

Coverage Summary

Change in Membership Status while Hospitalized (Acute, LTC and SNF) or Receiving Home Health

Policy Number: C-005	Products: UnitedHealthcare Medicare Advantage Plans	Original Approval Date: 11/17/2015
Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee		Last Review Date: 10/20/2020

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The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

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I. COVERAGE

Coverage Statement: Financial payment responsibility of covered services when a beneficiary changes membership status while hospitalized or receiving home health services is dependent on Medicare regulations.

Guidelines/Notes:

1. Hospitalization in an inpatient acute care hospital, inpatient psychiatric hospital, inpatient rehabilitation facility or a long term care hospital.
 - a) When UnitedHealthcare coverage begins during an inpatient hospital stay (see Definition Section for definition):
 - 1) The member's previous health plan (e.g., another Medicare Advantage organization or Medicare) will continue to pay for Part A inpatient services until the date of the member's discharge.
 - 2) UnitedHealthcare is not responsible for the Part A inpatient services until the date after the member's discharge.
 - 3) UnitedHealthcare is responsible for Part B charges starting on the date the member

becomes eligible with UnitedHealthcare Medicare Advantage plan.

- b) When UnitedHealthcare coverage ends during an inpatient hospital stay (see Definition Section for definition):
 - 1) UnitedHealthcare is responsible for the Part A inpatient services through the beneficiary's discharge date.
 - 2) The member's succeeding health plan (e.g., another Medicare Advantage organization or Medicare) is not responsible for Part A services provided during the remainder of the beneficiary's inpatient hospital stay.
 - 3) UnitedHealthcare is not responsible for Part B charges incurred during the remainder of the member's inpatient hospital stay.
2. Hospitalization in a Medicare certified skilled nursing facility (SNF)
 - a) UnitedHealthcare is responsible for all services beginning on the member's effective date with the UnitedHealthcare Medicare Advantage plan.
 - b) When a member disenrolls, UnitedHealthcare is not responsible for any services beginning the day after disenrollment.
3. Home Health
 - a) If a beneficiary was enrolled with UnitedHealthcare before start of home health care, UnitedHealthcare is liable until the member's disenrollment. Upon disenrollment, an episode must be opened under home health PPS for billing Medicare.
 - b) If a beneficiary was not a UnitedHealthcare Medicare Advantage member upon admission to home health, but enrolls with UnitedHealthcare Medicare Advantage before discharge from home health, UnitedHealthcare is not responsible for payment.
 - c) If the home health provider is not a PPS provider, UnitedHealthcare is responsible for payment for services on and after the day of enrollment up through the day that disenrollment with UnitedHealthcare is effective.

4. Continuation of Care

Terminating MA (Medicare Advantage) organizations and those plans reducing their service area may, in certain situations, be responsible for costs incurred for Medicare beneficiaries hospitalized beyond the last day of the contracts.

- If the Medicare beneficiary is hospitalized in a prospective payment (PPS) hospital, the Medicare Advantage is responsible for all Part A inpatient services until the beneficiary is discharged. Original Medicare or beneficiary next Medicare-contracting managed care organization will assume payment for all services covered under Part B after the termination Medicare Advantage organization's Medicare Advantage contract ends.
- If a Medicare beneficiary is in a non-PPS hospital, your organization is responsible for the covered charges through the last day of your contract or, for plans reducing their service areas, the last day in which service in a particular county are discontinued.

With respect to member receiving care in a skilled nursing facility (SNF) upon the termination of the Medicare Advantage contract, terminating Medicare Advantage organization are financially liable for such care through December 31 of the final contract year. After that date, Medicare beneficiaries continuing a SNF stay may receive coverage through either fee-for-service Medicare or enrollment in another Medicare Advantage plan. Assuming that the SNF stay is Medicare covered the number of days of the beneficiary's SNF stay while enrolled in

the Medicare Advantage plan will be counted toward the 100-day Medicare limit.

Also see the [Coverage Summary for Hospital Services \(Inpatient and Outpatient\)](#) and the [Coverage Summary for Skilled Nursing Facility \(SNF\) Care and Exhaustion of SNF Benefits](#).

II. DEFINITIONS

Hospital Discharge: A hospitalized member is considered discharged when that member is formally released from the hospital or dies; or member is transferred from a hospital to the care of another hospital or from one inpatient area or unit of a hospital to another inpatient area or unit of the hospital. [Code of Federal Regulations 42 CFR §412.4 Discharges and transfers](#). (Accessed October 8, 2020)

Inpatient Hospital Stay: An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. [Medicare Benefit Policy Manual, Chapter 1, §1 – Definition of Inpatient Hospital Services](#). (Accessed October 8, 2020)

Prospective Payment System (PPS): A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. [CMS Prospective Payment Systems – General Information](#). (Accessed October 8, 2020)

III. REFERENCES

[Code of Federal Regulations 42 CFR §422.318 Special Rules for coverage that begins or ends during an inpatient hospital stay](#). (Accessed October 8, 2020)

[Medicare Claims Processing Manual, Chapter 1, § 90 – Patient Is a Member of a Medicare Advantage \(MA\) Organization for Only a Portion of the Billing Period](#). Accessed October 8, 2020.

[Medicare Managed Care Manual, Chapter 11, §70.2 – Responsibilities of Non-renewing MA Organizations](#). Accessed October 8, 2020.

[Social Security Act 1886 Title XVIII, Part E, §1861 – Definition of Services, Institutions](#). Accessed October 8, 2020.

IV. REVISION HISTORY

10/20/2020 • Routine review; no change to coverage guidelines