

MEDICARE'S HOSPITAL AT HOME PROGRAM IS DANGEROUS FOR PATIENTS

Introduction 2

I. The Acute Hospital Care at Home Program Cannot Provide Acute Hospital-Level Care in a Patient's Home..... 3

II. The Acute Hospital Care at Home Program Allows Hospitals to Shift Care to Inappropriate Settings Rather Than Increasing Acute Inpatient Capacity by Investing in Staffing and Infrastructure..... 7

III. The Acute Hospital Care at Home Program is Vulnerable to Fraudulent Billing Practices..... 9

Conclusion..... 10

Endnotes..... 11



INTRODUCTION

Nursing is a highly-skilled profession that is based on scientific knowledge and attention to detail. It demands an ability to address the physical, psychological, and emotional needs of a patient with compassion, empathy, and advocacy to honor the dignity in all people. Registered nurses are essential to providing acute, hospital-level inpatient treatment. Indeed, acute care hospitals that admit Medicare patients are required to provide nursing services at all times: 24-hours a day, seven days a week.

During the pandemic, the Centers for Medicare and Medicaid Services' (CMS) Acute Hospital Care at Home (AHCaH) program fulfilled a long-sought goal of the hospital industry: full reimbursement at inpatient rates for “treating” patients in their homes. Under the AHCaH program, CMS waives the 24-hour nursing requirement that defines acute inpatient treatment, meaning care is often provided by unpaid family members or left to the patient alone. Moreover, CMS requires only very limited reporting measures from AHCaH participants and has not made any of the data public.¹

The hospital industry has been automating nursing and medical decision-making for years, reducing people to a list of symptoms which are then interpreted by technology that is racially and ethnically biased and often excludes relevant details about an individual patient.² The hospital industry uses this automated approach to justify reducing the number of licensed health care professionals providing patient care and then profits from the reduced labor costs. The hospital industry has used the Covid-19 public health emergency to further exploit the desire to normalize automated care and to shift care to the home.

Finally, the apparent corporate influence on the program is extremely troubling. In November 2020, the Trump administration launched the AHCaH program outside the normal rulemaking process and in record time: CMS senior leadership worked with industry insiders to take “the waiver from concept approval to publication in 8 days[.]”³ CMS acted without a detailed public evaluation of any evidence justifying the program nor any opportunity for the public to review or comment on it, while hospital administrators who wanted the program were closely consulted.⁴ Indeed, the American Hospital Association (AHA) took credit for CMS’s expansion of the program, stating: “[As urged by the AHA, CMS expanded on its Hospitals Without Walls program by introducing the AHCaH program.”⁵ Despite the irregular implementation, the AHCaH program grew rapidly. As of July 27, 2022, CMS has approved AHCaH rollouts in 110 health systems, with 245 hospitals in 36 states.⁶

I. THE ACUTE HOSPITAL CARE AT HOME PROGRAM CANNOT PROVIDE ACUTE HOSPITAL-LEVEL CARE IN A PATIENT'S HOME

CMS's AHCAH program endangers patients requiring acute hospital-level care by allowing hospitals to treat them in their homes.⁷ The AHCAH program builds on previous blanket Covid waivers for the hospital industry, including the Hospitals Without Walls program. Blanket waivers allow hospitals to bypass certain CMS requirements so they do not have to apply for an individual waiver, though the AHCAH program does require an individual waiver application. The AHCAH program waives numerous Medicare provider requirements and patient safety standards that apply to acute care hospitals, including nursing, medical, and emergency services requirements.

Specifically, the AHCAH program waives certain CMS Hospital Conditions of Participation, including a key provision which requires "nursing services to be provided on premises 24 hours a day, seven days a week and the immediate availability of a registered nurse for care of any patient."⁸ In an emergency, patients in a fully operational hospital can be treated immediately under CMS's 24-hour nursing services requirement for acute care facilities. But for patients being treated at home, CMS only requires an emergency response to a patient's home within 30 minutes. From there, a patient may need to be transported to a hospital, a process that can further delay life-saving care. Moreover, after a doctor performs an initial medical history and physical exam for an AHCAH patient, CMS does not require any additional in-person registered nurse or doctor visits with the patient. Instead, the AHCAH program requires just two in-person patient visits a day by a community paramedic. These lower standards for nursing, medical, and emergency care under the AHCAH program put patients' lives at risk.

THE ACUTE HOSPITAL CARE AT HOME PROGRAM LACKS THE ONGOING, IN-PERSON ASSESSMENT AND TREATMENT BY HEALTH CARE PROFESSIONALS THAT DEFINES ACUTE-LEVEL CARE

First, the AHCAH program does not and cannot provide patients with the ongoing, in-person assessment and treatment by health care professionals that acute care requires. Although the bulk of patient care in hospitals is provided by registered nurses, hospitals employ a wide variety of health care professionals who are readily available 24 hours a day, including doctors, respiratory therapists, and pharmacists. Within the inpatient hospital setting, RNs and other health care professionals are able to draw on the collective experience of nursing, medical, pharmaceutical, and other staff.⁹ This knowledge base is lost when a patient's care is shifted to the home and a patient's family must provide this care with limited outside support. Some hospitals currently participating in the AHCAH program do not require another person to be present in the home. Instead, they may leave the patient alone for long stretches of time or provide intermittent support from home health aides to supplement the twice daily visits from an RN or community paramedic.¹⁰

The AHCAH program is designed to eliminate the in-person, 24-hour observation and ongoing assessment by a registered nurse that is foundational to acute inpatient care. In contrast to inpatient facilities which provide ongoing, in-person assessment by RNs around the clock in a hospital where there is ready availability of other health care professionals, the AHCAH program requires only two in-person visits a day by paramedics or RNs and monitoring that may consist of just two sets of patient vital signs per day.¹¹ Hundreds of studies, spanning decades, have demonstrated the value of higher RN

staffing levels and reduced patient care loads in improving patient outcomes, including lowering mortality rates and reducing readmissions, infections, falls, and bedsores.¹² Additionally, studies on the skill mix of those providing patient care have demonstrated that substituting lesser-licensed and unlicensed personnel for registered nurses worsens patient outcomes and increases mortality rates, whereas increasing the percentage of personnel providing care who are RNs improves patient outcomes and lowers mortality rates.¹³ Finally, intermittent patient visits do not foster the type of inherently holistic care afforded by round-the-clock inpatient acute nursing care.¹⁴ The relational aspect of nursing, the connection between nurse and patient, is integral to patient health and wellbeing and relies on ongoing, in-person interactions.¹⁵ Ongoing RN care ensures the regular assessment of patients' mental and physical health status. Based on these regular assessments, RNs are able to perform health care examinations and tests without delay.¹⁶

RNs are also the last line of defense in preventing medical errors. For example, prior to medication administration, nurses check to make sure that medication is administered with the right dose, right route, right drug, right time, and right patient.¹⁷ Medication errors are more common in patients treated at home than in patients treated in a health care facility. Even when medications are administered correctly, life-threatening reactions can occur. For example, according to a large retrospective study, “[h]ome infusions were associated with 25% increased odds of [emergency department] or hospital admission on the same or next day after the infusion.”¹⁸ Moreover, the patients receiving home infusions were younger and had fewer comorbidities than those receiving infusions at a health care facility;¹⁹ thus, the increase in emergency department visits and hospital admissions after home infusions may be higher than the study showed. Another recent study, which reviewed 50 patient charts in an AHCaH program, found 14 adverse drug events among 11 patients and 44 potential adverse drug events among 30 patients.²⁰ Among the 44 potential adverse drug events, the most common issue was

patient or caregiver difficulty in administering medications (32%), followed by “unintentional nonadherence (20%), ... potentially inappropriate prescriptions (18%), and lack of medication availability (16%).”²¹ Immediate access to emergency care can be crucial to saving the life of a patient experiencing an adverse drug event.

Family members and home health aides are an inadequate and inappropriate substitute for the provision of acute care by skilled and licensed health care professionals. Worse yet, a patient may be at home all alone.²² As noted above, studies demonstrate that, even in a hospital setting, substituting lesser-licensed personnel for registered nurses increases rates of patient complications, readmissions, and mortality.²³ Family members and home health aides do not have the education and clinical experience to provide acute, hospital-level patient care nor to perform the necessary ongoing assessment of patients. Even the simplest RN-patient interactions involve assessment and evaluation of the patient's overall condition. Subtle changes in a patient's skin tone, respiratory rate, demeanor, and affect provide critical information to patient health and wellbeing, which can be easily overlooked or misinterpreted by a family member or unlicensed support staff. Clearly, care in the home by a family member or home health aide plus two in-person visits by an RN or paramedic does not meet the same standards and level of care of acute inpatient care in a hospital. The lack of 24/7 RNs and other health care professionals is likely to lead to higher levels of missed care, medication errors, and miscommunication, leaving patients vulnerable to grave consequences. Burdening family members with care that should be provided by registered nurses and other health care professionals allows the hospital industry to increase its profits at the expense of patient safety.

THE ACUTE HOSPITAL CARE AT HOME PROGRAM ALLOWS A 30-MINUTE RESPONSE TIME TO EMERGENCIES, WHICH ENDANGERS PATIENTS' LIVES

Further placing patients at risk, the AHCAH program does not require the immediate availability of emergency response services by licensed health care professionals.

In the AHCAH program, CMS requires an emergency response within 30 minutes rather than requiring that an emergency response be available immediately.²⁴ Without immediate attention from health care professionals and access to necessary treatment resources, patient morbidity and mortality rates increase.²⁵ In contrast to the AHCAH program, most acute care hospitals have trained and certified staff readily available to respond to emergencies. These emergency response teams most often consist of an RN and a respiratory therapist, as well as either a physician, an advanced practice registered nurse, or a physician assistant.²⁶ It is the registered nurse, based on the regular monitoring and assessing of patient status, who most often initiates the rapid response emergency code. Unlike the AHCAH program, a hospital's rapid response team can respond within seconds of the emergency code being activated.

Delaying emergency response by 15 minutes or more is shown to increase the likelihood of intensive care unit admission or death in a variety of conditions.²⁷ For example, early recognition and treatment of patients with sepsis and septic shock reduce mortality rates and morbidity.²⁸ Severe cases of sepsis can lead to long-term cognitive impairment and physical disability.²⁹ A delayed response to adverse medication reactions may also have negative health consequences. In a study comparing adverse events among home- vs. facility-administered biologic infusions, discussed above, authors “hypothesize[d]” that “less intensive monitoring, less physician oversight, and lack of immediate access to urgent medical treatment in the event of an acute infusion reaction ... can result in delayed care and a more frequent

need for escalation of care.”³⁰ Finally, studies demonstrate that delays by emergency response teams lead to increased mortality and morbidity rates in cardiac arrest events, while a rapid response from the team leads to improved patient outcomes.³¹ Delaying cardiopulmonary resuscitation when a cardiac arrest occurs leads to higher mortality rates and a greater likelihood of brain damage and associated neurological deficits. For every minute without CPR, the likelihood of survival from cardiac arrest decreases by 7 to 10 percent.³² Assuming that AHCAH programs are treating patients actually in need of acute hospital-level care, because the AHCAH program does not require the immediate availability of emergency response teams as is required in acute hospital settings, CMS should expect mortality and morbidity rates to rise among patients cared for under the AHCAH program.



THE ACUTE HOSPITAL CARE AT HOME PROGRAM FAILS TO PROVIDE THE APPROPRIATE LEVEL OF SERVICES, EQUIPMENT, AND INFRASTRUCTURE NECESSARY TO PROVIDE ACUTE HOSPITAL-LEVEL CARE

In addition to the unavailability of health care professionals, patients' homes lack the full complement of resources available in a hospital setting to respond to unexpected complications or deterioration of patients' health status. Although the AHCaH program requires participating organizations to provide laboratory, radiology, pharmacy, and respiratory services, these services are not immediately available in a patient's home, as they would be in a hospital. In many instances, these services and medical supplies are crucial. For example, diagnosing sepsis, discussed above, requires blood cultures and lactate measurement, followed by administration of broad-spectrum antibiotic agents if sepsis is confirmed. All of these processes are difficult to complete rapidly outside of an inpatient hospital setting.³³ Similarly, resources may be needed to evaluate patients' respiratory status by checking blood gas and electrolyte levels. Additionally, epinephrine may be needed for resuscitation and dopamine may be needed to stabilize blood pressure. Finally, if a patient needs to be intubated, necessary supplies and radiological services to confirm tube placement are crucial. Ready access to all of these resources is essential to saving patients' lives.

AHCaH patients are extremely vulnerable in the event of a power, telephone, or internet outage because internet and phone service are lifelines that connect AHCaH patients to nurses and doctors for ongoing care and to emergency services when needed. In contrast to most homes, hospitals caring for Medicare patients must have emergency power and lighting in many hospital areas and battery lamps and flashlights in all other areas.³⁴ Additionally, even though it is not a Medicare condition of participation, many hospitals maintain an emergency power supply for the entire facility. Finally, hospitals treating Medicare patients must have an emergency gas and water supply, which patients' homes typically lack.³⁵

II. THE ACUTE HOSPITAL CARE AT HOME PROGRAM ALLOWS HOSPITALS TO SHIFT CARE TO INAPPROPRIATE SETTINGS RATHER THAN INCREASING ACUTE INPATIENT CAPACITY BY INVESTING IN STAFFING AND INFRASTRUCTURE

CMS's AHCAH temporary waiver program, if extended, would accelerate the troubling, long-term trend of hospitals and insurers pushing patients out of hospitals and into more profitable settings at the expense of patient care. Since CMS launched the AHCAH waiver program allowing hospitals to transfer or admit acute care patients to their homes, the hospital industry has been advocating to make the temporary waiver permanent. The AHCAH program is part of a decades-long industrial trend seeking to maximize industry profits, which has led to the steady reduction in acute inpatient services and hospital beds available across the country.

If the CMS waiver is extended or another change is approved allowing acute patients covered by Medicare to receive care at home, the health care industry would use the opportunity to push even more patients out of the hospital and further reduce acute care capacity in the United States. Indeed, in a recent webinar, Dr. Bruce Leff, a leading proponent of AHCAH programs, quipped that once the hospital at home program matures, many hospitals will be "turned into condos."³⁶

Over the last two years, the Covid-19 pandemic has shown us that the acute care provided in hospitals is essential to the health of our communities and that we cannot afford to have it further whittled away by the profit-hungry hospital industry. Acute inpatient hospital capacity has declined dramatically over the last few decades, as the data below demonstrates:

» **Loss of acute beds:** Over the last 25 years, a period in which the U.S. population increased by 25 percent, the number of acute care beds available was reduced by about 70,000. The United States now has only 2.8 hospital beds per 1,000 people,

far fewer than other developed countries.³⁷ In 1994, the United States had 4.3 hospital beds per 1,000 people.³⁸

- » **Hospital closures:** Since 1990, about 1,400 general acute care hospitals have closed nationwide, with a net loss of 890 when accounting for openings.³⁹ We have lost 181 rural hospitals since 2005.⁴⁰ According to the Kaiser Family Foundation, the United States has 19.1 hospitals per 1,000,000 people, while the "Comparable Country Average" is 32.7.⁴¹
- » **Emergency department closures:** From 1990 to 2009, the number of hospital emergency departments in urban areas declined by 27 percent.⁴²

During the Covid-19 pandemic, the loss of U.S. inpatient hospital capacity increased the overall death rate. The Covid-19 crisis laid bare the devastating impact of the reduction of our acute care capacity. A study published by the Centers for Disease Control and Prevention (CDC) found that, between July 2020 and July 2021, intensive care unit bed use at 75 percent capacity was associated with an additional 12,000 excess deaths two weeks later.⁴³ As hospitals exceeded 100 percent intensive care unit bed capacity, 80,000 excess deaths would be expected two weeks later.⁴⁴ Another study published by the CDC found significant associations between the availability of hospital-based resources, including beds and staff, and excess Covid-19 deaths.⁴⁵

There have been numerous reports over the past two years of hospitals becoming overwhelmed with acute patients, Covid-19 and otherwise, with nowhere to send the patients they cannot treat.⁴⁶ Simply put, our national capacity for acute care, weakened by decades of industry profiteering, resulted in needless

deaths during the Covid-19 health crisis. For example, Tony Tsantinis died while waiting for treatment after finding that 17 hospitals had no room for him.⁴⁷ Another man, Ray DeMonia, died in September of 2021 after being turned away from 43 hospitals.⁴⁸ Sadly, these stories are not uncommon and are a direct result of the elimination of acute care capacity.

Further allowing hospitals to shift acute care to non-acute care settings, such as patient homes, will exacerbate declining acute care capacity. The AHCAH program allows hospitals to retain inpatient hospital reimbursement rates for inadequate and unsafe care in the home, rather than making desperately needed investment in hospital staffing and infrastructure. National Nurses United (NNU) has detailed several recommendations on how to increase hospital staffing capacity without resorting to crisis standards in our November 2021 report, *Protecting Our Front Line: Ending the Shortage of Good Nursing Jobs and the Industry-Created Unsafe Staffing Crisis*.⁴⁹



III. THE ACUTE HOSPITAL CARE AT HOME PROGRAM IS VULNERABLE TO FRAUDULENT BILLING PRACTICES

The AHCaH program is highly susceptible to fraud and abuse by hospitals through upcoding and other fraudulent billing practices. As discussed above, acute hospital-level care cannot be provided in patient homes because patient homes lack the defining elements of acute hospital-level care, including 24/7 registered nursing care; rapid response capability; and other necessary services, equipment, and infrastructure. Thus, the perfect patient for an AHCaH program is a patient who does not actually need acute hospital-level care. The AHCaH program provides an opportunity for hospitals to diagnose patients at an inappropriately high severity level, send them home, provide only the sub-acute care the patient actually needs, and then charge CMS for acute-level care. Providing care in patients' homes allows hospitals to expand care beyond the limits on the number of inpatient acute-care beds available, letting hospitals rapidly expand their existing fraudulent billing practices under the AHCaH program.

The Office of the Inspector General (OIG) at the Department of Health and Human Services found a widespread pattern of hospitals diagnosing patients with a higher severity level than is justified by their health condition to receive

a greater reimbursement from Medicare.⁵⁰ From FY 2014 to FY 2019, the number of stays at the highest Medicare severity level—and highest reimbursement rate—increased by 20 percent while stays at other severity levels decreased. Meanwhile, the average length of stay for patients at the highest severity level decreased while other levels stayed the same. The OIG concluded that it is likely that hospitals systematically bill Medicare for inappropriately high severity levels. Another analysis ruled out demographic changes as the cause of increases in diagnosed severity and confirmed that upcoding was the likely culprit in spending increases.⁵¹

Fraudulent upcoding is common among hospitals serving Medicare patients. Indeed, many of the health systems and hospitals currently participating in the AHCaH program have been sued for submitting false claims to CMS as well as other irregularities.⁵² Even supporters of providing acute hospital care at home caution that “vigilance against overuse and unnecessary care intensity must remain[.]”⁵³ Based on past behavior, it seems likely that hospitals participating in the AHCaH program will fraudulently bill CMS for treating patients who do not need acute hospital-level care.

CONCLUSION

NNU strongly urges CMS to withdraw the AHCaH waivers immediately and to discontinue the program. The AHCaH program cannot provide acute hospital-level care in a patient's home because it lacks the ongoing, in-person assessment and treatment by health care professionals that defines acute care in a hospital inpatient setting. It also fails to ensure the rapid response by health care professionals to deteriorating patient status that is necessary to reduce mortality and morbidity rates. Moreover, it allows the hospital industry to capture wind-fall profits by dramatically scaling back patient care rather than investing in the necessary hospital staffing and infrastructure that would actually increase acute inpatient capacity. The AHCaH program, established by the Trump administration outside the normal rulemaking process, affords the hospital industry a prime opportunity to expand its fraudulent billing practices. In all, it presents a grave threat to patient care and safety and to the future of U.S. national public health and safety.



ENDNOTES

- 1 U.S. Centers for Medicare & Medicaid Services. Undated. Reporting Measures. <https://qualitynet.cms.gov/acute-hospital-care-at-home/measures>.
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- 3 Clarke Jr D et al. 2021. Acute Hospital Care at Home: The CMS Waiver Experience. *New England Journal of Medicine Catalyst Innovations in Care Delivery*. 2(6). <https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0338>.
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- 9 Dzikowicz D et al. 2020. Comparing an all-RN Unit to a Mixed-Skill Unit at a Hospital. *The Journal of Nursing Administration*. 50(12): e14-e22.
- 10 There are at least two hospitals or health systems participating in the CMS AHCaH program, Brigham and Women’s Hospital (MA) and Presbyterian Health Services (NM) that do not require in-home support for admission to their acute hospital care at home programs. Based on publicly available information, the CMS AHCaH program does not require in-home support services. For example, see the inclusion criteria for the acute hospital care at home program run by Mass General Brigham, which includes Brigham and Women’s Hospital, as stated at clinicaltrials.gov under registration number NCT03203759: “Can identify a potential caregiver who agrees to stay with patient for first 24 hours of admission. Caregiver must be competent to call care team if a problem is evident to her/him. After 24 hours, this caregiver should be available for as-needed spot checks on the patient. This criterion may be waived for highly competent patients at the patient and clinician’s discretion.” (Available at <https://clinicaltrials.gov/ct2/show/NCT03203759>.) This clinical trial is discussed in these articles:
Levine D et al. 2020. Hospital-Level Care at Home for Acutely Ill Adults: A Randomized Controlled Trial. *Annals of Internal Medicine*. 172(2): 77-85.
Levine D et al. 2021. Hospital-level Care at Home for Acutely Ill Adults: A Qualitative Evaluation of a Randomized Controlled Trial. *Journal of General Internal Medicine*. 36(7): 1965-1973.
Levine D et al. 2022. Predictors and Reasons Why Patients Decline to Participate in Home Hospital: A Mixed Methods Analysis of a Randomized Controlled Trial. *Journal of General Internal Medicine*. 37(2): 327-331. Note that CMS cites the first study as providing an “[e]xample of published [i]nclusion and [e]xclusion criteria” here: <https://qualitynet.cms.gov/acute-hospital-care-at-home/resources#tab2>. But the article does not include information regarding whether a

- caregiver must be present in the home as specified in the trial at clinicaltrials.gov. Presbyterian Health Services provides another example of an acute hospital care at home program that admits patients into without in-home support. See *Hospital at Home Admission Diagnoses and Criteria* available at <https://www.hahusersgroup.org/wp-content/uploads/2021/03/Sample-Criteria-Presbyterian-Healthcare-Services.doc>.
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- 22 There are at least two hospitals or health systems participating in the CMS AHCaH program, Brigham and Women’s Hospital (MA) and Presbyterian Health Services (NM) that do not require in-home support for admission to their acute hospital care at home programs. Based on publicly available information, the CMS AHCaH program does not require in-home support services. For example, see the inclusion criteria for the acute hospital care at home program run by Mass General Brigham, which includes Brigham and Women’s Hospital, as stated at clinicaltrials.gov under registration number NCT03203759: “Can identify a potential caregiver who agrees to stay with patient for first 24 hours of admission. Caregiver must be competent to call care team if a problem is evident to her/him. After 24 hours, this caregiver should be available for as-needed spot checks on the patient. This criterion may be waived for highly competent patients at the patient and clinician’s discretion.”

- (Available at <https://clinicaltrials.gov/ct2/show/NCT03203759>.) This clinical trial is discussed in these articles:
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