# Money Follows the Person

Change in Eligibility Guidelines –
Effective July 2010

# Former MFP Eligibility Standards

- Qualified institutional stay (nursing home) of six (6) months or more.
- Medicaid beneficiary/recipient a minimum of one month prior to community transition
- Nursing home level of care (DoN score) for IDoA & DRS participants

# New MFP Eligibility Standards

- Qualified institutional stay (nursing home) of 90 days or more
  - Any days an individual spends in an institution receiving short-term rehabilitative services will "not be taken into account for purposes of determining the 90-day period."
- Medicaid beneficiary/recipient for a minimum of one day prior to community transition
- Nursing home level of care (DoN score) for IDoA & DRS participants

# Definition of short-term rehabilitative days

- A nursing home stay that is ordered by a physician *and*
- Requires skills of technical or professional personnel such as nurses, physical, occupational & speech &/or hearing therapists *and*
- Are furnished directly by & supervised by one of these professions *and*
- Person received inpatient treatment in a hospital prior to admission *and*
- Is now a current resident of a skilled nursing unit paid for in whole or in part by Medicare.

# Medicare Skilled Nursing (SNF) Benefits

- Costs to insured/patient:
  - Day 1 – 20: $0 each day (Traditional Medicare covers at 100%)*
  - Day 21 to 100: up to $137.50 each day
  - Beyond 100 days: 100% of costs are insured/patient's responsibility
- There is a limit of 100 days of Medicare Part A SNF coverage in each benefit period
  - A benefit period begins with a new hospitalization & a period of at least 60 days between hospitalizations

* Medicare Advantage (HMO) plans vary & may have co-payments beginning on the first day of admission to a Skilled Nursing Facility.

# Examples of medical treatments provided in a SNF

- An older adult with a history of diabetes & angina who is recovering from an open reduction of a fracture of the femur requires careful skin care, oral medications, exercise to preserve muscle tone & observation
- A patient with congestive heart failure may require observation to detect signs of decompensation, abnormal fluid balance or adverse effects of medications
- A patient who has had a recent leg amputation needs rehabilitative services for gait training & to teach prosthesis care

*All of the above examples were taken from 42 CFR 409.31* - Level of care requirement. - Code of Federal Regulations - Title *42*: Public Health - TITLE *42* - PUBLIC HEALTH *CHAPTER IV* - CENTERS FOR MEDICARE AND MEDICAID

# Examples of qualifying services in a SNF

- Intravenous *(injections into a vein)* or intramuscular injections & intravenous feedings
- Enteral *(via the digestive track)* feeding that comprises at least 26% of daily calorie requirements & provides at least 501 milliliters of fluid
- Nasopharyngeal & tracheosotomy aspiration
- Insertion & sterile irrigation & replacement of suprapubic catheters
- Dressings involving prescription medication & aseptic techniques
- Treatment of extensive decubitus ulcers

# Case study of Mary

- Mary, a 72 year old recipient of Social Security & Medicare has a history of severe arthritis & congestive heart failure. She is hospitalized after a fall resulting in a hip fracture & subsequent orthopedic surgery. After five days in the hospital after her surgery, she transfers to a SNF for wound care & physical therapy utilizing her Medicare Part A SNF benefit. After six weeks or 42 days in the SNF, she has met her rehabilitative goals & no longer qualifies for Medicare SNF benefits. However, Mary finds that she feels too weak to return home & decides to remain at the nursing home. Because of limited assets, during the first few weeks, she applies for Medicaid. On day 60 of her nursing home stay she is visited by a MFP transition coordinator. She tells the nice transition coordinator that she wants to return home.
- Does Mary qualify for MFP?

# Transition Coordinator's response to Mary:

- Mary has only experienced a total of 48 qualifying days towards her count of 90 days in a nursing home.
- Even though Mary has resided in the nursing home for 90 days already, she will need to reside in the nursing home for 42 more days before she qualifies for MFP. The 42 Medicare paid-for SNF days do not count towards the minimum of 90 qualifying days.
- The transition coordinator may begin working with Mary, but she cannot receive the benefits under MFP till she reaches a total of 132 days or close to 4 1/2 months.

# Case study of Eric

- Eric is referred to the transition coordinator for a first contact assessment. During their discussion, Eric states that he has resided at the nursing home for the past five months. Eric shows that he has limited use of his right arm caused by a bus accident. He has several physical challenges to performing many of his activities of daily living such as personal care & eating. In addition, Eric has a diagnosis of insulin dependent diabetes.
- When the transition coordinator was reviewing Eric's medical chart at the nursing home, she notes that Eric has both Medicare and Medicaid & that while he was admitted to the nursing home five months ago, he initially received intensive physical therapy & IV therapy for his diabetes. The nurse now gives Eric shots of insulin for his diabetes.
- The transition coordinator explores with nursing home staff & learns that Eric was admitted to the nursing home's skilled nursing unit & received skilled nursing & therapy for 20 days.
- Does Eric qualify for MFP?

# Transition Coordinator's response to Eric:

- At the time of the first contact with Eric, he had lived at the nursing home for 150 days or five months. He experienced a total of 130 qualifying days, because 20 of those days were days in which he received rehabilitative services paid for by Medicare. The 130 days exceeds the minimum number of 90 days in a nursing home.
- The transition coordinator may begin working with Eric; he is currently eligible for MFP at this time.