ANYONE HOME? THE LANDSCAPE OF HOSPITAL AT HOME IN MASSACHUSETTS

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INTRODUCTION

"Hospital at home" (HAH) programs have attracted hospital interest and grown in Massachusetts over the past few years because of their potential to alleviate in-patient capacity and provide patients with a better care experience. Through HAH programs, hospitals provide acute care services in a patient's home rather than in a traditional hospital setting. While hospitals have experimented with HAH for years, the Centers for Medicare & Medicaid Services (CMS) launched the Acute Hospital Care at Home (AHCAH) program in November 2020 due to concerns about hospital capacity during the COVID-19 pandemic. As of April 2025, 39 states have hospitals participating in AHCAH. In Massachusetts, ten hospitals have been approved for an AHCAH program. Although AHCAH is a Medicare program, other payers have developed their own payment policies for HAH.

OBJECTIVES

Because of the potential impact of HAH programs on state and federal spending, hospital capacity, and patient outcomes, the Massachusetts Health Policy Commission (HPC) sought to begin a foundational analysis of the program in Massachusetts including volume, trends, patient demographic characteristics and diagnoses, and hospital resource use. The HPC developed methods to compare HAH discharges in Massachusetts to similar traditional inpatient discharges.

STUDY DESIGN

The HPC used the Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database to identify HAH discharges and create a traditional inpatient comparison group. HAH discharges were identified using 1) revenue code 0161, created by CMS in 2022 specifically for AHCAH, 2) an organization site code requested by UMass Memorial Medical Center to identify HAH, and 3) generic revenue code 0119 for hospitals that reported to CHIA that they used this code to identify HAH. Results were validated by comparing against publicly available information in news articles and press releases.

To create an inpatient comparison group, the HPC matched HAH 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 (LOS) and charges per discharge for each hospital-DRG-SOI mix was calculated for both HAH and traditional inpatient samples. The traditional inpatient sample was weighted to match the hospital-DRG-SOI distribution of the HAH sample.

This study identified 19,49 HAH discharges in Massachusetts from January 2020 to December 2024 and a total of 183,503 discharges in the traditional inpatient comparison sample.

RESULTS

The number of HAH discharges in Massachusetts in 2024 was nearly ten times its 2020 volume but remained only 0.6% of total inpatient discharges in 2024. Discharges were concentrated among a few hospitals in early years, and growth over time reflects both existing program expansion and more programs becoming active. (**Exhibit 1**)

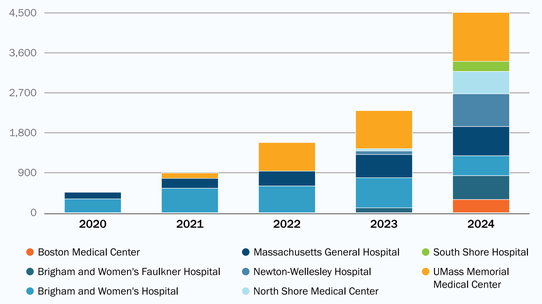
HAH discharges represented a relatively small number of conditions: the 10 APR-DRGs with the most volume accounted for 70% of HAH discharges in 2024, the most common being sepsis, COPD/respiratory infections, and heart failure. The number of DRGs treated in HAH programs increased over time, as did the average SOI of discharges.

In 2024, 66% of HAH discharges were Medicare patients, while commercial and Medicaid patients comprised 18% and 13% of HAH discharges, respectively. HAH discharges were similar to traditional inpatient discharges in terms of patient race/ethnicity, gender, and community income.[1]

LOS among HAH discharges was consistently higher than for comparable inpatient discharges from 2020 to 2024. LOS grew from 2020 to 2022, likely reflecting programs becoming more seasoned and admitting patients with different and potentially more complex conditions, but declined in 2024. In 2024, average LOS was higher for HAH patients overall (by 1.7 days) and for nine of ten top DRGs compared to the traditional inpatient sample. (**Exhibit 2**)

In contrast, average charges per discharge, a measure of hospital resource use, became similar between groups. While HAH discharges had higher average routine (or "room and board") charges, reflecting the higher average LOS, charges for other categories of services were lower. Average charges per discharge grew substantially faster for HAH discharges than for traditional inpatient discharges, mostly attributable to a rapid rise in ancillary charges (professional hospital services such as imaging or labs) and special charges (ICU services). (**Exhibit 3**)

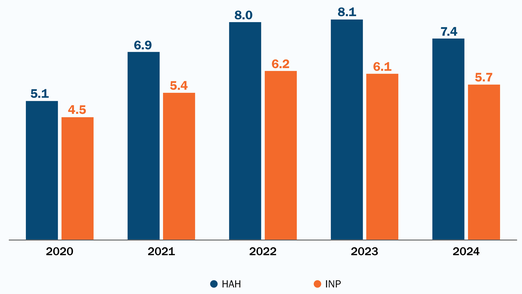
EXHIBIT 1. Hospital at home discharges by hospital and calendar year, 2020 – 2024



Notes: Bars in blue represent discharges from hospitals within the Mass General Brigham health care system.

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

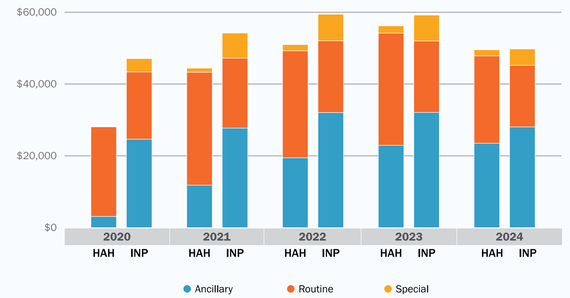
EXHIBIT 2. Average length of stay (days) per discharge, inpatient vs hospital at home, 2020 – 2024



Notes: 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 3. Average charges per discharge by charge type, inpatient vs hospital at home, 2020 – 2024



Notes: Averages are weighted by the distribution of hospitals, APR DRGs, and SOI mix in the hospital at home sample for each year. Ancillary charges are defined as professional services by a hospital or other inpatient health program (e.g., imaging, drug, or laboratory services). Routine charges are considered to be "room and board' charges. Special charges typically reflect ICU utilization.

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

CONCLUSIONS

Conditions treated in HAH programs in the Commonwealth were similar to those treated by programs nationwide. In contrast to national findings, demographics for HAH patients were similar to those of patients who used traditional inpatient care in Massachusetts.

Since the majority of HAH patients are insured by Medicare and there are many fixed costs of operating a HAH program, the ongoing financial sustainability of HAH programs likely depends on whether Medicare continues to pay for this care.

Higher routine charges among HAH discharges reflect longer LOS, among other factors. The decline in total charges from 2023 to 2024 likely reflects community hospitals expanding their programs, which may admit lower-acuity patients or have lower internal costs to providing care compared to the academic medical centers that represented most of the HAH volume prior to 2024. Shorter LOS among traditional inpatient discharges may reflect hospital urgency to discharge the patient to manage capacity, patient urgency to return home, or other factors. Higher ancillary and special charges among traditional inpatient discharges may reflect unmeasured differences in patient acuity (patients who need more intensive care may not be appropriate for HAH), as well as potential excess use of these services during a traditional stay. The higher relative growth in these charges among HAH discharges over time may reflect increased capacity for HAH programs to care for more acute patients as the programs have developed.

POLICY IMPLICATIONS

Hospital at home programs are currently authorized through September 2025, and the future of hospital at home is uncertain. Questions for policymakers include how to measure and safeguard quality in these programs, ensure appropriate use and capacity, support health equity, and consider appropriate payment levels and spending impact.

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1. Community income comparisons were made using data from Q1 to Q3 of calendar year 2024 due to data limitations in Q4.