119TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
119–359

HOSPITAL INPATIENT SERVICES MODERNIZATION ACT

OCTOBER 31, 2025.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. SMITH of Missouri, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

SUPPLEMENTAL VIEWS

[To accompany H.R. 4313]

The Committee on Ways and Means, to whom was referred the bill (H.R. 4313) to amend title XVIII of the Social Security Act to extend acute hospital care at home waiver flexibilities, and to require an additional study and report on such flexibilities, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

CONTENTS

69–006

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Hospital Inpatient Services Modernization Act".

SEC. 2. EXTENDING ACUTE HOSPITAL CARE AT HOME WAIVER FLEXIBILITIES.

Section 1866G(a)(1) of the Social Security Act (42 U.S.C. 1395cc–7(a)(1)) is amended by striking "2025" and inserting "2030".

SEC. 3. REQUIRING ADDITIONAL STUDY AND REPORT ON ACUTE HOSPITAL CARE AT HOME WAIVER FLEXIBILITIES.

Section 1866G of the Social Security Act (42 U.S.C. 1395cc–7), as amended by section 2, is further amended—

(1) in subsection (a)(3)(E)—

(A) in clause (ii), by striking "the study described in subsection (b)" and inserting "the studies described in subsections (b) and (c)"; and

(B) by adding at the end the following new flush sentence:

"The Secretary may require that such data and information be submitted through a hospital's cost report, through such survey instruments as the Secretary may develop, through medical record information, or through such other means as the Secretary determines appropriate.";

(2) in subsection (b), in the subsection heading, by striking "STUDY" and inserting "INITIAL STUDY";

(3) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(4) by inserting after subsection (b) the following new subsection:

"(c) SUBSEQUENT STUDY AND REPORT.—

"(1) IN GENERAL.—Not later than September 30, 2028, the Secretary shall conduct a study to—

"(A) analyze, to the extent practicable, the criteria established by hospitals under the Acute Hospital Care at Home initiative to determine which individuals may be furnished services under such initiative; and

"(B) analyze and compare (both within and between hospitals participating in the initiative, and relative to comparable hospitals that do not participate in the initiative, for relevant parameters such as diagnosis-related groups)—

"(i) quality of care furnished to individuals with similar conditions and characteristics in the inpatient setting and through the Acute Hospital Care at Home initiative, including health outcomes, hospital readmission rates (including readmissions both within and beyond 30 days post-discharge), hospital mortality rates, length of stay, infection rates, composition of care team (including the types of labor used, such as contracted labor), the ratio of nursing staff, transfers from the hospital to the home, transfers from the home to the hospital (including the timing, frequency, and causes of such transfers), transfers and discharges to post-acute care settings (including the timing, frequency, and causes of such transfers and discharges), and patient and caregiver experience of care;

"(ii) clinical conditions treated and diagnosis-related groups of discharges from inpatient settings relative to discharges from the Acute Hospital Care at Home initiative;

"(iii) costs incurred by the hospital for furnishing care in inpatient settings relative to costs incurred by the hospital for furnishing care through the Acute Hospital Care at Home initiative, including costs relating to staffing, equipment, food, prescriptions, and other services, as determined by the Secretary;

"(iv) the quantity, mix, and intensity of services (such as in-person visits and virtual contacts with patients and the intensity of such services) furnished in inpatient settings relative to the Acute Hospital Care at Home initiative, and, to the extent practicable, the nature and extent of family or caregiver involvement;

"(v) socioeconomic information on individuals treated in comparable inpatient settings relative to the initiative, including racial and ethnic data, income, housing, geographic proximity to the brick-and-mortar facility and whether such individuals are dually eligible for benefits under this title and title XIX; and

"(vi) the quality of care, outcomes, costs, quantity and intensity of services, and other relevant metrics between individuals who entered into the Acute Hospital Care at Home initiative directly from an emergency department compared with individuals who entered into the Acute Hospital Care at Home initiative directly from an existing inpatient stay in a hospital.

"(2) SELECTION BIAS.—In conducting the study under paragraph (1), the Secretary shall, to the extent practicable, analyze and compare individuals who participate and do not participate in the initiative controlling for selection bias or other factors that may impact the reliability of data.

"(3) REPORT.—Not later than September 30, 2028, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the study conducted under paragraph (1).".

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The policy would extend the Acute Hospital at Home Initiative through December 31, 2030, and require the Centers for Medicare & Medicaid Services (CMS) to conduct a study of the waiver and submit a report to the House Committee on Ways & Means and the Senate Committee on Finance no later than September 30, 2028.

B. BACKGROUND AND NEED FOR LEGISLATION

Generally, to participate in the Medicare program, hospitals must comply with Medicare's basic health and safety rules, called Conditions of Participation (CoPs), as well as a variety of other regulatory requirements. In 2020, as part of the CMS response to the Covid–19 public health emergency (PHE), the Trump Administration launched the Hospital Without Walls Initiative and its constituent part, the Acute Hospital at Home Initiative (Initiative), designed to provide hospitals needed flexibility to increase hospital capacity. To do this, the Initiative leveraged Section 1135 of the Social Security Act to waive Medicare CoPs and other statutory and regulatory requirements, enabling hospitals to provide inpatient care in beneficiaries' homes. The Initiative was due to end upon the expiration of the Covid–19 PHE, but Congress extended it through December 31, 2024, requiring the Secretary of Health and Human Services to submit to Congress a report on the Initiative's status by the conclusion of Fiscal Year 2024. CMS submitted the report in September 2024. Congress extended the waiver through September 30, 2025, and legislative action is needed to extend the Acute Hospital at Home waiver past that date.

C. LEGISLATIVE HISTORY

Background

H.R. 4313 was introduced on July 10, 2025, and was referred to the Committee on Ways and Means.

Committee Hearings

The Committee on Ways and Means held the following hearing(s) concerning the policy in H.R. 4313:

On June 25, 2025, the Ways and Means Subcommittee on Health held a hearing titled "Health at Your Fingertips: Harnessing the Power of Digital Health Data" where access to technologies including those used through the Acute Hospital at Home Initiative were discussed.

Committee Action

The Committee on Ways and Means marked up H.R. 4313, the "Hospital Inpatient Services Modernization Act" on September 17, 2025, and favorably reported the bill, as amended, to the House of Representatives (with quorum being present).

D. Designated Hearing

Pursuant to clause 3(c)(6) of rule XIII, the following hearing was used to develop and consider H.R. 8261:

On June 25, 2025, the Ways and Means Subcommittee on Health held a hearing titled "Health at Your Fingertips: Harnessing the Power of Digital Health Data".

II. EXPLANATION OF THE BILL

A. Reasons for Change

The Initiative will expire after September 30, 2025, absent congressional action.

B. Explanation of Provisions

The policy would extend the Initiative through December 31, 2030, and require CMS to conduct a study of the waiver and submit a report to the House Committee on Ways & Means and the Senate Committee on Finance no later than September 30, 2028.

C. Effective Date

The bill, as amended, would become effective upon enactment.

III. VOTES OF THE COMMITTEE

In compliance with the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 4313, the "Hospital Inpatient Services Modernization Act," on September 17, 2025.

The vote on Mr. Buchanan's motion to table Mr. Horsford's appeal of the ruling of the chair was agreed to by a roll call vote of 26 yeas to 15 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Smith (MO)	X			Mr. Neal		X	
Mr. Buchanan	X			Mr. Doggett		X	
Mr. Smith (NE)	X			Mr. Thompson		X	
Mr. Kelly	X			Mr. Larson		X	
Mr. Schweikert	X			Mr. Davis			

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. LaHood	X			Ms. Sánchez			
Mr. Arrington	X			Ms. Sewell			
Mr. Estes	X			Ms. DelBene		X	
Mr. Smucker	X			Ms. Chu		X	
Mr. Hern	X			Ms. Moore		X	
Mrs. Miller	X			Mr. Boyle		X	
Dr. Murphy	X			Mr. Beyer		X	
Mr. Kustoff	X			Mr. Evans		X	
Mr. Fitzpatrick	X			Mr. Schneider		X	
Mr. Steube	X			Mr. Panetta		X	
Ms. Tenney	X			Mr. Gomez		X	
Mrs. Fischbach	X			Mr. Horsford		X	
Mr. Moore	X			Ms. Plaskett			
Ms. Van Duyne	X			Mr. Suozzi		X	
Mr. Feenstra	X						
Ms. Malliotakis	X						
Mr. Carey	X						
Mr. Yakym	X						
Mr. Miller	X						
Mr. Bean	X						
Mr. Moran	X						

In compliance with the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 4313, the "Hospital Inpatient Services Modernization Act," on September 17, 2025.

The vote on Mr. Buchanan's motion to table Mr. Thompson's appeal of the ruling of the chair was agreed to by a roll call vote of 26 yeas to 17 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Smith (MO)	X			Mr. Neal		X	
Mr. Buchanan	X			Mr. Doggett		X	
Mr. Smith (NE)	X			Mr. Thompson		X	
Mr. Kelly	X			Mr. Larson		X	
Mr. Schweikert	X			Mr. Davis		X	
Mr. LaHood	X			Ms. Sánchez			
Mr. Arrington	X			Ms. Sewell			
Mr. Estes	X			Ms. DelBene		X	
Mr. Smucker	X			Ms. Chu		X	
Mr. Hern	X			Ms. Moore		X	
Mrs. Miller	X			Mr. Boyle		X	
Dr. Murphy	X			Mr. Beyer		X	
Mr. Kustoff	X			Mr. Evans		X	
Mr. Fitzpatrick	X			Mr. Schneider		X	
Mr. Steube	X			Mr. Panetta		X	
Ms. Tenney	X			Mr. Gomez		X	
Mrs. Fischbach	X			Mr. Horsford		X	
Mr. Moore	X			Ms. Plaskett		X	
Ms. Van Duyne	X			Mr. Suozzi		X	
Mr. Feenstra	X						
Ms. Malliotakis	X						
Mr. Carey	X						
Mr. Yakym	X						
Mr. Miller	X						
Mr. Bean	X						
Mr. Moran	X						

In compliance with the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of

H.R. 4313, the "Hospital Inpatient Services Modernization Act," on September 17, 2025.

The vote on Mr. Buchanan's motion to table Ms. Chu's appeal of the ruling of the chair was agreed to by a roll call vote of 26 yeas to 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Smith (MO)	X			Mr. Neal		X	
Mr. Buchanan	X			Mr. Doggett		X	
Mr. Smith (NE)	X			Mr. Thompson		X	
Mr. Kelly	X			Mr. Larson		X	
Mr. Schweikert	X			Mr. Davis		X	
Mr. LaHood	X			Ms. Sánchez			
Mr. Arrington	X			Ms. Sewell			
Mr. Estes	X			Ms. DelBene		X	
Mr. Smucker	X			Ms. Chu		X	
Mr. Hern	X			Ms. Moore		X	
Mrs. Miller	X			Mr. Boyle		X	
Dr. Murphy	X			Mr. Beyer		X	
Mr. Kustoff	X			Mr. Evans		X	
Mr. Fitzpatrick	X			Mr. Schneider		X	
Mr. Steube	X			Mr. Panetta			
Ms. Tenney	X			Mr. Gomez		X	
Mrs. Fischbach	X			Mr. Horsford		X	
Mr. Moore	X			Ms. Plaskett		X	
Ms. Van Duyne	X			Mr. Suozzi		X	
Mr. Feenstra	X						
Ms. Malliotakis	X						
Mr. Carey	X						
Mr. Yakym	X						
Mr. Miller	X						
Mr. Bean	X						
Mr. Moran	X						

In compliance with the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 4313, the "Hospital Inpatient Services Modernization Act," on September 17, 2025.

The vote on Mr. Buchanan's motion to table Mr. Schneider's appeal of the ruling of the chair was agreed to by a roll call vote of 25 yeas to 18 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Smith (MO)	X			Mr. Neal		X	
Mr. Buchanan	X			Mr. Doggett		X	
Mr. Smith (NE)	X			Mr. Thompson		X	
Mr. Kelly	X			Mr. Larson		X	
Mr. Schweikert	X			Mr. Davis		X	
Mr. LaHood	X			Ms. Sánchez			
Mr. Arrington				Ms. Sewell		X	
Mr. Estes	X			Ms. DelBene		X	
Mr. Smucker	X			Ms. Chu		X	
Mr. Hern	X			Ms. Moore		X	
Mrs. Miller	X			Mr. Boyle		X	
Dr. Murphy	X			Mr. Beyer		X	
Mr. Kustoff	X			Mr. Evans		X	
Mr. Fitzpatrick	X			Mr. Schneider		X	
Mr. Steube	X			Mr. Panetta		X	
Ms. Tenney	X			Mr. Gomez		X	
Mrs. Fischbach	X			Mr. Horsford		X	
Mr. Moore	X			Ms. Plaskett		X	
Ms. Van Duyne	X			Mr. Suozzi		X	

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Feenstra	X						
Ms. Malliotakis	X						
Mr. Carey	X						
Mr. Yakym	X						
Mr. Miller	X						
Mr. Bean	X						
Mr. Moran	X						

In compliance with the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 4313, the "Hospital Inpatient Services Modernization Act," on September 17, 2025.

H.R. 4313 was ordered favorably reported to the House of Representatives as amended by a roll call vote of 44 yeas to 0 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Smith (MO)	X			Mr. Neal	X		
Mr. Buchanan	X			Mr. Doggett	X		
Mr. Smith (NE)	X			Mr. Thompson	X		
Mr. Kelly	X			Mr. Larson	X		
Mr. Schweikert	X			Mr. Davis	X		
Mr. LaHood	X			Ms. Sánchez			
Mr. Arrington	X			Ms. Sewell	X		
Mr. Estes	X			Ms. DelBene	X		
Mr. Smucker	X			Ms. Chu	X		
Mr. Hern	X			Ms. Moore	X		
Mrs. Miller	X			Mr. Boyle	X		
Dr. Murphy	X			Mr. Beyer	X		
Mr. Kustoff	X			Mr. Evans	X		
Mr. Fitzpatrick	X			Mr. Schneider	X		
Mr. Steube	X			Mr. Panetta	X		
Ms. Tenney	X			Mr. Gomez	X		
Mrs. Fischbach	X			Mr. Horsford	X		
Mr. Moore	X			Ms. Plaskett	X		
Ms. Van Duyne	X			Mr. Suozzi	X		
Mr. Feenstra	X						
Ms. Malliotakis	X						
Mr. Carey	X						
Mr. Yakym	X						
Mr. Miller	X						
Mr. Bean	X						
Mr. Moran	X						

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

With respect to clause 3(d) of rule XIII of the Rules of the House of Representatives, a cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974 was not made available to the Committee in time for the filing of this report.

B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill in-

volved no new or increased budget authority. The Committee states further that the bill involves no new or increased tax expenditures.

C. Cost Estimate Prepared by the Congressional Budget Office

With respect to the requirements of clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the *Congressional Budget Act of 1974* and with respect to requirements of clause (3)(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the *Congressional Budget Act of 1974*, the Committee has requested but not received a cost estimate for this bill from the Director of Congressional Budget Office. The Chairman of the Committee shall cause such estimate and statement to be printed in the Congressional Record upon its receipt by the Committee.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. Committee Oversight Findings and Recommendations

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee made findings and recommendations that are reflected in this report.

B. Statement of General Performance Goals and Objectives

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the bill does not authority funding, so no statement of general performance goals and objectives is required.

C. Information Relating to Unfunded Mandates

This information is provided in accordance with section 423 of the *Unfunded Mandates Reform Act of 1995* (Pub. L. No. 104–4).

The Committee has determined that the bill does not contain Federal mandates on the private sector. The Committee has determined that the bill does not impose a Federal intergovernmental mandate on State, local, or tribal governments.

D. Congressional Earmarks, Limited Tax Benefits, and Limited Tariff Benefits

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the bill, and states that the provisions of the bill do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

E. Duplication of Federal Programs

In compliance with clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that no provision of the bill establishes or reauthorizes: (1) a program of the Federal Government known to be duplicative of another Federal program; (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public

Law 111–139; or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to the Federal Program Information Act (Pub. L. No. 95–220, as amended by Pub. L. No. 98–169).

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART E—MISCELLANEOUS PROVISIONS

* * * * * * *

SEC. 1866G. EXTENSION OF ACUTE HOSPITAL CARE AT HOME INITIATIVE.

(a) IN GENERAL.—

(1) EXTENSION.—With respect to inpatient hospital admissions occurring during the period beginning on the first day after the end of the emergency period described in section 1135(g)(1)(B) and ending on September 30, [2025] *2030*, the Secretary of Health and Human Services shall grant waivers and flexibilities (as described in paragraph (2)) to an individual hospital that submits a request for such waivers and flexibilities and meets specified criteria (as described in paragraph (3)) in order to participate in the Acute Hospital Care at Home initiative of the Secretary.

(2) ACUTE HOSPITAL CARE AT HOME WAIVERS AND FLEXIBILITIES.—For the purposes of paragraph (1), the waivers and flexibilities described in this paragraph are the following waivers and flexibilities that were made available to individual hospitals under the Acute Hospital Care at Home initiative of the Secretary during the emergency period described in section 1135(g)(1)(B):

(A) Subject to paragraph (3)(D), waiver of the requirements to provide 24-hour nursing services on premises and for the immediate availability of a registered nurse under section 482.23(b) of title 42, Code of Federal Regulations (or any successor regulation), and the waivers of the phys-

ical environment and Life Safety Code requirements under section 482.41 of title 42, Code of Federal Regulations (or any successor regulation).

(B) Flexibility to allow a hospital to furnish inpatient services, including routine services, outside the hospital under arrangements, as described in Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating; COVID–19 (87 Fed. Reg. 71748 et seq.).

(C) Waiver of the telehealth requirements under clause (i) of section 1834(m)(4)(C), as amended by section 4113(a) of the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022, such that the originating sites described in clause (ii) of such section shall include the home or temporary residence of the individual.

(D) Other waivers and flexibilities that, as of the date of enactment of this section, were in place for such initiative during such emergency period.

(3) SPECIFIED CRITERIA.—For purposes of paragraph (1), the specified criteria for granting such waivers and flexibilities to individual hospitals are:

(A) The hospital shall indicate to the Secretary the criteria it would use to ensure that hospital services be furnished only to an individual who requires an inpatient level of care, and shall require that a physician document in the medical record of each such individual that the individual meets such criteria.

(B) The hospital and any other entities providing services under arrangements with the hospital shall ensure that the standard of care to treat an individual at home is the same as the standard of care to treat such individual as an inpatient of the hospital.

(C) The hospital shall ensure that an individual is only eligible for services under paragraph (1) if the individual is a hospital inpatient or is a patient of the hospital's emergency department for whom the hospital determines that an inpatient level of care is required (as described in subparagraph (A)).

(D) The hospital shall meet all patient safety standards determined appropriate by the Secretary, in addition to those that otherwise apply to the hospital, except those for which the waivers and flexibilities under this subsection apply.

(E) The hospital shall provide to the Secretary, at a time, form and manner determined by the Secretary, any data and information the Secretary determines necessary to do the following:

(i) Monitor the quality of care furnished, and to the extent practicable, ensure the safety of individuals and analyze costs of such care.

(ii) Undertake [the study described in subsection (b)] *the studies described in subsections (b) and (c)*.

The Secretary may require that such data and information be submitted through a hospital's cost report, through such survey instruments as the Secretary may develop, through medical record information, or through such other means as the Secretary determines appropriate.

(F) The hospital meets such other requirements and conditions as the Secretary determines appropriate.

(4) TERMINATION.—The Secretary may terminate a hospital from participation in such initiative (and the waivers and flexibilities applicable to such hospital) if the Secretary determines that the hospital no longer meets the criteria described in paragraph (3).

(b) [STUDY] *INITIAL STUDY* AND REPORT.—

(1) IN GENERAL.—The Secretary shall conduct a study to—

(A) analyze, to the extent practicable, the criteria established by hospitals under the Acute Hospital Care at Home initiative of the Secretary to determine which individuals may be furnished services under such initiative; and

(B) analyze and compare, to the extent practicable—

(i) quality of care furnished to individuals with similar conditions and characteristics in the inpatient setting and through the Acute Hospital Care at Home initiative, including health outcomes, hospital readmission rates, hospital mortality rates, length of stay, infection rates, and patient experience of care;

(ii) clinical conditions treated and diagnosis-related groups of discharges from the inpatient setting and under the Acute Hospital Care at Home initiative;

(iii) costs incurred by furnishing care in the inpatient setting and through the Acute Hospital Care at Home initiative;

(iv) the quantity, mix and intensity of such services (such as in-person visits and virtual contacts with patients) furnished in the Acute Hospital Care at Home initiative and furnished in the inpatient setting; and

(v) socioeconomic information on beneficiaries treated under the initiative, including racial and ethnic data, income, and whether such beneficiaries are dually eligible for benefits under this title and title XIX.

(2) REPORT.—Not later than September 30, 2024, the Secretary of Health and Human Services shall post on a website of the Centers for Medicare & Medicaid Services a report on the study conducted under paragraph (1).

(3) FUNDING.—In addition to amounts otherwise available, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2023, out of any amounts in the Treasury not otherwise appropriated, $5,000,000, to remain available until expended, for purposes of carrying out this subsection.

(c) SUBSEQUENT STUDY AND REPORT.—

(1) IN GENERAL.—Not later than September 30, 2028, the Secretary shall conduct a study to—

(A) analyze, to the extent practicable, the criteria established by hospitals under the Acute Hospital Care at Home initiative to determine which individuals may be furnished services under such initiative; and

(B) analyze and compare (both within and between hospitals participating in the initiative, and relative to comparable hospitals that do not participate in the initiative, for relevant parameters such as diagnosis-related groups)—

(i) quality of care furnished to individuals with similar conditions and characteristics in the inpatient setting and through the Acute Hospital Care at Home initiative, including health outcomes, hospital readmission rates (including readmissions both within and beyond 30 days post-discharge), hospital mortality rates, length of stay, infection rates, composition of care team (including the types of labor used, such as contracted labor), the ratio of nursing staff, transfers from the hospital to the home, transfers from the home to the hospital (including the timing, frequency, and causes of such transfers), transfers and discharges to post-acute care settings (including the timing, frequency, and causes of such transfers and discharges), and patient and caregiver experience of care;

(ii) clinical conditions treated and diagnosis-related groups of discharges from inpatient settings relative to discharges from the Acute Hospital Care at Home initiative;

(iii) costs incurred by the hospital for furnishing care in inpatient settings relative to costs incurred by the hospital for furnishing care through the Acute Hospital Care at Home initiative, including costs relating to staffing, equipment, food, prescriptions, and other services, as determined by the Secretary;

(iv) the quantity, mix, and intensity of services (such as in-person visits and virtual contacts with patients and the intensity of such services) furnished in inpatient settings relative to the Acute Hospital Care at Home initiative, and, to the extent practicable, the nature and extent of family or caregiver involvement;

(v) socioeconomic information on individuals treated in comparable inpatient settings relative to the initiative, including racial and ethnic data, income, housing, geographic proximity to the brick-and-mortar facility and whether such individuals are dually eligible for benefits under this title and title XIX; and

(vi) the quality of care, outcomes, costs, quantity and intensity of services, and other relevant metrics between individuals who entered into the Acute Hospital Care at Home initiative directly from an emergency department compared with individuals who entered into the Acute Hospital Care at Home initiative directly from an existing inpatient stay in a hospital.

(2) SELECTION BIAS.—In conducting the study under paragraph (1), the Secretary shall, to the extent practicable, analyze and compare individuals who participate and do not participate in the initiative controlling for selection bias or other factors that may impact the reliability of data.

(3) REPORT.—Not later than September 30, 2028, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report on the study conducted under paragraph (1).

[(c)**]** *(d)* IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this section by program instruction or otherwise.

[(d)**]** *(e)* PUBLICLY AVAILABLE INFORMATION.—The Secretary shall, as feasible, make the information collected under subsections (a)(3)(E) and (b)(1) available on the Medicare.gov internet website (or a successor website).

* * * * * * *

VII. SUPPLEMENTAL VIEWS

H.R. 4313 would extend the Acute Hospital Care at Home (AHCaH) waivers for five additional years, through December 31, 2030. It would also require the Secretary to conduct a follow-up study, analyzing aspects of AHCaH including, but not limited to, inclusion criteria for AHCaH across hospitals, quality of care, costs of furnishing such care, socioeconomic information of individuals treated through AHCaH, and point of entry into AHCaH (either directly from an emergency department or from an existing inpatient stay in a hospital).

While Democrats broadly support extending the HaH program while we gather more data, recent Republican actions are jeopardizing the ability of hospitals to continue to serve many communities. Just months ago, Republicans passed H.R. 1, which cut more than $1.4 trillion from the health care system and would cause more than 15 million people to lose insurance coverage. These cuts and resultant coverage loss will strain the health system and lead to more uncompensated and forgone care. The University of North Carolina's Cecil G. Sheps Center found that more than 300 rural hospitals are at risk because of the policies in H.R. 1.[1] Additionally, the Republicans' law increases the deficit by trillions of dollars, triggering additional automatic Medicare cuts under the statutory Pay-As-You-Go Act (PAYGO). These cuts will reduce payments to Medicare providers—including hospitals—by over $500 billion, or four percent, all in service of a giant tax giveaway to the richest 1 percent of Americans.[2]

Democrats offered several amendments to mitigate the Republican assault on health care. First, Congressman Horsford (D–NV) offered an amendment to permanently extend the tax credits that help make insurance coverage affordable for those who purchase their own insurance. On average, low-and-middle income Americans will see their premiums increase by 93 percent, and many more will pay thousands more for health care due to Republican choices.[3] Republicans ruled this amendment out of order on a procedural vote. Then, Congressman Thompson (D–CA) offered an amendment to extend these tax credits for just one year. Even though Committee Republicans purport to support this modest approach, they voted to block its consideration.

Rep. Chu (D–CA) offered an amendment to prevent over $500 billion in Medicare cuts over the next ten years, which are triggered by the Republicans' tax breaks for the wealthiest. The Republicans ruled this amendment out of order as well. Rep. Schneider offered an amendment to continue Medicare beneficiaries' access to the

[1] https://www.wral.com/lifestyle/health/nc-rural-hospitals-risk-closure-one-big-beautiful-bill-act-june-2025/.
[2] https://www.cbo.gov/system/files/2025-08/61659-SPAYGO.pdf.
[3] https://americanscovered.org/about/about-the-issue/.

same scientific and evidence-based vaccines as they had in 2024, including the no cost-sharing terms. Under the Trump Administration, evidence-based vaccines that have saved millions of lives are under attack. Secretary Kennedy at HHS has upended the Advisory Committee on Immunization Practices (ACIP) in favor of pseudo-science, threatening the lives of Americans who rely on vaccines to prevent diseases and potentially increasing costs for those who access vaccines no longer recommended by ACIP despite sound scientific evidence. The Republicans once again blocked this amendment from consideration.

Hospital at Home Background and Considerations

Hospital at Home (HaH) refers to a specific care model developed by Johns Hopkins University in which a health care organization provides inpatient-level care to patients in their homes.[4] Several other countries, as well as some U.S. hospitals, have implemented versions of a HaH program; however, broader uptake in the U.S. was limited until the COVID–19 pandemic.[5]

As part of the COVID–19 Public Health Emergency waivers CMS implemented in March 2020, CMS began the "Hospitals Without Walls" initiative, which provided broad regulatory flexibility to allow health systems and hospitals to provide hospital-level care to patients beyond their existing walls.[6] Using waiver authorities granted to CMS under section 1135 of the Social Security Act (the pandemic waivers), hospitals could transfer patients to non-hospital facilities while still receiving hospital payments under Medicare.[7] [8] This waiver allowed hospitals to reserve inpatient beds for the most critically ill patients and expand capacity during the initial COVID–19 response.

In November 2020, CMS launched the Acute Hospital Care at Home (AHCaH) initiative, which built off Hospitals Without Walls. Under AHCaH, CMS allows certain Medicare-certified hospitals to request to waive § 482.23(b) and (b)(1) of the Hospital Conditions of Participation (CoP), which require 24/7 on-premises nursing services and a registered nurse (RN) to be immediately available to care for a patient.[9] In addition, the Secretary waived hospital

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[4] *Hospital at Home*, JOHNS HOPKINS MEDICINE (last visited on Mar. 8, 2024), https://www.johnshopkinssolutions.com/solution/hospital-at-home/.

[5] Sarah Klein, *"Hospital at Home" Programs Improve Outcomes, Lower Costs But Face Resistance from Providers and Payers*, THE COMMONWEALTH FUND (last visited on Mar. 8, 2024), https://www.commonwealthfund.org/publications/newsletter-article/hospital-home-programs-improve-outcomes-lower-costs-face-resistance.

[6] ADDITIONAL BACKGROUND: SWEEPING REGULATORY CHANGES TO HELP U.S. HEALTHCARE SYSTEM ADDRESS COVID–19 PATIENT SURGE, CENTERS FOR MEDICARE AND MEDICAID SERVICES (Mar. 30, 2020), https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient.

[7] *CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID–19 Surge*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (Nov. 25, 2020), https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge.

[8] ADDITIONAL BACKGROUND: SWEEPING REGULATORY CHANGES TO HELP U.S. HEALTHCARE SYSTEM ADDRESS COVID–19 PATIENT SURGE, CENTERS FOR MEDICARE AND MEDICAID SERVICES (Mar. 30, 2020), https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient.

[9] *Acute Hospital Care at Home*, CMS QUALITYNET (last visited on Mar. 8, 2024), https://qualitynet.cms.gov/acute-hospital-care-at-home.

physical environment and "Life Safety Code" requirements for delivering care in patients' homes.[10]

Under this model, each hospital determines the clinical conditions and criteria for ACHaH services. Medicare's other CoPs remain unchanged, and CMS performs a review of off-site hospital operations and processes to ensure that each requesting hospital could satisfy them in the home environment. Hospitals must also have two in-person daily clinical visits by a nurse or paramedic, ensure 24/7 contact between patients and the hospital, and be able to reach the patient at home within 30 minutes. Approved hospitals receive full payment under the inpatient prospective payment system (IPPS) through Medicare Severity-Diagnosis Related Groups (MS–DRG) as well as applicable add-on payments.[11]

Hospitals participating in AHCaH must submit waivers for each individual entity with a CMS Certification Number (CCN) rather than for a whole hospital system.[12] CMS categorizes AHCaH waiver requests based on prior hospital experience with home acute hospital services.[13] Hospitals previously providing care to 25 or more patients go through an expedited process to allow experienced hospitals to rapidly expand care, while hospitals previously providing care to 25 or fewer patients (or who never previously furnished care in the home) must submit a more detailed waiver request demonstrating home patients will receive the same level of care as patients in traditional inpatient units. Hospitals approved via the expedited waiver pathway are required to submit monitoring data monthly. Similarly, hospitals approved via the detailed waiver pathway are required to submit monitoring data weekly. Monitoring data includes information on patient volume, unanticipated mortality during an acute episode of care, escalation rate (i.e., discharges involving transfer from acute hospital care at home to traditional inpatient setting), attestation that a hospital's acute hospital care at home safety committee reviewed the reported metrics, and the patient list.[14]

In December 2022, Congress enacted H.R. 2716, *Consolidated Appropriations Act for Fiscal Year 2023* (CAA, 2023), which extended flexibilities granted under the AHCaH waiver program through December 31, 2024.[15] The CAA, 2023, also requires hospitals to submit additional data the Secretary determines necessary to monitor quality of care, safety, and cost. CMS must release a report analyzing AHCaH utilization, quality, outcomes, and cost by September 30, 2024.

Policy considerations. Broadly, the goal of HaH is to treat acutely ill older adults in their homes, while improving outcomes, enhancing the patient experience, and reducing costs.[16] Researchers have

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[10] *Acute Hospital Care at Home Data Release Fact Sheet*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (Jan. 16, 2024), https://www.cms.gov/newsroom/fact-sheets/acute-hospital-care-home-data-release-fact-sheet.

[11] *Acute Care Delivery at Home*, ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE (Apr. 2021), https://files.asprtracie.hhs.gov/documents/aspr-tracie-acute-care-delivery-at-home-tip-sheet-.pdf.

[12] *Acute Hospital Care at Home*, CMS QUALITYNET (last visited on Mar. 8, 2024), https://qualitynet.cms.gov/acute-hospital-care-at-home.

[13] *Id.*

[14] *Id.*

[15] The Consolidated Appropriates Act, 2023, 42 U.S.C. § 1395(cc–7) (2023).

[16] *Hospital-at-home*, AMERICAN HOSPITAL ASSOCIATION (last visited on Mar. 8, 2024), https://www.aha.org/hospitalathome.

found that HaH programs in other countries are associated with reductions in mortality, readmission rates, and costs. These studies have also found increases in patient and caregiver satisfaction.[17] Early pilot studies in the U.S. show similar increases in patient satisfaction and decreases in cost without changes in readmission rates.[18] However, evaluations of U.S. HaH programs are limited and inconclusive—and quality, cost, and equity concerns remain.[19] Patients also often refuse participating when eligible for HaH.[20]

AHCaH Evaluation. In September 2024, CMS released a Congressionally-mandated report on AHCaH. CMS found that patients participating in AHCaH were more likely to be White and from urban areas, and less likely to be eligible for forms of governmental assistance.[21] The report found that the most-used diagnostic codes were related to respiratory, circulatory, renal, and infectious disease conditions. While the report included some information, analysis and findings were insufficient to provide conclusive evidence related to the quality of care beneficiaries received in the home. Furthermore, the report skirted around the cost of AHCaH in the home, making any substantive comparisons or analyses on the cost inputs of care futile. Additional data and more robust analysis are necessary to determine how Medicare beneficiaries are using and hospitals are furnishing hospital-level care in the home.

Early AHCaH evaluations. In 2023, CMS released its first analysis of AHCaH data. CMS found that 8,417 Medicare FFS beneficiaries were admitted under an AHCaH waiver between November 25, 2021, and March 20, 2023.[22] The most common diagnoses included respiratory infections, heart failure and shock, and severe sepsis or septicemia, all with major complication or comorbidity (MCC). The median length of stay was five days, 7.2 percent of patients were transferred back to the hospital, and 38 unexpected deaths occurred in participating hospitals, mostly due to COVID–19 infection. All but three deaths occurred after the patient was transferred back to the hospital and received medical and/or intensive care for several days before death. As of February 14, 2024, 315 hospitals across 131 systems in 37 states are approved for AHCaH.[23]

During its September 2023 public meeting, MedPAC flagged concerns about ACHaH, noting that 65 percent of hospitals approved for ACHaH had zero discharges (meaning they were not using the benefit) and active hospitals (those with at least one discharge)

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[17] Gideon A Caplan et al., *A meta-analysis of "hospital in the home,"* 197:9 THE MEDICAL JOURNAL OF AUSTRALIA 512–519 (2012), https://onlinelibrary.wiley.com/doi/abs/10.5694/mja12.10480.

[18] Sarah Klein, *"Hospital at Home" Programs Improve Outcomes, Lower Costs But Face Resistance from Providers and Payers*, THE COMMONWEALTH FUND (last visited on Mar. 8, 2024), https://www.commonwealthfund.org/publications/newsletter-article/hospital-home-programs-improve-outcomes-lower-costs-face-resistance.

[19] *Medicare's Acute Care Hospital at Home Program*, MEDPAC (Sep. 8, 2023), https://www.medpac.gov/wp-content/uploads/2023/03/Tab-F-ACHaH-Sept-2023.pdf.

[20] David M Levine et al., *Hospital-Level Care at Home for Acutely Ill Adults: A Randomized Controlled Trial*, 172:2 ANNALS OF INTERNAL MEDICINE 77–85 (2020), https://www.acpjournals.org/doi/10.7326/M19-0600.

[21] https://qualitynet.cms.gov/files/66fae9162702fb414b540545?filename=AHCAH_Study_092724.pdf.

[22] Danielle Adams et al., *Initial Findings From an Acute Hospital Care at Home Waiver Initiative*, JAMA HEALTH FORUM (Nov. 3, 2023), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2811346.

[23] *Approved Facilities/Systems for Acute Hospital Care at Home*, CMS QUALITYNET (last visited on Mar. 8, 2024), https://qualitynet.cms.gov/acute-hospital-care-at-home/resources#tab1.

were more likely to be urban, non-profit, larger in size, and higher in occupancy.[24] Of the 6,200 total ACHaH discharges in 2022, the largest 18 hospitals accounted for 62.5 percent of the volume. MedPAC also stated that evaluating ACHaH will be challenging because beneficiaries self-select into the service, data on services provided during an ACHaH stay are limited, services provided and clinical conditions covered by participating hospitals varies by hospital, and the potential for higher at-home costs is great. While Commissioners broadly agreed safe and effective HaH programs could provide value in the right settings, they also expressed concerns about costs and the need for caregiver support, among other limitations.[25] MedPAC will provide a full chapter on ACHaH in its upcoming report to Congress.

Equity considerations. CMS' evaluation and MedPAC's analysis raise concerns about equitable access to HaH. First, patients participating in ACHaH are disproportionately White, and HaH uptake is primarily concentrated among larger urban hospitals. Hospitals must rethink current practices and develop the workforce and technical infrastructure necessary to support HaH, which may elude smaller or rural hospitals with fewer resources available for the necessary up-front investments.[26] [27] Smaller hospitals, those in rural and underserved areas, and safety net hospitals may face challenges building the scale and capacity necessary to implement and sustain HaH, given that some estimate only five percent of Medicare discharges would be eligible for HaH.[28] This translates to 15 patients per week for a 1,000-bed hospital. The digital infrastructure hospitals use to remotely monitor patients also demands a reliable and fast internet connection, sometimes unavailable in rural and underserved communities.[29] The program as currently constituted favors larger urban hospital systems with greater resource capacity—as evidenced by early adopters, such as Johns Hopkins University Hospital, Mount Sinai Medical Center in New York City, and Mass General Brigham in Boston.

Second, patient selection into HaH could exacerbate existing disparities and disproportionately favor patients with more resources. Hospitals implementing HaH determine which services and patients are eligible for HaH, while also considering their own liability.[30] In doing so, they may consider factors such as caregiver availability, housing conditions, and other perceived or required social supports needed for patients to successfully recover in the

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[24] *Medicare's Acute Care Hospital at Home Program*, MEDPAC (Sep. 8, 2023), https://www.medpac.gov/wp-content/uploads/2023/03/Tab-F-ACHaH Sept-2023.pdf.

[25] Emma Hammer, *MedPAC Holds September 2023 Meeting 09.15.2023*, APPLIED POLICY (Sep. 15, 2023), https://www.appliedpolicy.com/medpac-holds-september-2023-meeting/.

[26] Ksenia Gorbenko et al., *A national qualitative study of Hospital-at-Home implementation under the CMS Acute Hospital Care at Home waiver*, 71:1 Journal of the American Geriatrics Society 245–258 (2022), https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.18071.

[27] *Hospital at Home*, JOHNS HOPKINS MEDICINE (last visited on Mar. 8, 2024), https://www.johnshopkinssolutions.com/solution/hospital-at-home/.

[28] *Rosemary Batt & Eileen Appelbaum, The New Hospital-at-Home Movement: Opportunity or Threat for Patient Care?*, 33:2 PUBLIC POLICY & AGING REPORT? 63–69 (2023), https://academic.oup.com/ppar/article/33/2/63/7147165.

[29] Fady Sahhar & Mandy Sahhar, *Home Health Series—The Challenges to Widespread Implementation of Hospital at Home Programs*, THE VBP BLOG (Sep. 21, 2023), https://www.thevbpblog.com/home-health-series-the-challenges-to-widespread-implementation-of-hospital-at-home-programs/.

[30] David A Simon et al., *The hospital-at-home presents novel liabilities for physicians, hospitals, caregivers, and patients*, 28 NATURE MEDICINE 438–441 (2022), https://www.nature.com/articles/s41591-022-01697-3.

home environment. HaH may therefore serve certain populations more than others and access may be limited for historically marginalized communities that could benefit from it the most.

Quality of care and patient safety concerns. Given the small sample size and data availability, it remains unclear whether HaH programs provide the same level and quality of acute care that acute care hospitals provide. Compromised quality and safety can happen for several reasons. First, under ACHaH, hospitals must be able to reach patients within 30 minutes in the event of an emergency. That means if a patient needs to be transferred to a hospital, it could take up to an hour to begin receiving inpatient care.[31] Studies show that patients are more likely to experience adverse events or die when critical care is delayed in an emergency.[32]

Second, hospitals must train existing staff, hire additional staff, or contract out to groups such as home health agencies (HHA) to fulfill the waiver obligation of two visits per day by a nurse or emergency medical technician (EMT). However, the 2024 CMS report on ACHaH did not provide sufficient data to analyze how hospitals were using or training staff for patients in ACHaH. In addition, in 2022, OIG released a report showing HHAs failed to report over half of falls with major injury and hospitalizations in their Medicare population.[33] Some hospitals are also opting for less expensive EMTs for daily in-home visits rather than hiring nurses to make home visits. While this is allowable under the waiver and may be appropriate in certain circumstances, EMTs and nurses have different training, and the care they provide is not the same.[34] Replacing nurses with paramedics or EMTs could degrade the quality of care patients receive in the home. In both cases, HHAs and EMT groups are increasingly owned by private equity groups that have come under scrutiny in recent years for maximizing profits at the expense of patient care.[35] [36]

Third, substantial research over decades shows that higher nurse staffing levels and interdisciplinary care provided by care teams in hospitals improve care quality and reduce adverse events.[37] Sending home patients who previously would have been admitted to the hospital—without the same supports or requirements for additional staffing—could lead to a drop in care quality. Understanding the implications of inpatient care provided in a home setting is critical,

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[31] *Medicare's Hospital at Home Program is Dangerous for Patients*, NATIONAL NURSES UNITED (Sep. 2022), https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0922_Medicare_HospitalAtHome_Report.pdf.

[32] Jack Chen et al., *Delayed Emergency Team Calls and Associated Hospital Mortality: A Multicenter Study*, 43:10 CRITICAL CARE MEDICINE 2059–2065 (2015), https://journals.lww.com/ccmjournal/abstract/2015/10000/delayed_emergency_team_calls_and_associated.3.aspx.

[33] *Home Health Agencies Failed To Report Over Half of Falls With Major Injury and Hospitalization Among Their Medicare Patients*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Office of Inspector General (Sep. 5, 2023), https://oig.hhs.gov/oei/reports/OEI-05-22-00290.asp.

[34] *Rosemary Batt & Eileen Appelbaum, The New Hospital-at-Home Movement: Opportunity or Threat for Patient Care?*, 33:2 PUBLIC POLICY & AGING REPORT? 63–69 (2023), https://academic.oup.com/ppar/article/33/2/63/7147165.

[35] *Id.*

[36] *Dangers Facing EMS: For-Profit Takeover*, EMERGICON (Nov. 14, 2022), https://emergicon.com/blog/dangers-facing-ems-for-profit-takeover/.

[37] *Rosemary Batt & Eileen Appelbaum, The New Hospital-at-Home Movement: Opportunity or Threat for Patient Care?*, CENTER FOR ECONOMIC AND POLICY RESEARCH (Jan. 24, 2023), https://cepr.net/report/the-new-hospital-at-home-movement-opportunity-or-threat-for-patient-care/.

and more data is needed to determine if patient safety is compromised.

Questions about cost and payment. The 2024 CMS report on ACHaH did not provide data to determine the cost of providing hospital care in the home. The American Hospital Association (AHA) and its members point to reports of early HaH pilots that show potential savings of 20 to 40 percent compared to inpatient treatment.[38] However, the small scale and limited sample size of pilots mostly in larger urban hospitals raises questions about whether these savings would be similar in other settings. It is also not clear whether cost savings seen in early pilots are representative of the true financial picture as programs expand—and who would benefit from those savings.

At the same time, under ACHaH, Medicare pays hospitals at the inpatient rate despite far lower costs for in-home care.[39] Some have raised questions about whether this is the appropriate payment level, including MedPAC commissioners, who expressed skepticism that payment should be on par with inpatient payment, given the care provided is different.[40] The National Nurses Union has warned that there is a paucity of data to compare costs of HaH to inpatient care, and HaH shifts labor costs from hospitals to caregivers. Determining appropriate compensation under HaH is complex and involves considering both the upfront investment hospitals must make to provide care in the home as well as the cost savings hospitals see in the facility from shifting care.

Caregiver burden is often overlooked. Proponents of HaH make the case that the model allows patients to sleep better and spend more time with family members. At the same time, HaH places more burden on family members to serve as caregivers and *de facto* nurse aides by providing basic patient care, such as delivering meals and helping with hygiene.[41] [42] It is important to be clear with caregivers the responsibility that comes with HaH arrangements and understand the added burden placed on caregivers as HaH expands. In addition, patients living alone or without family members with the ability to care for them may be altogether unable to access HaH.

Sincerely,

RICHARD E. NEAL,
Ranking Member.

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[38] *Id.*
[39] *Id.*
[40] *September 2023 Public Meeting Transcript*, MEDPAC (Sep. 7, 2023), https://www.medpac.gov/wp-content/uploads/2023/03/September-2023-meeting-transcript-v2-SEC.pdf.
[41] Kat McGowan, *'Hospital-at-home' trend means family members must be caregivers—ready or not*, NPR (July 18, 2023), https://www.npr.org/sections/health-shots/2023/07/18/1188058399/hospital-at-home-caregivers-family-stress.
[42] Fady Sahhar & Mandy Sahhar, *Home Health Series—The Challenges to Widespread Implementation of Hospital at Home Programs*, THE VBP BLOG (Sep. 21, 2023), https://www.thevbpblog.com/home-health-series-the-challenges-to-widespread-implementation-of-hospital-at-home-programs/.