ADMINISTRATIVE POLICY STATEMENT
D-SNP

Policy Name & Number	Date Effective
Acute Hospital Care at Home-DSNP-AD-1367	11/01/2024
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

This policy applies to the following Marketplace(s):	
☒ **Georgia**	☒ **Ohio**

Table of Contents

A. Subject
Acute Hospital Care at Home

B. Background
The Johns Hopkins School of Medicine created a hospital at home program in 1995 to provide safe and effective hospital level care in the home setting. Since then, numerous studies and trials have evaluated and demonstrated the efficacy of this model.

In November 2020, the Centers for Medicare & Medicaid Service s (CMS) initiated a program to allow patients to be treated outside the traditional hospital setting in an effort to increase health care system capacity amid an increasing number of coronavirus disease (COVID-19) hospitalizations. Health care organizations are using an innovational care model for hospital care in the home as a full substitute for acute hospital care. The model was developed to support acute hospital care in the home setting following reports of success in leading hospital institutions and networks. CMS believes that treatment for more than 60 different acute conditions, such as exacerbations of asthma, congestive heart failure, pneumonia and chronic obstructive pulmonary disease (COPD) care can be treated appropriately and safely in home settings with proper monitoring and treatment protocols.

Participating hospitals are required to have appropriate screening protocols before care at home begins to assess both medical and non-medical factors, including working utilities, assessment of physical barriers and screenings for domestic violence concerns. Beneficiaries will only be admitted from emergency departments and inpatient hospital beds, and an in-person physician evaluation is required prior to starting care at home. A registered nurse will evaluate each patient once daily, either in person or remotely, and two in-person visits will occur daily by either registered nurses or mobile integrated health paramedics based on the patient's nursing plan and hospital policies.

This program is designed for patients who meet acute inpatient or have failed observation admission criteria for hospital-level care and can be treated safely in a home setting with appropriate monitoring and treatment protocols. The patient's home is considered part of the hospital during the admission.

The program does not have to be physically administrated within a hospital, but a hospital must accept responsibility for the program in order to satisfy the Conditions of Participation (CoP) for this level of patient care. Additionally, the program must be integrated within a hospital to a sufficient degree to ensure that rapid escalation of care is seamless. The program will be closely monitored to safeguard members. Hospitals will be required to report quality and safety data on a frequency that is based on their prior experience with the Hospital at Home model. (CMS 2021)

Hospitals must submit an application to CMS in order to qualify and be certified to participate in this program. This information can be accessed on the CMS website. Waiver requests will be divided into two categories based on the hospital applicant's prior experience with acute hospital care at home. Participating hospitals are required to

submit appropriate screening protocols for medical necessity review before care at home begins.

C. Definitions
- **Health Care Facilities Code (HCFC)** – A set of requirements intended to provide minimum requirements for the installation, inspection, testing, maintenance, performance and safe practices for facilities, material, equipment, and appliances.
- **Life Safety Code (LSC)** – A set of fire protection requirements designed to provide a reasonable degree of safety from fire.
- **Remote Monitoring** – Monitoring of physiologic parameters, including weight, blood pressure, heart monitoring, pulse oximetry, and respiratory flow rate.

D. Policy
I. CareSource considers acute hospital care at home medically necessary when **ALL** of the criteria in this policy are met. A prior authorization will be required for the approval of acute hospital care at home services. Appropriate and complete documentation to support medical necessity must be presented at the time of the review. Participating hospitals should submit appropriate screening protocols for medical necessity review before care at home begins. Acute hospital care at home services are subject to subsequent reviews following initial approval. Reviews will be based on clinical status of the member, and additional documentation may be requested.
   A. CMS-Approved Requirements for Participating Hospitals
      1. The hospital must be CMS-certified.
      2. Participating hospitals are required to have appropriate screening protocols in place before care at home begins, including all the following:
         a. Verification that the member's home meets their needs for safety, shelter and basic working utilities, including completion of a HCFC and LSC form;
         b. Assessment of physical barriers; and
         c. Screenings for domestic violence concerns and completion of form.
      3. The member's broadband service must meet 4G/5G requirements.
      4. The member needs inpatient-level of hospital care.
      5. The member must be identified and assessed by hospital staff as meeting the qualifying criteria for home admission and treatment.
      6. The member must sign a consent agreeing to receive care at home under the program.
      7. The member must meet one of the following acute conditions including, but not limited to:
         a. Exacerbations of Congestive Heart Failure
         b. Community-Acquired Pneumonia
         c. Exacerbations of Chronic Obstructive Pulmonary Disease (COPD)
         d. Exacerbations of Asthma
         e. Cellulitis
         f. Urinary Tract Infection (UTI) or
         g. Volume depletions / dehydration.

8. The member must enter the acute hospital care at home from either the Emergency Department or an inpatient hospital setting.
9. An in-person physician evaluation and exam must be completed prior to the member being transferred home.
    a. The in-person physician exam may be performed by the inpatient hospitalist, admitting physician or emergency room physician.
    b. The in-person physician evaluation must be performed by the same or designated physician completing the initial history and physical exam documentation and admission orders consistent with hospital policies.
10. The member must be considered clinically and hemodynamically stable.

B. Home Care Requirements
    1. The assigned physician must complete daily evaluations (telehealth or in-person) of the member, including an assessment and continued management of appropriate diagnostic and therapeutic measures.
        a. The physician must make one or more visits daily and must be available 24 hours a day, seven days a week for any emergent issues.
        b. Provider assessments should be consistent with the existing medical staff policies for requirements for physical assessments.
    2. Daily in-person visits
        a. An RN must evaluate the member daily. This may be in-person or remotely. An RN must be available 24/7 in person and remotely.
            01. Two daily in-person (not remote) visits are required with a set of vital signs and may be performed by: An RN, if the team determines that an RN should see the patient in-person; or
            02. A Mobile Integrated Health Paramedic if the team determines this is appropriate.
    3. Remote monitoring
        a. Remote monitoring must be consistent with the hospital policies and standards of care.
        b. Remote monitoring can be continuous or intermittent, and the intensity should be appropriate according to each member's needs.
        c. Assistive technology may be used for auscultative transmission of heart and lung exams.
            01. If physician or APP performed heart and lung exams are indicated, they may be performed via technological transmission or in-person examination.
            02. It is also acceptable to verify these parts of the exam with the RN and/or paramedic and exclude them from the daily physician exam based on the member's condition.
    4. Discharge Planning
        Documentation should support the following discharge standards:
        a. A discharge plan that includes the provider(s) responsible for follow up care (the discharge planning evaluation should be used as a guide in the development of the discharge plan)

b. All necessary medical information pertinent to illness and treatment, and post-discharge goals of care were provided to the appropriate post-acute care service providers at the time of discharge
c. Coordination and/or referrals with the CareSource case manager, community agencies, and providers responsible for follow up care
d. Completion of medication reconciliation/management
e. Needed DME and supplies are in place prior to discharge
f. Scheduled appointments are listed with dates, times, names, telephone numbers and addresses
g. Member/guardian and family engagement, as needed

II. Quality of Care
A. Hospitals are required to maintain specific standards of care to ensure patient safety and high quality of care, including tracking and maintaining documentation of preventable and non-preventable adverse events. CareSource may request documentation regarding hospital at home incidents and healthcare acquired conditions, including but not limited to the following:
1. falls with serious injury
2. pressure ulcers and injuries
3. catheter-associated urinary tract infections (CAUTI)
4. vascular catheter-associated conditions
5. patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
6. patients' death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
7. patient's suicide, or attempted suicide resulting in serious disability while being cared for in a hospital at home setting
8. serious injury to staff secondary to assault in the home environment

III. This program is not intended to be used by independent nursing home facilities that are not associated with the hospital participating in the acute hospital care at home program.

E. Conditions of Coverage
NA

F. Related Policies/Rules
Sentinel Events and Provider Preventable Conditions

G. Review/Revision History

	DATE	ACTION
Date Issued	09/15/2021	New Policy
Date Revised	05/11/2022 08/16/2023 08/14/2024	Changed from Medical to Admin. Added UTI and 26th ed. MCG references. Added new MCG Covid-19: Hospital-at-Home. M-281-HaH (ISC). Updated references. Approved at Committee Added Sentinel Events and Provider Preventable Conditions to Section F. Related Policies/Rules. Updated references. Approved at Committee.
Date Effective	11/01/2024	
Date Archived		

H. References

1. Acute hospital care at home individual waiver only (not a blanket waiver). Centers for Medicare and Medicaid Services. Accessed July 2, 2024. www.cms.gov
2. Acute hospital care at home resources. QualityNet, Centers for Medicare and Medicaid Services. Updated August 24, 2023. Accessed July 2, 2024. www.qualitynet.cms.gov
3. Cellulitis: hospital-at-home: M-70-HaH. MCG Health. 28th ed. 2024. Accessed July 2, 2024. www.careweb.careguidelines.com
4. Chronic obstructive pulmonary disease: hospital-at-home: M-100-HaH. MCG Health. 28th ed. 2024. Accessed July 2, 2024. www.careweb.careguidelines.com
5. Clarke DV, Newsam J, Olson DP, et al. Acute hospital care at home: the CMS waiver experience. *NEJM Catalyst*. December 7, 2021. doi:10.1056/CAT.21.0338
6. CMS announces comprehensive strategy to enhance hospital capacity amid COVID-19 surge. News release. Centers for Medicare and Medicaid Services. November 25, 2020. Accessed July 2, 2024. www.cms.gov
7. Covid-19: hospital-at-home: M-281-HaH. MCG Health. 28th ed. 2024. Accessed July 2, 2024. www.careweb.careguidelines.com
8. Friedberg M, Landon B. Measuring quality in hospitals in the United States. UpToDate. Updated April 10, 2024. Accessed July 2, 2024. www.UpToDate.com
9. Heart failure: hospital-at-home: M-190-HaH. MCG Health. 28th ed. 2024. Accessed July 2, 2024. www.careweb.careguidelines.com
10. Hospital at home. John Hopkins Medicine Healthcare Solutions. Accessed July 2, 2024. www.johnhopkins.com
11. Leff B, Burthon L, Mader SL, et al. Hospital at home: feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients. *Ann Intern Med*. 2005;143(11):798-808. doi:10.7326/0003-4819-143-11-200512060-00008
12. Life safety code and health care facilities code requirements. Centers for Medicare and Medicaid Services. Accessed July 2, 2024. www.cms.gov
13. *National Patient Safety Goals Effective January 2021 for the Hospital Program*. The Joint Commission; 2021. Accessed October 2, 2023. www.jointcommission.org
14. Pneumonia: hospital-at-home: M-282-HaH. MCG Health. 28th ed. 2024. Accessed July 2, 2024. www.careweb.careguidelines.com

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.

15. Shepperd S, Iliffe S, Doll HA, et al. Admission avoidance hospital at home. *Cochrane Database Syst Rev*. 2016;9:CD007491. doi:10.1002/14651858.CD007491.pub2
16. Urinary tract infection (UTI): hospital-at-home: M-300-HaH. MCG Health. 28th ed. 2024. Accessed July 2, 2024. www.careweb.careguidelines.com
17. Viral illness, acute: hospital-at-home: M-280-HaH. MCG Health. 28th ed. 2024. Accessed July 2, 2024. www.careweb.careguidelines.com
18. West N, Eng T. Monitoring and reporting hospital-acquired conditions: a federalist approach. *Medicare Medicaid Res Rev*. 2015;4(4):e1-e16. doi:10.5600/mmrr.004.04.a04