timely manner. The policy is limited to services within the state of Maryland and its adjacent neighboring states (Pennsylvania, Delaware, Virginia, West Virginia and the District of Columbia).

This policy applies to all inpatient services and, where practical, to all outpatient services. (For JHH, outpatient services are currently limited to JHOPC.)


The following procedures apply to inpatients within both *unbilled* and *billed* status for JHH and HCGH, but *only billed status* for JHBMC.

PROCEDURES

Inpatient Medicaid Eligibility

1. PFS receives notification of an inpatient admission of an either uninsured or underinsured patient requiring assessment for possible federal Medicaid eligibility via the following sources:
 - a) Event Notice/Facesheet printed from admitting system and distributed to PFS Medicaid Eligibility staff/Sr. Financial Counselor by admitting department staff on the day of admission or first workday thereafter.
 - b) Admitting Financial Counselor/Designated Authorization Group (DAG) determines that recorded insurance is invalid and/or unverifiable (resulting in an uninsured admission) and forwards file to the Sr. Financial Counselor/Medicaid Eligibility unit for eligibility assessment.
 - c) Admitting Financial Counselor/DAG discovers significant lapse in insurance coverage (underinsured) representing 50% or more of total charges, policy termination during an extended inpatient stay, or patient liability known or estimated to be significant (excluding Medicare deductibles and minor insurance co-pays).
 - d) Rejected insurance(s) from PFS where there is still sufficient time (generally 60-90 days from date[s] of service) to initiate a federal Medicaid application.
2. Patient Financial Coordinator (PFC)/Sr. Financial Counselor investigates Keane, Epic, Meditech and other sources for any evidence of insurance missed in the registration process.

If insurance coverage is discovered:

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PFC/Sr. Financial Counselor confirms coverage through insurer/employer and documents host system before forwarding account to Admitting Financial Counseling (AFC)/DAG for full insurance verification and pre-certification where required.

If no evidence of insurance:

- PFC/Sr. Financial Counselor will determine if patient/family/helper can be interviewed to determine potential medical-assistance eligibility;
- Failing that, PFC/Sr. Financial Counselor will contact Social Work/Case Manager/Nurse Manager for assistance/guidance on other options and/or Medical or Case Management staff for assessment of future ability to interview;
- If interview is not possible, consider the assistance of Social Work/Case Manager/Nurse Manager, incapacitation letter, and agency placement for investigation of family/helper or direct representation of patient for eligibility processes.

3. PFC/Sr. Financial Counselor will:

- Interview patient/family/helper in clinical setting;
- Assess eligibility potential, application type (ABD, MCHP, or Family & Children), and where to file (DSS or Health Dept.);
- Obtain (if applicable) patient's signature on JHHS Power of Attorney form, if possible;
- Provide appropriate application and assist with application if necessary;
- Place a 402b (medical report) on patient chart with either a progress note or sticker on front of chart for Medical-staff completion as needed;
- Follow up by retrieving completed documents and noting actions taken and outcome in Keane/Meditech.


4. If 402b not received timely (within two weeks in most cases), PFC/Sr. Financial Counselor will attempt to involve Medical staff, Social Work or Nurse Case Manager on the floor of service. If efforts are unsuccessful, refer to Supervisor/Case Management Director for follow-up with Social Work Director or Department Administrator or MD.

5. If interview reveals clear evidence that patient will **not** qualify for federal Medicaid and has resources to pay, refer to self-pay.

For deposit/payment plan at HCGH, the Sr. Financial Counselor will work with patient to make deposit or payment plan (as appropriate).

If failure to qualify is unrelated to ability to pay and patient appears to meet or possibly meet JHHS Financial Assistance Program criteria, provide an application and refer to self-pay—documenting the host billing system of actions taken.

6. If patient/family/helper either directly refuses an application or appears uncooperative after multiple attempts, consider placement with agency for assistance, submit bad-debt referral form, and document the host billing system if patient is still in-house; if patient has been discharged and final-billed, complete bad-debt referral process.

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7. The PFS Medicaid Eligibility/Sr. Financial Counselor goal, where possible, is to complete the aforementioned processes within forty-eight (48) hours of admission—recognizing that some patients will be discharged without being seen/contacted before these processes can be completed. In such cases all processes shall be attempted via telephone and/or written correspondence.
8. Upon completion of valid application, patient/family/helper can be scheduled for face-to-face interview—where applicable—with on-site Medicaid Caseworker, using either office visit (caseworker location) or floor visit (patient location), as appropriate. If patient/family/helper cannot complete interview, obtain an incapacitation letter from Medical staff for representative interview.
9. Obtain result of the face-to-face interview, including a copy of the 1052 form indicating items needed to finalize the application; document the host billing system to indicate all needed items and application filing date so that applicable statutory deadlines can be determined. If patient remains in-house and a long stay can be anticipated, determine who, if anyone, will retrieve 1052 items and establish contact to determine expectations for completion within deadline.
10. Assess and monitor progress in all cases and document this information in Keane/Meditech, ensuring compliance with applicable deadline (which is routinely 90 days from date[s] of service for initial application initiated at JHHS facility).

Care must be taken to determine if an application may have been initiated *prior to admission*, which can considerably shorten the time frame to complete an application. Give consideration to timing of agency placement and allow sufficient time to complete an application—using two weeks as the absolute minimum.


Following the face-to-face interview a caseworker may close a case within as few as 30 days if all 1052 items are not received; cases can be reinstated within up to 180 days from the date of the first application associated with the current admission.

11. The PFS goal for completion of an application is within thirty (30) days of the date of the face-to-face interview, with a minimum follow-up guideline of every two (2) weeks until completed.

It must be recognized that some cases may require more frequent follow-up; to avoid statutory loss, continuous assessment of compliance and the potential need for agency assistance may be required.

At HCGH the Sr. Financial Counselor will follow up with the on-site MA caseworker on a weekly basis to address outstanding cases.


12. Upon receipt of a valid (EVS'd) Medicaid number:
 - Enter all applicable data in the host billing system (including 216 amount when known);
 - Reclass revenue;
 - Change financial class to T2 (JHH); MAM06M (JHBMC); or MA.MD (HCGH);
 - Enter a reminder or appropriate MCO/MHP insurance group;

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- Forward to appropriate location for pre-billing processes on all accounts *within the consideration period*;
 - Provide data to appropriate staff for the monthly Medicaid number compilation for each entity.
13. If the Medicaid number is obtained on an account placed with agency, perform all above functions after the account has been reinstated to Accounts Receivable from Bad Debt.
 14. All accounts assigned shall be reviewed/updated at least every thirty (30) days, with actions taken documented in the host billing system; this includes accounts assigned to agency >60 days, where current status should be obtained from the agency.
 15. Accounts closed from agency without Medicaid eligibility shall be handled according to the reason for closure:
 - a) *Unable to locate or no cooperation—*
 - JHH:** *If patient is billed and sent routine data mailers, account will be recoded to appropriate collection agency and ARMS status code changed to “804”; if not final-billed and data mailers were not sent, code as self pay (financial class P) and forward to Alpha Commons for handling.*
 - JHBMC:** Change collection agency to appropriate code and Meditech will generate placement file.
 - HCGH:** Change BD agency from MA Extender to appropriate BD agency.
 - b) *Excess assets or income—*

If it appears patient may qualify for Financial Assistance and patient/family was cooperative in process, send Financial Assistance application and recode as above.

 - HCGH:** If within 90 days of discharge, change to self pay; if outside of 90 days, update to BD agency.
 - c) *Denied as not disabled after appeal, patient would qualify on financial criteria, and there is no potential third-party liability—*
 - JHH:** Change to financial class “TS” after reinstatement from bad debt.
 - JHBMC:** Change ARMS status to “804” and re-place account with appropriate collection agency; change collection agency code to appropriate agency for system placement.
 - HCGH:** Change to SP and offer hospital financial assistance to patient. Outside the 90 days update to BD agency.

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- d) *As above (c) except possible third-party liability circumstance (accidental injury, criminal injury)—*

Recode to appropriate collection agency as in “a” above to pursue possible liability.

HCGH: Update to appropriate vendor to pursue.

16. Special Programs:

- a) *Maryland Children’s Health Program (MCHP)*—Use abbreviated application without attachments and no disability determination for pregnant women and all minor children under the age of nineteen (19) who are United States citizens. Send application to local department of health rather than social services and follow up more frequently (weekly)—because Medicaid number is routinely generated considerably faster than with a traditional application.

- b) *Newborns of a Medicaid-eligible mother*—Coordinate with Medicaid pre-billing staff to ensure that the Department of Health and Mental Hygiene (DHMH) Form 1184 is filed in a timely fashion (within three [3] days of birth), whenever possible, and follow up as in a, directly above.


HCGH: The Sr. Financial Counselor will complete the 1184 Form and ensure completion.

- c) *Children’s Protective Services*—Cases assigned to this DHMH unit will automatically obtain Medicaid without action on our part, but eligibility dates will begin with the date of assignment to CPS, which will most often postdate the JHH admit date. We must do a retroactive regular Medicaid application unless the CPS application falls within the same month that we have already made an MCHP application. In the case of a regular retroactive application, strong consideration must be given to agency placement, as there will be no available family member to complete the application.

- d) *Breast and Cervical Cancer Program*—Patients are routinely admitted to this program prior to admit but must be reviewed to ensure that services provided all relate to the cancer diagnosis; otherwise a regular Medicaid application must be initiated.

- e) *Foreign National Emergent Services*—Only foreign nationals who have established permanent residence and hold a Green Card dated August 1997 or earlier may make a regular Medicaid application. All other foreign nationals may apply for true emergent services only and may be treated up to the “point of stabilization.” No elective or urgent services are covered, and the patient must meet all of the normal financial considerations for regular federal Medicaid.

- f) *Family and Children Program*—Use abbreviated application both for adult household members and children under the age of 18 who are United States citizens and permanent residents of Maryland. Income scale is 115% of the federal poverty level for given household size. File application with the local health department unless concurrently

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applying for Temporary Cash Assistance and/or food stamps—which **must** be filed with the local department of social services. No face-to-face interview or asset test is required. Income is declaratory and proof is **not required**. Proof of identity and citizenship is **required**.

Performance Expectation


1. Initiate work on all cases on day of receipt.
2. Complete transfer of converted cases where insurance discovered to AFC/DAG and Pre-certification, where applicable, on day of discovery.
3. Attempt to complete interviews for all in-house cases at least daily until assessment as to potential eligibility has been made; enlist aid of Social Work, Medical staff and/or Medical Case Management as needed.
4. Goal is to complete an application within forty-eight (48) hours of receipt of case, schedule face-to-face interview while patient is in-house, and obtain completed 402b within one (1) week of placement on chart.
5. Complete and mail/fax (as appropriate) MCHP and/or Family & Children's application while patient is in-house and within same month as admit.
6. Obtain 1052 immediately following face-to-face interview and document needed items in Keane or Meditech.
7. Follow up at least bi-weekly on 1052 items needed to complete the application.
8. Follow up at least monthly on applications awaiting certification or SRT determination.
9. Follow up at least monthly on cases placed with agency sixty (60) days or more.

Critical Path Deadlines

1. Applications should be filed at JHH, HCGH, or JHBMC casework office or local or county district within six (6) weeks from discharge (on stays of less than thirty [30] days), or as appropriate to avoid statutory loss (on longer stays), or consider agency placement; absolutely submit applications for agency placement approval(s) if not on file by nine (9) weeks from discharge (sooner on long stays) unless agency already has JHHS-affiliate account placed that is within the same consideration period.
2. All 1052 items submitted for application must be completed and receipt verified by caseworker by twenty-one (21) weeks (approximately 150 days) from discharge—assuming short stay (see discussion above), or consider agency placement.
3. Consideration for agency placement can be initiated at any point from day of admission if there is compelling reason to do so. To avoid loss, PFC/Sr. Financial Counselor should continually assess patient/family/helper compliance in relation to federal Medicaid eligibility statutes.

Border States Medicaid Eligibility (JHH/HCGH only)

1. Patients who reside in states that border Maryland (Pennsylvania, Virginia, West Virginia and the District of Columbia) and indicate that they intend to apply for Federal Medicaid in their home state shall be followed by PFS Medicaid Eligibility staff/Sr. Financial Counselor. Unless there is compelling evidence that the patient has both the means and motivation to

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complete such an application in a timely and prompt fashion, most such cases will be placed with agency to promote compliance and provide resources for proper & timely completion of the application process.

Citizens of U.S. states other than those listed above shall **not** be tracked by PFS Medicaid Eligibility/Sr. Financial Counselor and are treated as self-pay until such time as a verified Medicaid number is obtained.

Note: The border state of **Delaware** does not permit retroactive Medicaid applications in Maryland hospitals until an inpatient has had an uninterrupted stay of thirty (30) days or more. A patient from Delaware who initiates an application in that state *before becoming an inpatient* may receive coverage for the stay—or, once hospitalized for thirty (30) days, may receive coverage for subsequent inpatient days. All Delaware cases will be referred to an Agency Extender, and the first thirty (30) non-covered days will be considered a self-pay responsibility.

2. HCGH:


- Cases identified in 1 above are categorized as insurance code **MA.Pend** and revenue is reclassified as such;
- Once a verified Medicaid number is obtained, the appropriate OOS MA insurance code is assigned;
- Revenue is reclassified and the bill is queued.

3. JHBMC:

Similar cases are treated as self-pay accounts until such time as the patient/family/helper has produced a verified Medicaid number from their home state.

Outpatient Medicaid Eligibility (JHH/HCGH only)

1. PFS Medicaid Eligibility staff /Sr. Financial Counselor do not routinely follow JHH/HCGH Outpatients; there is normally insufficient interview capability for JHH-housed Medicaid Caseworkers to take Outpatients because all available staff for face-to-face interviews are exhausted by JHH Inpatients. HCGH does not have such limitations. Exceptions can and have been made for certain patients for whom it is known that extensive OPD costs will be incurred (e.g., extended course of chemotherapeutic treatments, etc.).
2. PFS has made budgetary provision for a vendor-staffed Medicaid Extender housed within JHOC to serve Outpatients seen both there and at other OPD clinics. Referral to the Extender can be made by clinical staff, Social Work, Patient Service Coordinators (PSCs) and JHOC Financial Counselors.
3. The Medicaid Extender will see patients on an ad hoc basis and counsel/assist them in completion of the appropriate Medicaid application (individual, family, MCHP, and Breast & Cervical Cancer). The patient will then be instructed to complete the application process within their home county/municipality at either the local department of Social Services or Health Department, as appropriate.

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4. Because of the volume of patients, OPD Extender cases cannot be tracked on a routine basis but patients are encouraged to report progress/completion to the Extender and the referring source as well as to any additional provider of service.

SPONSOR

Senior Director, Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years

APPROVAL



 Senior Director, JHHS

_____ Date



 Director, PFS Operations, JHHS

 2/20/09
 _____ Date