MASSACHUSETTS
HEALTH POLICY COMMISSION

HOSPITAL AT HOME IN MASSACHUSETTS:

TRENDS IN AN EMERGING CLINICAL MODEL

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EXECUTIVE SUMMARY

Through the 'hospital at home' model, hospitals provide acute care in a patient's home rather than in a traditional inpatient hospital setting. This model of care has expanded dramatically in Massachusetts and nationwide since the Centers for Medicare & Medicaid Services (CMS) launched the Acute Hospital Care at Home (AHCAH) program in November 2020 in the context of concern about hospital capacity during the COVID-19 pandemic. As of August 2025, Massachusetts has eight active hospital at home programs and 20 total hospitals approved for an AHCAH waiver.

Hospital at home programs provide hospital-level services such as nursing, diagnostic, and therapeutic services in a patient's home. Medicare's AHCAH program waives some inpatient care requirements, such as the requirement to have nursing services available on the premises 24/7, while adding others such as twice-daily in-person visits by clinical staff. These programs offer services that a patient would normally receive in a hospital, including daily in-person and virtual visits, 24/7 connection via telehealth, oral and IV medication, diagnostic testing, specialty consultation, oxygen, therapy, social work, and food services. In a traditional inpatient stay, aide services (such as assistance with dressing, eating, and toileting) are fully provided by hospital staff. For a hospital at home stay, this assistance is often provided by a family caregiver or a care aide privately employed by the patient. However, some hospitals provide aide services in their hospital at home programs.

To be eligible for hospital at home, a patient must require hospital-level care but be stable enough to be treated at home. AHCAH allows two avenues for admission: (1) admission avoidance, where patients are admitted to hospital at home directly from the emergency department, and (2) transfer to hospital at home or continuing hospitalization, in which a patient is transferred from a traditional inpatient setting to hospital at home. Other requirements include living within 30 minutes driving distance of the participating hospital in case an emergency transfer is necessary and having a home environment conducive to receiving hospital-level care.

Under AHCAH, Medicare fee-for-service pays the same amount for hospital at home care as for traditional inpatient care. MassHealth also pays at parity between settings. Commercial payers may have other program requirements and may have different payment approaches.

The Health Policy Commission (HPC) studied hospital at home in Massachusetts by using the Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database to identify hospital at home discharges and create a comparison group of traditional inpatient discharges. To create the comparison group, the HPC matched hospital at home discharges with traditional inpatient discharges in each year on the basis of same hospital, All Patient Refined Diagnosis Related Group (APR-DRG), and severity of illness (SOI). The average length of stay and charges per discharge for each hospital-DRG-SOI mix was calculated for both hospital at home and the traditional inpatient sample. The HPC studied discharges in Massachusetts from January 2020 to December 2024.

The number of hospital at home discharges in Massachusetts in 2024 was nearly ten times greater than in 2020. Even with this rapid growth, hospital at home discharges remain a small share of total inpatient discharges, representing approximately 0.6% of total inpatient discharges. The most common DRGs were sepsis, chronic obstructive pulmonary disease (COPD) and respiratory infections, and heart failure. From January 2024 to December 2024, 65.8% of hospital at home discharges were Medicare patients, while commercial and Medicaid patients comprised 17.7% and 12.6% of hospital at home discharges, respectively. In contrast to national trends that found hospital at home patients were more likely to be White and less likely to have lower incomes, hospital at home discharges in Massachusetts were similar to traditional inpatient discharges in terms of patient race/ethnicity, gender, and community income. Length of stay among hospital at home discharges was higher overall (by an average 1.7 days) and for nine of the top ten DRGs than traditional inpatient stays. Longer average lengths of stay for hospital at home patients may reflect less urgency to discharge a patient to free the bed for another patient, as well as less patient urgency to return home and leave a hospital environment.

The HPC analyzed hospital charges as a proxy for resource use in seeking to understand differences between hospital at home stays and traditional inpatient stays. Charges are akin to the "list price" a hospital sets for providing a given service before negotiating any discounts and are recorded for broad categories of services.

Average charges grew substantially for hospital at home stays between 2020 and 2024 in Massachusetts. By 2024, charges per stay were roughly the same for hospital at home and the comparison

traditional inpatient group. Trends in the type of charges suggest that the nature of the services typically provided through hospital at home are changing over time, from mostly nursing and monitoring in 2020 to the addition of significant ancillary services, as programs were able to serve patients with more complex needs over time.

Hospital at home patients were far less likely to be discharged to skilled nursing facilities (SNFs) compared to the matched inpatient comparison group (0.8% vs 11%) and far more likely to be discharged to home health (40% vs 25%). These differences may reflect that candidates for hospital at home may be lower acuity cases than their traditional inpatient counterparts and therefore less likely to need SNF-level care following their stay. However, hospital at home may also offer advantages that reduce the need for SNF care, such as longer lengths of stay translating to more time for recovery and potentially greater patient mobility in their familiar home environment leading to better functional outcomes.

Congressional action is needed to extend Medicare's participation in these programs, which is now set to expire September 30, 2025. As the majority of patients participating in hospital at home have Medicare coverage, a long-term reauthorization is necessary to provide stability for hospitals, as they determine whether to invest in starting or continuing programs.

Hospital at home is a promising clinical model that may offer advantages for eligible patients and their families. Recognizing the continued growth of these programs in the Commonwealth, the HPC poses a number of areas that policymakers should consider monitoring, including:

- **Appropriate admissions:** To ensure that hospital at home is not used as a substitute for lower-cost, lower-intensity services such as home health care, program requirements should ensure that patients enrolling in a program require hospital-level care.
- **Hospital capacity:** The impact of these programs on hospital capacity should be monitored, including the potential to relieve hospitals from emergency department crowding and discharge delays, as well as potential spending impact from hospital bed expansion.
- Other important issues include:
  - Continuing research on the **benefit to patients**, including **care quality** and **patient and caregiver experience**
  - Determining **appropriate payment rates**
  - **Standardizing data collection**
  - **Financial sustainability**

INTRODUCTION

Through the hospital at home model, hospitals provide acute care in a patient's home rather than in a traditional inpatient hospital setting. While hospitals have experimented for years[1] with providing inpatient-level care in a patient's home, these programs gained traction when the Centers for Medicare & Medicaid Services (CMS) launched the Acute Hospital Care at Home (AHCAH) program in November 2020 in the context of concern about hospital capacity during the COVID-19 pandemic. Congress has passed multiple short-term reauthorizations of the program, with the latest set to expire September 30, 2025.

This largely new model has attracted hospital interest nationwide: as of August 2025, 39 states have hospitals participating in AHCAH, with 400 approved hospitals in total.[2] In Massachusetts, there are eight active hospital at home programs and 20 total hospitals approved for an AHCAH waiver.

In this policy brief, the HPC explores the landscape of hospital at home in Massachusetts, including trends in volume, patient population, length of stay and hospital resource use, as well as comparing hospital at home to traditional inpatient care on these dimensions. The brief also identifies a number of policy considerations as these promising programs continue, including implications for hospital capacity and ensuring appropriate admissions, among others.

BACKGROUND

Hospital at Home Services

Hospital at home provides acute care services (e.g., nursing, diagnostic, and therapeutic services) in a patient's home. Medicare's AHCAH program waives some inpatient care requirements, in particular the requirement to have nursing services available on the premises 24/7, while adding other requirements, such as twice daily in-person visits by clinical staff. These programs provide services that a patient would normally receive in a hospital, including daily in-person and virtual visits, 24/7 connection via telehealth, oral and IV medication, diagnostic testing, specialty consultation, oxygen, therapy, social work, and food services.

Clinical care is provided at home with a combination of remote clinician services and in-person nursing services. Medicare's AHCAH regulations also allow the use of community paramedics, as an alternative to nurses, to make clinical visits to the patient at home.[3] In discussions with the HPC, hospitals noted the reliance on community paramedics as part of the workforce for hospital at home programs.

In a traditional inpatient stay, hospital staff fully provide aide services, such as assistance with dressing, eating, and toileting. For a hospital at home stay, this assistance is often provided by a family caregiver or a care aide privately employed by the patient, since AHCAH waives the hospital requirement to have nursing services available 24/7. Notably, due to current federal regulations, MassHealth is not allowed to cover personal care aides (PCAs) for a patient during a hospital at home stay, mirroring the policy that a PCA would not care for a patient during a traditional inpatient stay. Therefore, MassHealth patients and other patients with lower incomes may be less able to participate in hospital at home than patients with similar needs who are able to privately employ an aide. However, some hospitals opt to provide aide services in their hospital at home programs. The HPC met with three hospital groups with hospital at home programs (Mass General Brigham (MGB), Beth Israel Lahey Health (BILH), and UMass), all of which provide some aide services when appropriate. MGB cited this service as important for MassHealth patients being able to participate in hospital at home care. Lahey's hospital at home program emphasized the importance of clear communication with the patient and family about what the program can offer and what the family responsibility would be, in helping the patient decide whether to elect hospital at home. They also noted that sometimes the family prefers to be in charge of aide care.

While hospital at home programs share some characteristics with home health programs, these programs differ on many key dimensions (see **Exhibit 1**), given that hospital at home is intended to provide hospital-level care, a far higher acuity of need than in home health programs.

Exhibit 1: Characteristics of care provided by setting

	ACUTE CARE		POST-ACUTE CARE
	Traditional hospital	**Hospital at home (HAH)**	**Home Health**
Setting of care	"Brick and mortar" hospital	Patient home	Patient home
Acute care services (e.g., medication administration, diagnostic testing, specialty consultation, oxygen)	✓	✓	N/A (Patient does not need acute care)
Intensive care services (e.g., surgical procedures, ICU)	✓	Patient needing these services would not be appropriate for HAH; patient may be transferred to HAH after intensive care services, or conversely, if needs arise during HAH stay, patient would be transferred to traditional inpatient	N/A (Patient does not need acute care)
Other hospital services (e.g., meals, 24/7 monitoring)	✓	✓	—
Aide services (e.g., dressing, eating, toileting)	Full range of needs provided by hospital staff	Provided by family or privately employed caregiver; may be provided by hospital staff if HAH program offers this service and if ordered by a provider	Limited services provided by agency staff
Nursing services (e.g., checking vitals, wound care)	✓	✓	✓
Physical or occupational therapy	Yes, if ordered by provider	Yes, if ordered by provider	Yes, if ordered by provider
Social services (e.g., connecting with community resources for food, clothing, shelter, school or employment concerns, substance use issues)	✓	✓	✓

Exhibit 2: An illustration of a hospital at home admission's first day

THE ADMISSION:

6PM

Patient with COPD goes to the ED due to a flare up.

8PM

In the ED, the patient is diagnosed with pneumonia. After managing immediate symptoms, doctors deem the patient to be an appropriate candidate for HAH and discuss the option with him. The patient elects HAH rather than a traditional inpatient stay.

10PM

The patient is met at home by hospital staff to set up oxygen therapy, equipment for remote vital monitoring, antibiotics for the pneumonia, and a care plan. The patient sleeps in his own bed that night.

AT HOME THE NEXT DAY:

8am	A paramedic visits the patient at home to check vitals and oxygen and administer IV antibiotics for the pneumonia. The paramedic also educates the patient on using nebulizer treatment and assists with any other medications.
9am	Food services delivers breakfast and other medically-tailored meals for the day.
12pm	The patient's caregiver heats the lunch that was dropped off earlier and serves the patient lunch.
1pm	The patient has a telehealth visit with the physician in charge of his care, who asks how the patient is responding to the oxygen, antibiotics, and steroids. The physician answers the patient's questions and recommends starting physical/occupational therapy to work on endurance, as well as respiratory therapy to work on minimizing oxygen dependance.
3pm	A nurse comes to the patient's home to check vitals and oxygen, sets up the patient's evening medications, and reviews the care plan with the patient and family, which includes starting respiratory therapy in the coming days.
6pm	The patient's caregiver heats the dinner that was provided by the hospital earlier in the day and serves the patient dinner.
8pm	The patient takes the second dose of antibiotics. The patient notices a potential malfunction with his heart rate monitoring device, so a paramedic is dispatched to swap the equipment.
9pm	The patient goes to sleep for the night.

Payment Policies

Medicare fee-for-service (FFS) pays the same amount for a hospital at home stay as for a traditional inpatient stay. If a patient initiates the stay in the brick-and-mortar setting and is transferred to hospital at home, the hospital receives payment for only one stay. In Massachusetts, MassHealth also pays for hospital at home at parity with a traditional inpatient stay. Commercial payers may have different payment approaches.

Patient Eligibility

To be eligible for a hospital at home stay, a patient must require hospital-level care but be stable enough to be treated at home. AHCAH allows two avenues for admission: (1) admission avoidance, where patients are admitted to hospital at home directly from the emergency department (ED), and (2) transfer to hospital at home or continuing hospitalization, in which a patient is transferred from a traditional inpatient setting to hospital at home. AHCAH does not allow patients to be admitted to hospital at home directly from the community; patients must first interact with a hospital's ED or inpatient unit. Patients are admitted after a review of their medical condition and home setting to assess whether they are appropriate for this model of care delivery. Patients must affirmatively elect to receive hospital at home instead of a traditional inpatient admission.

Other requirements include living within 30 minutes driving distance of the participating hospital in case an emergency transfer is necessary, being clinically stable, and having a home environment conducive to receiving hospital-level care, which may include the presence of a caregiver (whether a family member or privately employed by the patient) to assist with tasks of daily living. Hospitals develop their own clinical and environmental criteria for patient inclusion, which CMS approves as part of the hospital's AHCAH application.

National Findings: CMS Report on the AHCAH Initiative

In September 2024, CMS released a report evaluating the AHCAH initiative, which examined demographics and clinical conditions of program participants, quality of care, and spending and utilization trends.[4] Nationally, patients who participated in AHCAH were more likely to be White, live in urban areas, and less likely to qualify for Medicaid or other low-income subsidies compared to Medicare patients with traditional brick-and-mortar stays.

The study found mixed evidence on quality measures: overall, AHCAH patients experienced fewer hospital-acquired conditions (although this result was not statistically significant), had either higher or lower rates of readmission depending on their clinical condition, and had lower mortality rates compared to the traditional inpatient comparison group. The report notes that the eligibility criteria for AHCAH likely impacted patient demographics and resulted in a less clinically complex population in the home group. While research on hospital at home is relatively nascent, available literature has generally concluded that acute-level care can be safely provided in the home setting.[5]

METHODS

The HPC used the Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database (HIDD) to identify hospital at home discharges between January 2020 and December 2024. Hospital at home discharges were identified using site of service and revenue codes.[i] Discharge volume was validated with publicly available information from news articles and press releases, as well as an internal data collection effort led by the Massachusetts Health & Hospital Association (MHA).

To create an inpatient comparison group, the HPC matched hospital at home discharges with traditional inpatient discharges in each year on the basis of same hospital, same All Patient Refined Diagnosis Related Group (APR-DRG), and same severity of illness (SOI). The traditional inpatient sample was weighted to match the hospital-DRG-SOI distribution of the hospital at home sample.

This matched group was the basis for comparison of length of stay, discharge destination, and hospital charges as a proxy for hospital resource use, as described in more detail in later sections. For comparison of patient demographics (race/ethnicity, patient community income, and sex) and clinical conditions, the HPC compared hospital at home discharges to all traditional inpatient discharges from hospitals with a hospital at home program.

Limitations

An important limitation of this analysis is that hospitals use different methods to identify their hospital at home discharges in discharge data, and therefore the HPC's analysis may not fully capture all hospital at home volume in all years, despite extensive validation efforts. In 2022, CMS began requiring a standard code (revenue code 0161) to identify hospital at home discharges for the AHCAH program, but other payers may not reimburse for that code, leading some hospitals to also use other revenue codes. Lahey Hospital & Medical Center has an active hospital at home program as of 2024, but the HPC could not identify discharges

i Revenue codes used to identify hospital at home discharges were generic revenue code (0119) for Mass General Brigham hospitals and code 0161, which was created by CMS in 2022 specifically for identifying hospital at home. UMass Memorial Medical Center requested its own site of service code (20201) to identify hospital at home.

from this program in HIDD and could not include this hospital in the analysis. Therefore, the results in this brief underestimate the number of hospital at home discharges in Massachusetts.

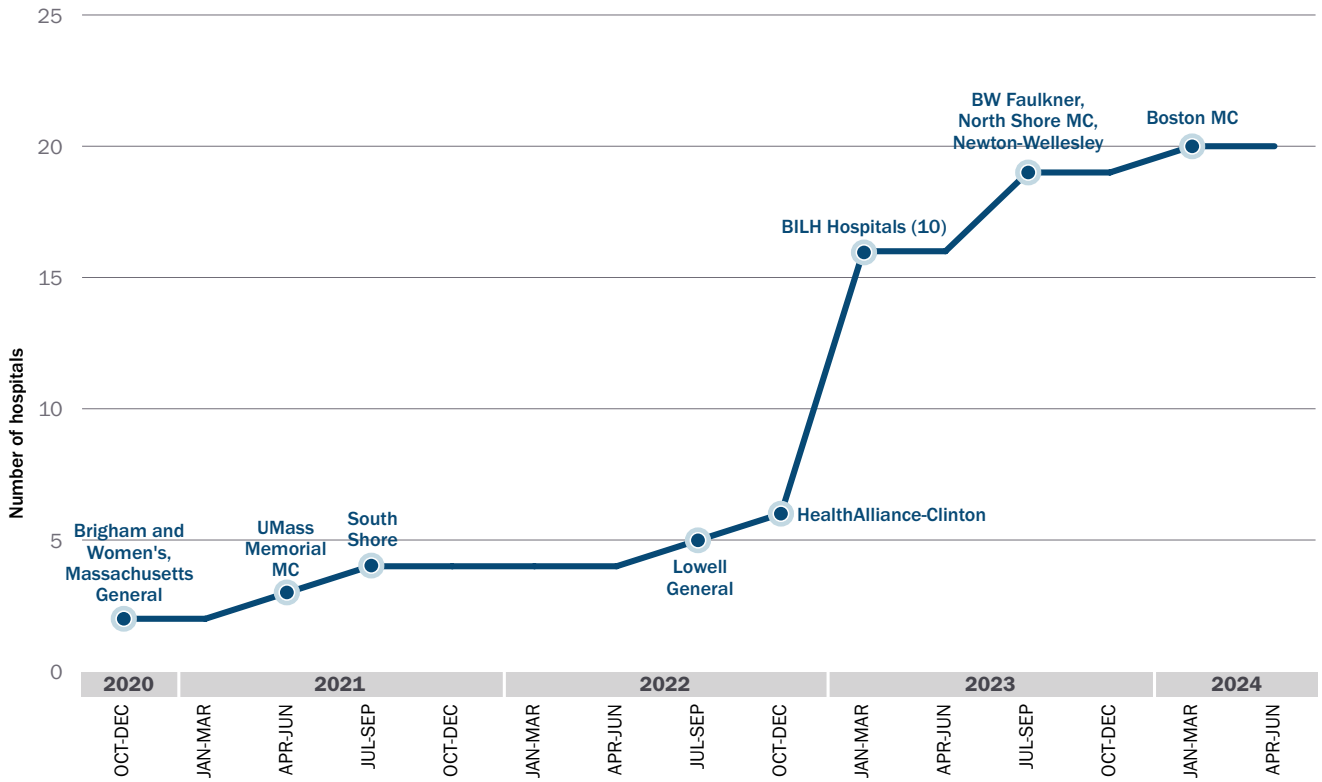
In addition, due to the eligibility criteria needed to participate in hospital at home programs, hospital at home patients and traditional inpatient patients likely differ in ways that cannot be accounted for, which may affect results.

HOSPITAL AT HOME UTILIZATION IN MASSACHUSETTS

Exhibit 3 shows a timeline of CMS-approved AHCAH programs in Massachusetts. Hospital at home programs at Brigham and Women's Hospital and Massachusetts General Hospital predated the AHCAH waiver. In 2024, Massachusetts had nine active hospital at home programs and 20 total hospitals approved for an AHCAH waiver (see **Exhibits 3 and 4**). By August 2025, there were no additional Massachusetts hospitals with an AHCAH waiver, and South Shore Hospital had closed its hospital at home program.[6]

Between 2020 and 2024, hospital at home discharges in Massachusetts rose nearly ten-fold, from 461 discharges in 2020 to 4,523 discharges in 2024. This increase in volume reflects both the entry of new hospital programs and existing programs increasing their capacity. Despite this rapid growth, hospital at home discharges remain a small share of total inpatient discharges, representing approximately 0.6% of total inpatient discharges in Massachusetts in 2024.

Exhibit 3: Timeline of CMS-approved Acute Hospital Care at Home programs in Massachusetts



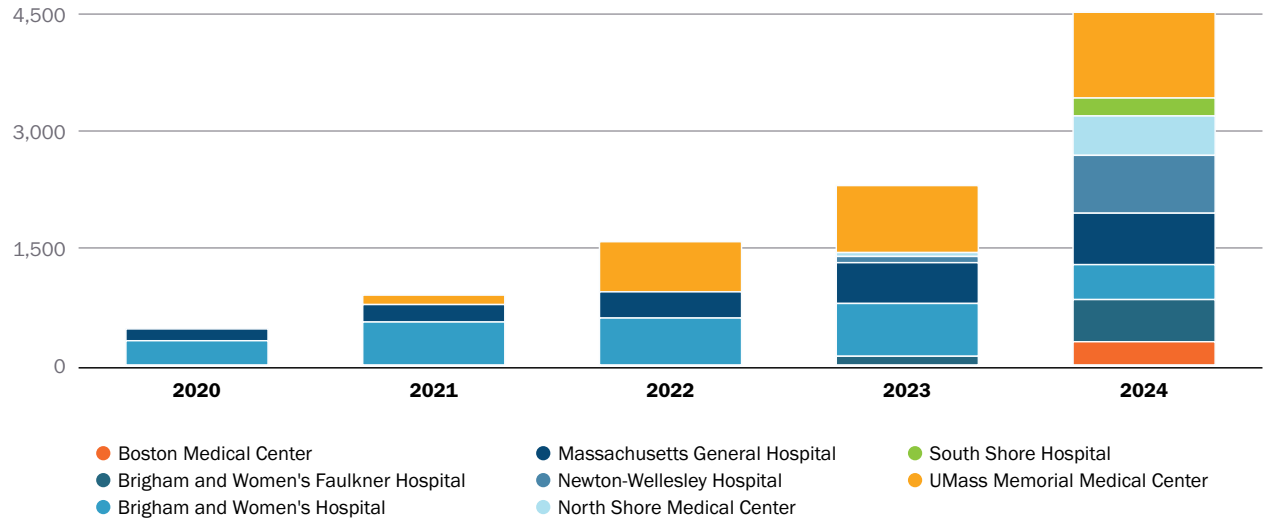
Notes: CMS approved 10 BILH hospitals in Feb 2023, but lists these programs as located in New York. These hospitals are Beth Israel Deaconess Plymouth, Beth Israel Deaconess Needham, Beth Israel Deaconess Milton, Beth Israel Deaconess Hospital, New England Baptist Hospital, Mount Auburn Hospital, Anna Jacques Hospital, Winchester Hospital, Northeast Hospital Corp DBA (Beverly Hospital), and Lahey Hospital & Medical Center.

Sources: Approved Facilities/Systems for Acute Hospital Care at Home. CMS QualityNet. August 18, 2025. Available at: https://qualitynet.cms.gov/acute-hospital-care-at-home/resources

In the first years following the passage of AHCAH, the volume of hospital at home discharges was dominated by a few academic medical centers (namely Brigham and Women's Hospital, Massachusetts General Hospital, and UMass Memorial Medical Center), but many other programs – particularly those in community hospitals – became active in 2023 (**Exhibit 4**).

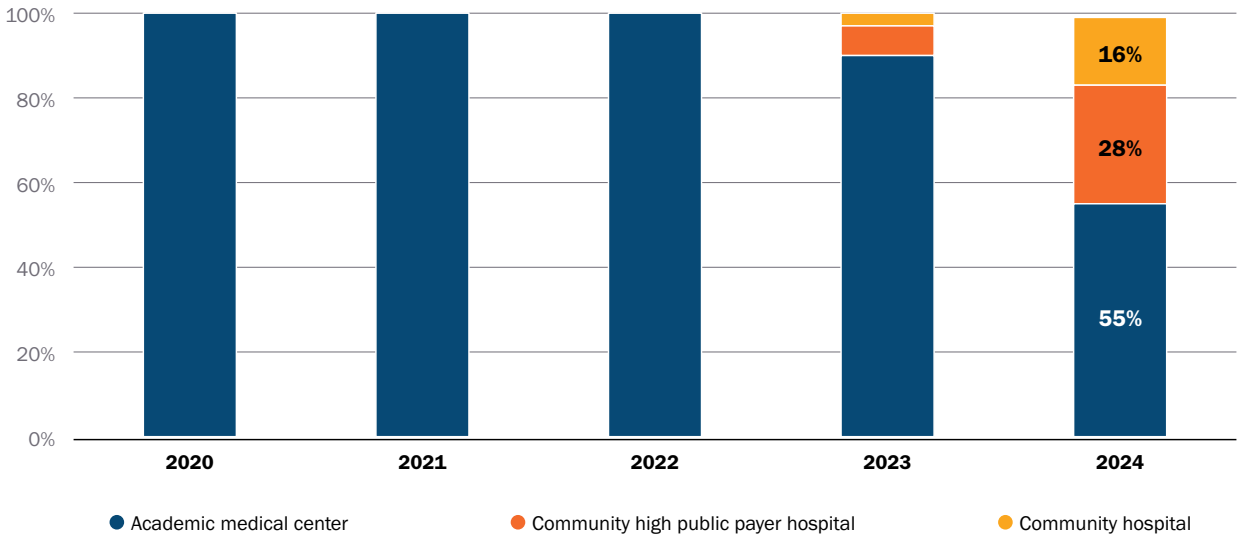
By 2024, discharges from community hospitals represented 45% of the total hospital at home volume for that year (**Exhibit 5**).

Exhibit 4: Hospital at home discharges by hospital, 2020–2024



Notes: In 2024, Lahey Hospital had an active hospital at home program, but these discharges could not be identified in the database.
Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2020-2024

Exhibit 5: Share of hospital at home discharges by hospital cohort, 2020–2024



Sources: Center for Health Information and Analysis FY23 Massachusetts Hospital Profiles, January 2025. HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2020-2024

CHARACTERISTICS OF PATIENTS PARTICIPATING IN HOSPITAL AT HOME

Hospital at home programs in Massachusetts are concentrated in Central Massachusetts and the Metro Boston area (**Exhibit 6**).

In 2024, about two-thirds of hospital at home discharges were patients with Medicare coverage (**Exhibit 7**). About half of hospital at home patients were covered by traditional Medicare.

More than half of patients with a hospital at home stay were at least 70 years old in 2024 (**Exhibit 8**), consistent with the majority of patients having Medicare coverage. Among patients with hospital at home stays, 57% were female (43% male), compared to 55% of patients with traditional inpatient stays (45% male).[ii]

Exhibit 6: Zip codes within a 30-minute driving distance of hospitals with an active hospital at home program, 2024

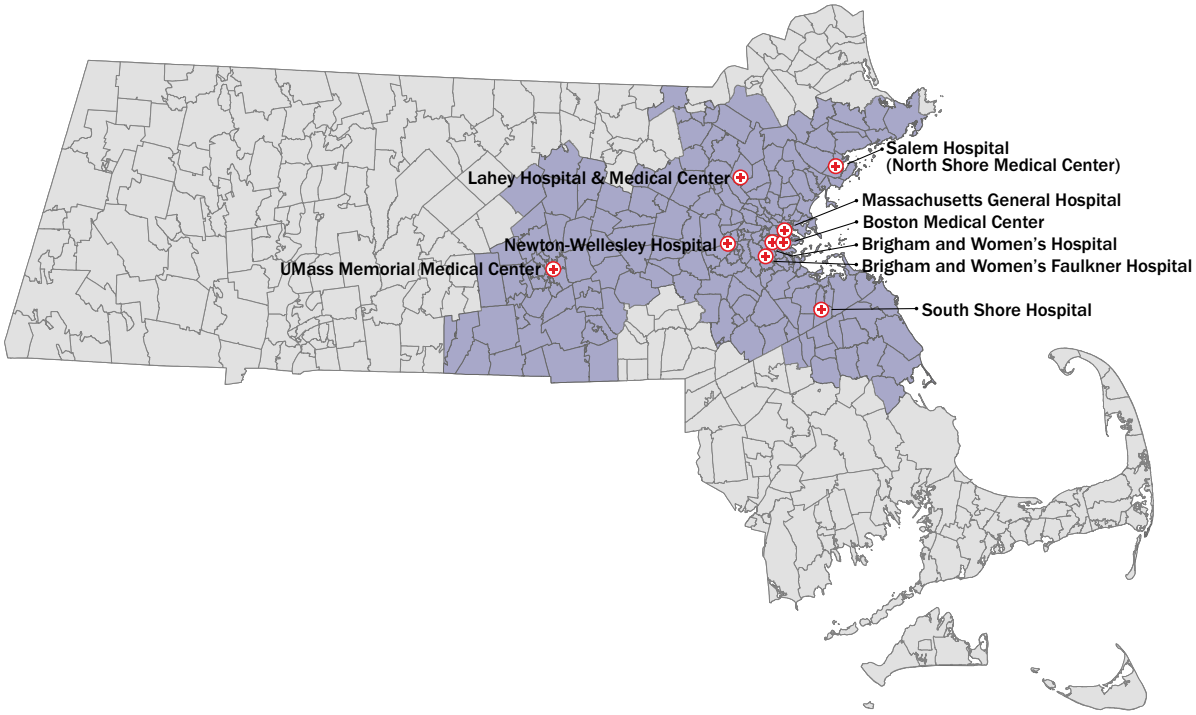
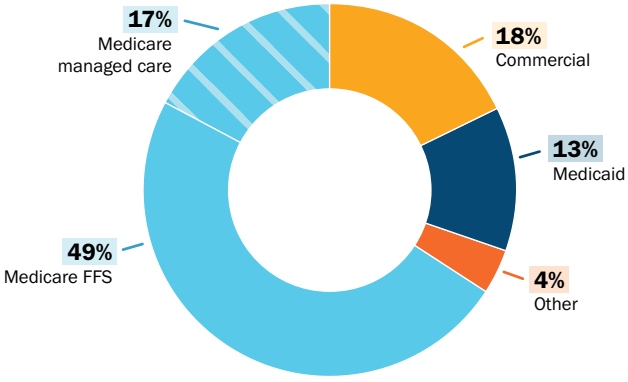


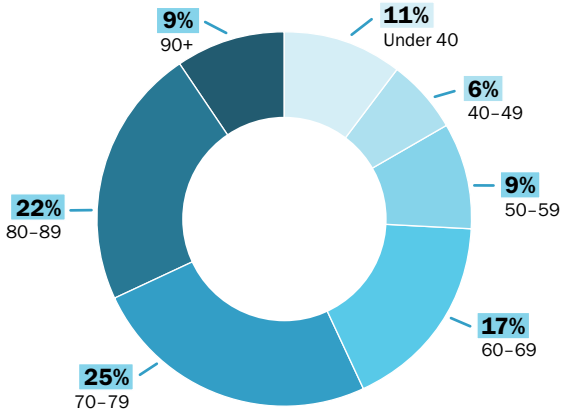
Exhibit 7: Hospital at home discharges by payer, 2024



Notes: FFS = Fee-for-service.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2024

Exhibit 8: Hospital at home discharges by patient age group, 2024

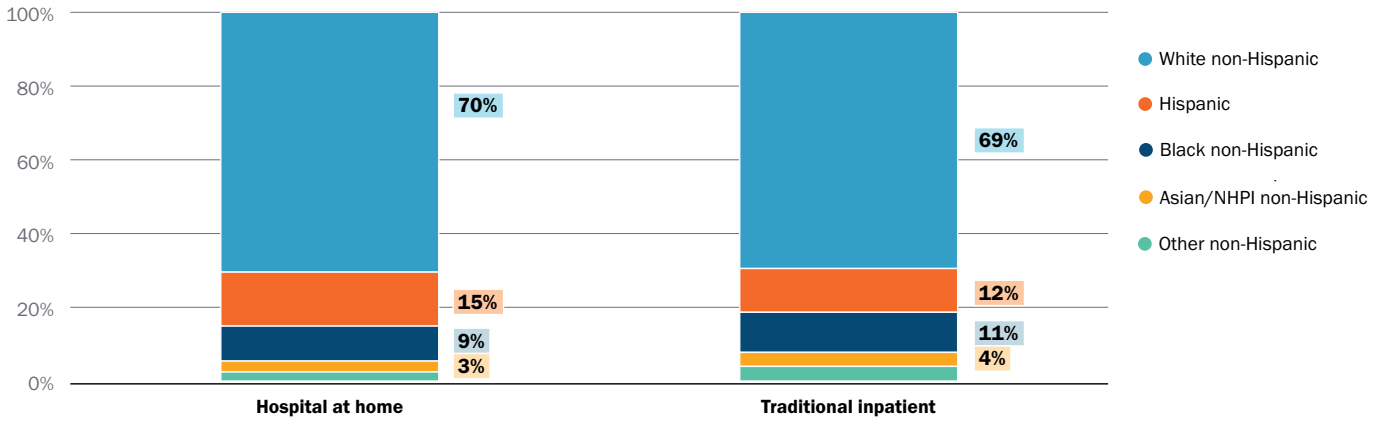


Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2024

ii Similarly, in the matched traditional inpatient group, 55% of patients were female (45% male).

In contrast to national trends, patients who participated in hospital at home were generally similar to patients with traditional inpatient stays in terms of race/ethnicity and income in 2024 (**Exhibits 9 and 10**). National research found that hospital at home patients were more likely to be White and less likely to have lower incomes than patients with traditional inpatient stays.[4]

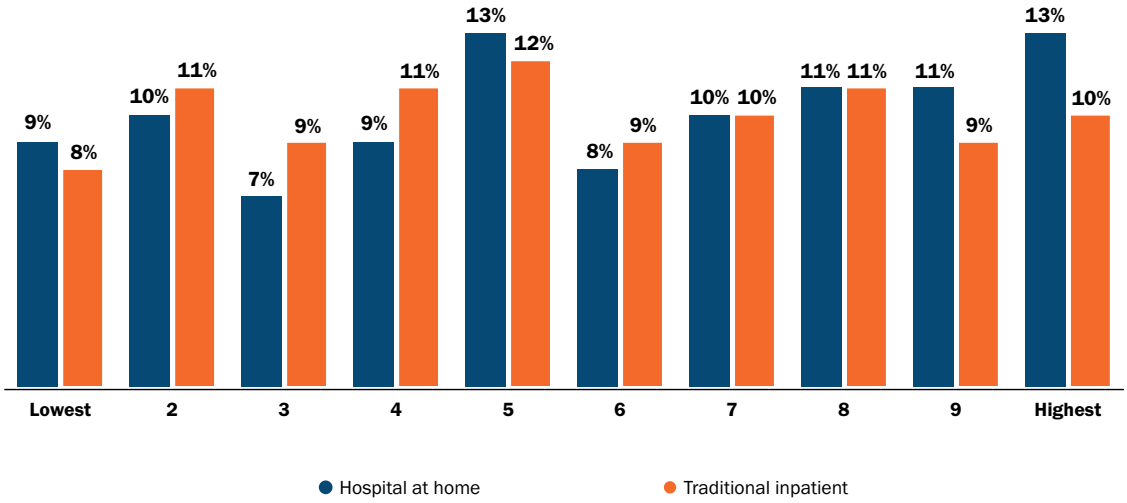
Exhibit 9: Share of discharges by patient race/ethnicity by setting, 2024



Notes: Other includes American Indian and Alaskan Natives, multiracial individuals, other races, and individuals whose race could not be identified. Groups are mutually exclusive. Traditional inpatient includes all traditional inpatient discharges from hospitals that had a hospital at home program in 2024.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2024

Exhibit 10: Share of discharges by patient community income decile by setting, 2024



Notes: Individuals with missing income decile information were dropped from the sample. Traditional inpatient includes all traditional inpatient discharges from hospitals that had a hospital at home program in 2024.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2024

The HPC also examined the types of conditions associated with hospital at home patients. Similar to national findings, hospital at home patients in Massachusetts are concentrated among a relatively small number of diagnoses. The 10 APR-DRGs with the most volume accounted for 70% of hospital at home discharges in 2024 (**Exhibit 11**).[iii] Many of these APR-DRGs are related to respiratory conditions, infections, or cardiac conditions, which are more highly represented among hospital at home discharges than among traditional inpatient stays at the same hospitals.

Yet even this concentration of hospital at home discharges among relatively few conditions in 2024 represents an expansion from the conditions treated in hospital at home programs several years earlier. The number of conditions treated in these programs increased from 54 to 146 unique DRGs from 2020 to 2024, as programs have become more comfortable with and capable of treating more varied or severe conditions.

COMPARING HOSPITAL AT HOME AND TRADITIONAL INPATIENT DISCHARGES

For the following analyses, the HPC compared hospital at home discharges to a comparison group of traditional inpatient discharges matched on same hospital, same APR-DRG, same SOI.

Exhibit 11: Top 10 APR-DRGs by setting, 2024

APR-DRG	Hospital at home		Traditional inpatient
	Share of discharges	Cumulative	Share of discharges
HEART FAILURE	13.4%	13.4%	2.5%
SEPTICEMIA AND DISSEMINATED INFECTIONS	12.5%	25.9%	4.1%
MAJOR RESPIRATORY INFECTIONS AND INFLAMMATIONS	9.0%	34.8%	1.8%
OTHER PNEUMONIA	8.4%	43.2%	1.3%
CELLULITIS AND OTHER SKIN INFECTIONS	7.1%	50.3%	0.9%
KIDNEY AND URINARY TRACT INFECTIONS	6.7%	57.0%	1.3%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	5.9%	62.9%	0.8%
MALFUNCTION, REACTION, COMPLICATION OF GENITOURINARY DEVICE OR PROCEDURE	3.1%	66.0%	1.0%
ASTHMA	1.9%	67.9%	0.5%
ACUTE KIDNEY INJURY	1.8%	69.7%	1.1%

Notes: APR-DRG = All Patient Refined Diagnosis Related Group. Traditional inpatient includes all traditional inpatient discharges from hospitals that had a hospital at home program in 2024.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2024

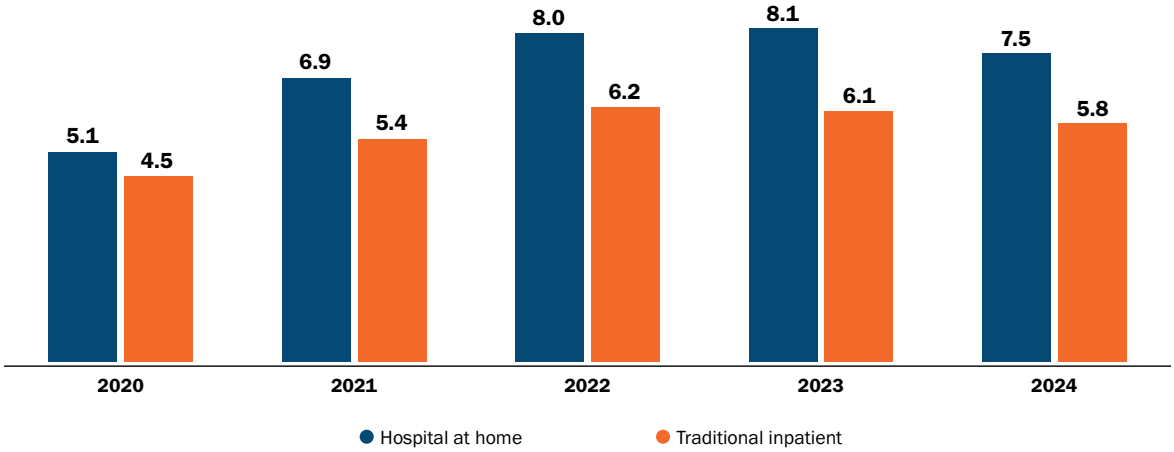
iii In contrast, the top 10 DRGs with the most volume among traditional inpatient discharges accounted for only 40% of all traditional inpatient discharges in 2024.

Length of Stay

Length of stay, the average number of days for a patient's hospital stay, was consistently higher for hospital at home discharges compared to traditional inpatient discharges (**Exhibit 12**). The difference grew from roughly half a day longer in 2020 to roughly two days longer in more recent years.

This difference is also apparent for nearly all conditions with significant hospital at home volume. In 2024, average length of stay was longer in hospital at home for nine of the 10 APR-DRGs with the highest hospital at home volume (**Exhibit 13**). Longer length of stay for hospital at home patients in Massachusetts is consistent with national findings from CMS and may reflect greater urgency in traditional hospital operations to free the bed for another case as well as greater patient urgency to return home.[3]

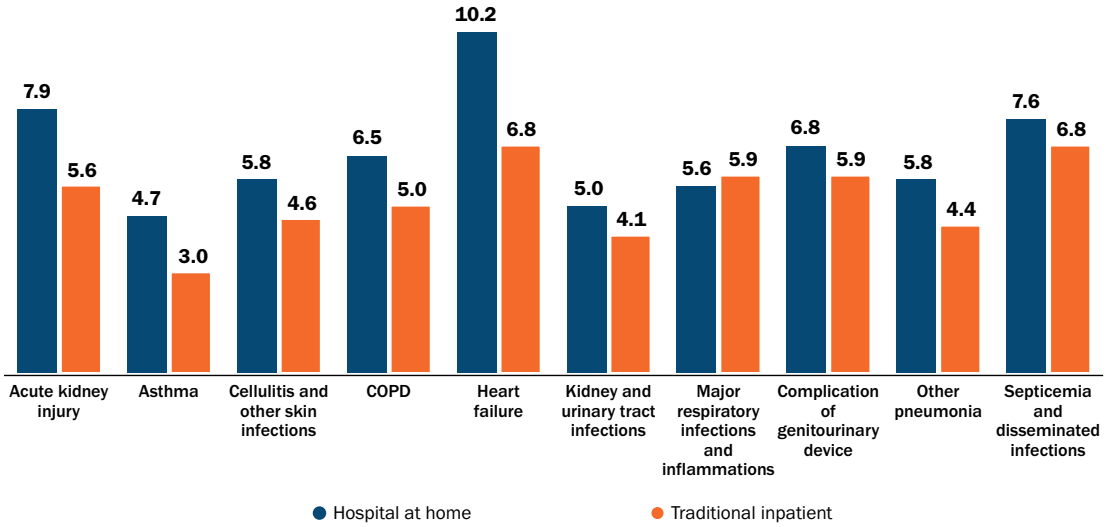
Exhibit 12: Average length of stay (days) by setting, 2020–2024



Notes: Traditional inpatient includes discharges matched to the hospital at home sample by hospital-DRG-SOI. Averages are weighted by the distribution of hospitals, APR DRGs, and SOI mix in the hospital at home sample for each year.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2020-2024

Exhibit 13: Average length of stay (days) for top APR-DRGs by setting, 2024



Notes: COPD = chronic obstructive pulmonary disease. Complication of genitourinary device includes malfunction, reaction, or complication of genitourinary device or procedure. Traditional inpatient includes discharges matched to the hospital at home sample by hospital-DRG-SOI.

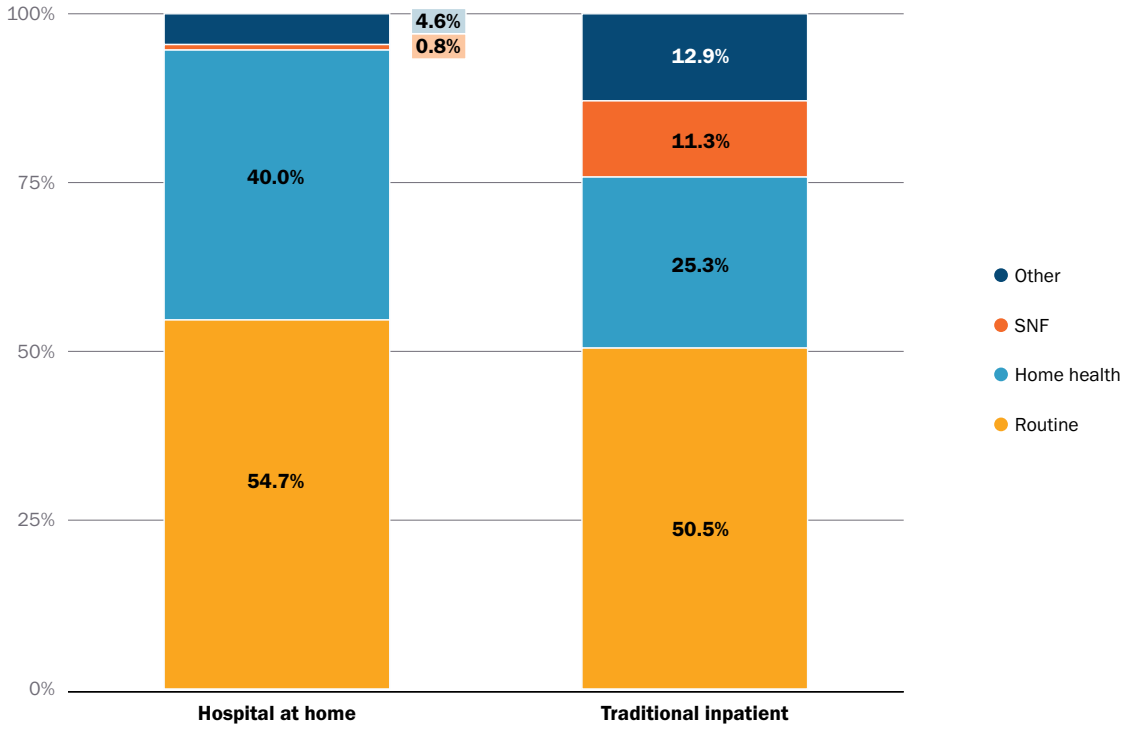
Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2024

Discharge Destination

Hospital at home patients were less likely to be discharged to skilled nursing facilities (SNFs) compared to the matched inpatient comparison group. In 2024, fewer than 1% of hospital at home stays resulted in discharge to a SNF, compared to about 11% of the stays in the traditional inpatient comparison (**Exhibit 14**). Hospital at home patients were more likely to be discharged to home health compared to the traditional inpatient group (40% vs 25%).[iv] These outcomes may reflect unmeasured differences in the patient population, in that candidates for hospital at home may be lower acuity cases than their traditional inpatient counterparts and therefore less likely to need SNF-level care following their stay. However, hospital at home may also offer advantages that reduce the need for SNF care, such as longer lengths of stay translating to more time for recovery and potentially greater patient mobility in their familiar home environment leading to better functional outcomes.

The HPC was not able to evaluate readmission rates due to data limitations.

Exhibit 14: Discharge destination by setting, 2024



Notes: SNF = skilled nursing facility. Traditional inpatient includes discharges matched to the hospital at home sample by hospital-DRG-SOI. Other destinations include discharge or transfer to another facility (e.g., another short-term general hospital, federal health care facility, hospice medical facility, inpatient rehab, long term care hospital), leaving against medical advice, expired, and home hospice.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2024

iv The share of matched inpatient stays discharged to "Other" is similar to the share in the general inpatient population in 2024 (11%, see the HPC's 2024 Cost Trends Report: Chartpack, Hospital Utilization p.60). In the matched inpatient stays, top "Other" destinations included expired (3.0%), hospice (2.3%), against medical advice (1.8%), inpatient rehab (1.7%), and transferred to another general hospital (1.1%).

Charges

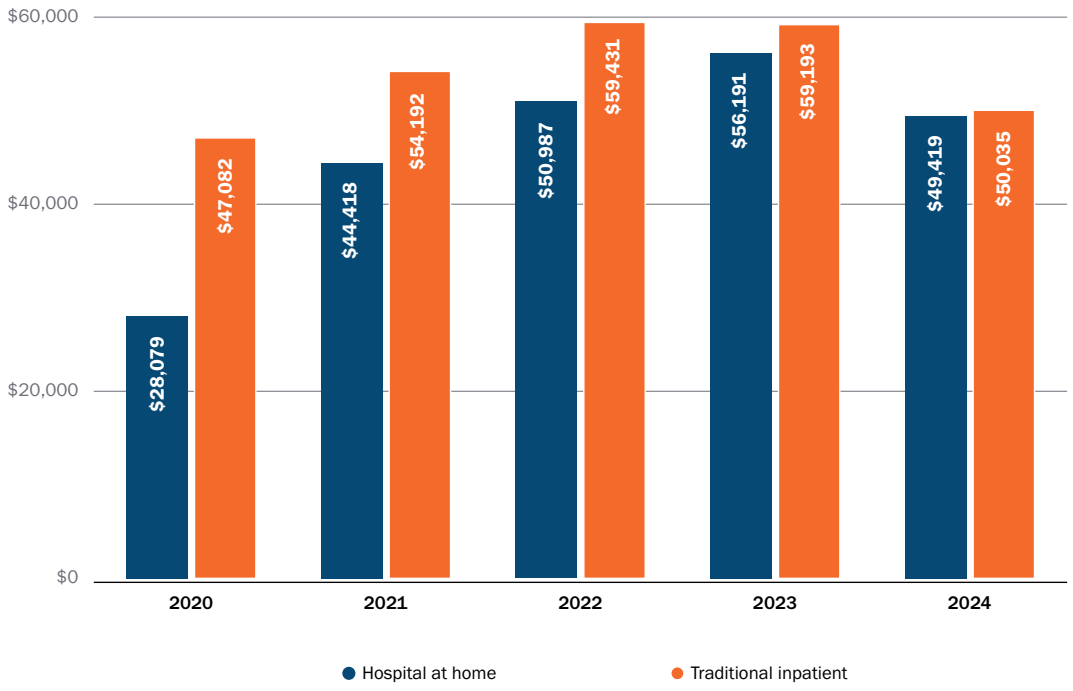
The HPC analyzed hospital charges as a proxy for comparing resource use between hospital at home and traditional inpatient stays. Charges are akin to "list prices," that is, the dollar amount that a hospital lists as compensation for providing a given service before negotiating any discounts. While imperfect, the use of charges is well established in research literature as a means to compare resource use between services within the same hospital.

The HIDD includes three components of charges:

- **Routine charge**s reflect "room and board" charges,
- **Ancillary charges** reflect professional services provided during a hospital stay (e.g., imaging, drug, or laboratory services),
- **Special charges** typically reflect ICU utilization.

Comparing resource use for hospital at home versus traditional inpatient care, as measured by charges, provides insight into the services that patients receive. In 2020, charges per traditional inpatient stay were 68% higher than a hospital at home stay. Yet average charges grew dramatically for hospital at home stays between 2020 and 2024, with far greater growth than charges for comparable traditional inpatient stays. Between 2020 and 2023, average charges per hospital at home stay doubled (from around $28,100 to $56,200), while average charges per traditional inpatient stay grew 26% between these years (from $47,100 to $59,200) (**Exhibit 15**). Average charges dropped between 2023 and 2024 for both hospital at home stays and their matched traditional inpatient cases, reflecting the significant expansion of hospital at home volume at community hospitals in 2024, which tend to have lower charges per stay than at academic medical centers. By 2024, charges per stay were roughly the same between settings.

Exhibit 15: Average charges per discharge by setting, 2020–2024



Notes: Traditional inpatient includes discharges matched to the hospital at home sample by hospital-DRG-SOI. Averages are weighted by the distribution of hospitals, APR DRGs, and SOI mix in the hospital at home sample for each year.

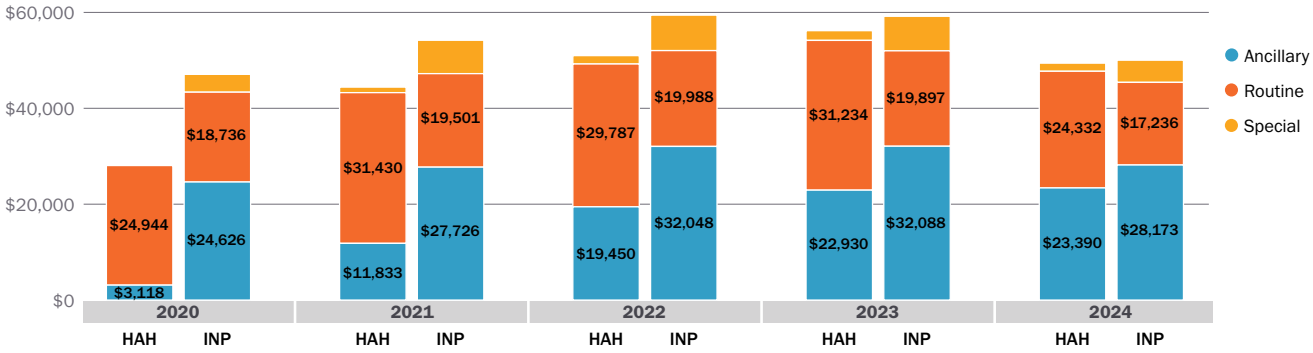
Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2020-2024

Regarding different categories of charges, routine charges were higher for hospital at home than for traditional inpatient care in all years from 2020 to 2024; the growth in hospital at home charges was almost entirely due to increases in ancillary charges (**Exhibit 16**). Higher routine charges in hospital at home likely reflect longer lengths of stay, as well as other potential factors such as additional costs and inefficiencies of providing care (including equipment and staff) in patient homes. Higher ancillary charges (and special charges) in traditional inpatient care may reflect unmeasured differences in patient acuity, as well as potential excess use of these services since ancillary services may be more easily ordered in a traditional inpatient setting. The dramatic growth in ancillary charges among hospital at home stays may reflect that these programs are able to treat patients with higher acuity needs over time, such that the unmeasured differences in patient acuity between settings may be narrowing.[v]

These overall differences in charges in 2024 in **Exhibit 16** are generally consistent across top conditions, although results vary somewhat by condition (**Exhibit 17**).

Overall, trends in the type of charges suggest that the nature of the services typically being provided through hospital at home are changing over time, from mostly nursing and monitoring in 2020 to the addition of significant ancillary services, potentially to serve patients with more complex needs by 2024.

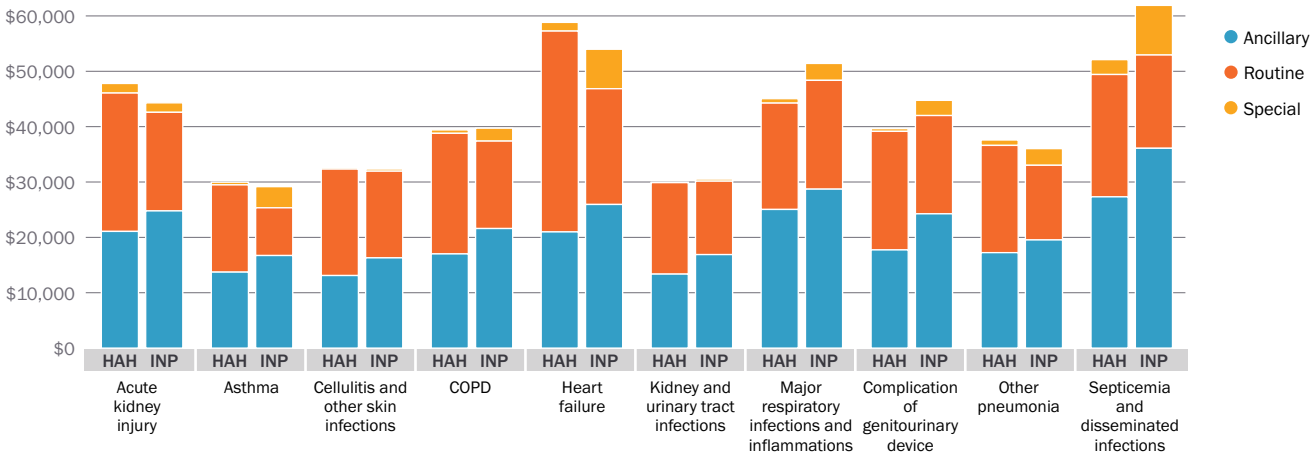
Exhibit 16: Average charges per discharge by charge type and setting, 2020–2024



Notes: Traditional inpatient includes discharges matched to the hospital at home sample by hospital-DRG-SOI. Averages are weighted by the distribution of hospitals, APR DRGs, and SOI mix in the hospital at home sample for each year.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2020-2024

Exhibit 17: Average charges per discharge for top 10 APR DRGs by charge type and setting, 2024



Notes: COPD = chronic obstructive pulmonary disease. Complication of genitourinary device includes malfunction, reaction, or complication of genitourinary device or procedure. Traditional inpatient includes discharges matched to the hospital at home sample by hospital-DRG-SOI.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2024

v To investigate whether patients in these programs were more acute on average, the HPC looked at average Case Mix Index and found that it increased 36% from 2020 to 2024.

POLICY CONSIDERATIONS

Recognizing the growing and promising role of hospital at home programs in the Commonwealth, the HPC identifies the following issues that policymakers should consider as these programs evolve.

Standardizing Data Collection

Currently each hospital determines its own approach to coding hospital at home stays, and payers may also have different requirements for billing. Statewide standards for hospital reporting of hospital at home stays, including methods for recording transfers between hospital at home programs and traditional hospital settings, would improve accuracy in data collection and support efforts for ongoing research and monitoring. In addition, standardization among payers and alignment with Medicare requirements where possible would reduce administrative burden for hospitals. Continued collaboration between Massachusetts state agencies, including CHIA and the Executive Office of Health and Human Services (EHS), and the MHA is important to determine best practices and improve methods to measure hospital at home in HIDD.

Understanding Benefit to Patients

Care quality

Quality measures currently collected by CMS for hospital at home – including excess mortality, escalations to traditional inpatient, and readmissions – provide a limited measurement of quality of care. State and federal policymakers should continue to consider how to measure outcomes compared to traditional inpatient care and safeguard quality, including assessing the effectiveness of remote patient monitoring, adverse events such as falls and infections, as well as timeliness of response to urgent patient needs. However, efforts to safeguard quality of care should be aligned across payers to limit administrative complexity for hospitals.

Some research has identified advantages for hospital at home in advancing health equity, such as an enhanced ability for clinical staff to identify patient needs through being able to directly assess the patient's home environment and then assisting with access to community resources.[7] The state should monitor demographics of patients participating in hospital at home, including location, income, and race/ethnicity and identify opportunities to support equitable access to hospital at home programs where appropriate.

Caregiver impact and patient experience

The impact of hospital at home on patient experience and the experience of the patient's family and loved ones is an important area for continued study. Compared to traditional inpatient care, the hospital at home model may increase the burden on a patient's loved ones, since aide services that would be provided by hospital staff in a traditional inpatient setting may need to be performed by a family caregiver (or separately employed aide) under hospital at home. Some hospital at home programs provide some level of aide services, and burden on caregivers may depend on patient and family resources, hospital at home program coverage, patient level of need, and caregiver preferences. At the same time, hospital at home may alleviate the burden for family to travel back and forth to a brick-and-mortar hospital.

While some patients may feel more comfortable with traditional inpatient care than home-based care, others may prioritize remaining in a familiar setting. The CMS report on AHCAH reported largely positive patient and caregiver feedback, and patients described feeling at peace and more comfortable while being cared for in their own space.[4,8]

Appropriate Admissions

Admission standards for hospital at home programs will affect their spending impact. In its June 2024 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) emphasizes the need to ensure that hospital at home is not used as a substitute for lower-cost, lower-intensity services such as home health care.[3] Such inappropriate admissions would increase total health care spending through providing higher intensity services than are needed for safe patient care, for example paying the rate for a full hospital admission when only home health care was needed. The AHCAH program currently requires that patients be evaluated at a hospital (either in the ED or through an inpatient transfer). MedPAC highlights the requirement for evaluation at a brick-and-mortar hospital (through an ED visit or transfer from an overnight stay) as a critical safeguard to minimize inappropriate admissions. Policymakers will need to consider how to ensure that patients admitted to hospital at home require inpatient-level care.

Hospital Capacity

A hospital's acute care bed capacity is an important consideration in its decision to implement a hospital at home program: it may not be sensible for hospitals with excess bed capacity to take on the costs of implementing a hospital at home program. Hospitals with a high inpatient occupancy rate may have particular operational and financial incentives to expand their acute care capacity through hospital at home. Operationally, the additional inpatient capacity through hospital at home may help relieve hospitals from ED crowding, discharge delays, and other capacity issues. Financially, if a hospital at home stay had similar margins or even potentially lower margins than a comparable traditional stay, a crowded hospital may still benefit financially from a hospital at home program through a higher total number of admissions and/or by freeing up traditional inpatient beds for higher-margin cases.

Hospital at home provides an avenue for hospitals to expand their acute care capacity outside of the Determination of Need process with the Department of Public Health. As hospital at home programs continue, it will be important to monitor the impact on hospital inpatient capacity, including the potential to relieve hospitals from ED crowding and discharge delays, as well as the impact on total number of hospital admissions (in particular, any growth in lower-acuity admissions), hospital market share, and any potential spending impact from the expansion of hospital capacity.

At the current time, capacity requirements do not appear warranted. The HPC, under the Office of Health Resource Planning, will continue to monitor trends in hospital at home programs and consider future recommendations as needed.

Payment Rates

Under current policy for Medicare FFS and MassHealth, payment is at parity with traditional inpatient stays. Commercial payers may have different approaches. As programs continue, public and private payers may consider whether payment rates should be adjusted if hospital at home stays can be provided at a lower cost than similar inpatient discharges. Detailed study could evaluate whether hospital at home involves true net efficiencies. For example, using the patient's home may save some room and board costs, but involves other inefficiencies of travel to bring supplies to patient homes rather than delivering care in a central location. UMass program administrators highlighted bringing acute care resiliency to patient homes, such as supplying patients with systems for back-up internet access, which adds program costs. Hospital at home may further result in lower health care spending over an episode of care if the program results in a lower readmission rate and less costly post-acute care use, namely a lower likelihood of discharge to SNF. Payers may wish to consider total episode spending in determining appropriate payment rates.

The HPC is currently unable to analyze commercial payment rates for hospital at home in the CHIA All-Payer Claims Database (APCD) due to data limitations and the relatively small number of discharges. However, the HPC hopes to use the APCD in future research to examine commercial payments for hospital at home to better understand variation between payers, including any discounts compared to traditional inpatient discharges, as well as the cost of broader episodes of care.

Financial Sustainability

Since the majority of hospital at home patients have Medicare coverage, the viability of these programs depends on the ability of Medicare to pay for this care. As of early September 2025, AHCAH programs are authorized through September 30, 2025. Previous Congressional action has provided short-term reauthorization of AHCAH, rather than a long-term reauthorization that would provide stability for hospitals. The uncertainty of Congressional reauthorization of the AHCAH waiver poses a challenge for the sustainability of these programs, as hospitals need stability to determine whether to invest logistical and financial resources in the startup or continuation of a hospital at home program. Given the potential of this model to meet patient needs, the HPC calls on Congress to pass a long-term reauthorization of AHCAH.

In conclusion, hospital at home is a promising clinical model that may offer advantages for eligible patients and their families. As these programs continue, considerations for policymakers include how to support access and leverage innovations in home-based care, while ensuring appropriate use and considering impact on health care spending.

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