HEALTH TRANSFORMATION ADVISORY

The Assessment Nobody Owns

The environmental and psychosocial assessment that decides who gets hospital care at home has no owner, no instrument, and no record.

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A patient comes into an emergency department with pneumonia. She is sick enough to be admitted, stable enough to be a candidate for Hospital at Home, and willing. A physician makes the admission decision. Someone runs a screening protocol. An ambulance takes her home, and a nurse or a community paramedic meets her there a few hours later. That nurse is the first member of the care team to see the house.

The decision was made in a hospital, based on what the patient and her family said about a place none of them could see. The assessment that determines whether a home can safely hold an acute inpatient admission happens after the patient has already been discharged from the emergency department. If the patient's home fails the nurse's assessment, there is an admitted patient in an unsuitable house and a reversal to execute. This is not a criticism of the clinicians making the decisions, who are working the sequence they were given. The sequence is the problem, and nobody wrote it down.

WHAT THE WAIVER SPECIFIES

The Acute Hospital Care at Home ("AHCAH") initiative (the "Waiver") is one of the most precisely engineered programs in Medicare. A physician or other qualified professional evaluates each patient daily, in person or remotely. A registered nurse evaluates each patient once daily. Two in-person visits occur every day, by a nurse or a mobile integrated health paramedic. The hospital must be capable of establishing an on-demand remote audio connection to a team member who can immediately reach a physician or an RN, and it must be able to respond to a decompensating patient within thirty minutes. That last number is the acuity ceiling for the entire model, and everything about who qualifies clinically flows from it. It is specified to the minute.

On the home itself, the AHCAH Waiver requires that hospitals have appropriate screening protocols in place to assess both medical and nonmedical factors before care at home begins. That is the whole instruction. One sentence, with no named owner, no instrument, no minimum scope, no documentation standard, and no reporting requirement.

WHAT THE SCREENING ACTUALLY ASKS

We know what these screening protocols contain because some programs have published theirs. Mount Sinai's implementation manual, written before AHCAH existed and reflecting one program's approach rather than a national standard, is the most detailed public example, and its administrative criteria have

nothing to do with how sick a patient is. The patient must live in the community and not in a nursing home or a shelter. If the residence is a single room occupancy facility, fewer than three people can share the bathroom, and that bathroom must be accessible to the patient given their current functional status. A patient without a fixed address for the duration of the program is excluded. A home that lacks a heating system, electricity, or a telephone is excluded, as is one that is structurally unsound. Active drug use is an exclusion because the program cannot send a patient home with an intravenous line. If a patient needs around-the-clock aide coverage, it has to already be in place, because the program cannot provide custodial care.

Read that list again and notice what it is. Heating, electrical service, telephone service, structural integrity, bathroom accessibility relative to a patient's functional state, household density, and the ability to produce around-the-clock aide coverage on short notice. A building inspector would recognize most of it. A social worker would recognize all of it. It is a housing assessment doing the work of a financial one, though not an income test exactly, and closer to a test of assets and stability. Someone with a good salary in a badly maintained rental fails the assessment. Someone with very little income living with adult children in a sound house passes. What gets measured is the quality of the building, the security of the tenancy, and whether a person can summon a caregiver within hours. Medicare does not pay for custodial care, so that last requirement is met in cash or it is met by family. We are conducting housing assessments hundreds of times a day in this country under a clinical name, and we are not recording the results.

WHO PERFORMS IT

Three people touch the determination for an AHCAH Waiver, and none of them is accountable for it. The admitting physician or advanced practice provider makes the decision, working from what the patient reports, about the patient’s eligibility and the home’s suitability. Intake staff run whatever questionnaire the program has built. The nurse or paramedic who arrives at the house is the first person with direct evidence of the home’s suitability, and by then the decision is behind them.

None of this is billable. It sits inside the Diagnosis-Related Group (“DRG”) with everything else the program does. There is no minimum time, no credential requirement, no defined competency, and no one whose performance is measured on it. Assessments that no one is paid to perform get compressed, and compressed assessments default to what a patient can tell you from a gurney.

THE COMPARISON THAT MAKES IT OBVIOUS

Medicare already knows how to make proper home assessments. Home health has OASIS: a federally mandated assessment instrument with specified timepoints, defined data elements, and, since July 2025, all-payer submission requirements. A home health agency delivering skilled nursing visits to that same patient in that same house operates under a standardized federal instrument. Acute inpatient care delivered in the identical setting, at higher acuity, with a thirty-minute rescue requirement, operates under one sentence.

The gap isn't philosophical, and it was never unimaginable. It's a drafting omission that has been carried through every extension of the Waiver since 2020, by people who had other things to specify and no reason to notice this one.

WHY IT MATTERS NOW

For five years, nobody could reasonably build governance around a program that expired every few months. That excuse is gone. The Consolidated Appropriations Act, 2026 extended AHCAH through September 30, 2030, and the statute requires the Secretary to report to the House Ways and Means Committee and the Senate Finance Committee by September 30, 2029. Congress specified what that report must contain, and the list includes socioeconomic information on beneficiaries treated under the initiative, including racial and ethnic data, income, housing, and dual eligibility.

So Congress has asked who is being served. The mechanism that most directly determines the answer is a screening step with no instrument behind it and no data trail. The report will describe the population that resulted, but it will not be able to describe how that population was selected, because we aren't capturing it. The evidence that decides this program's future is being generated right now, in the admissions being screened this week.

WHO GETS SORTED OUT

Medicare Part A is a universal entitlement. Eligibility has never turned on income or assets. But inpatient care delivered through this particular channel passes through a screen that functions as a means test, and that test exists in no statute and no regulation. It was never voted on. CMS has already

published what it produces: in its 2024 study, AHCAH patients were meaningfully different from brick-and-mortar inpatients at the same facilities, being more likely to be white, more likely to live in an urban location, and less likely to receive Medicaid or low-income subsidies. The agency attributed this in part to the inclusion and exclusion criteria that participating hospitals developed, which means it named the mechanism in its own report.

Inasmuch as every one of those criteria is clinically sound — and each of them is — the sorting they produce is still a sorting by wealth. You cannot run an intravenous line in a house with no electricity. You cannot manage a patient who is deteriorating and has no working phone. Nobody chose a wealth proxy in place of a safety requirement. The requirements are the safety requirements, and they happen to track wealth almost perfectly. So there is no policy to repeal and no author to hold responsible. A means test emerged from a set of correct clinical judgments, and because no one designed it, no one is accountable for it.

Consider who fails. Someone whose building has unreliable heat. Someone in a single room occupancy with a shared bathroom down the hall. Someone without a fixed address. Someone who lives alone and cannot arrange aide coverage on a few hours' notice. These are not judgments about whether a patient would benefit from care at home. They are findings about American housing, applied at the bedside, with no appeal and no record. Which brings the two halves of this together: Congress asked for income, housing, and dual-eligibility data in the 2029 report, and it will receive the output of a means test it does not know exists, with no way to trace the mechanism that produced it, because the screening that did the sorting was never written down.

The population served here also bifurcates in a way nobody has counted. One group lives with persistent functional limitation, and for them a house that doesn't work is a permanent condition. The other was fine last month and will be fine next month, and for six days has real functional limitations in a home that was never designed to accommodate even temporary ones. The second group has no advocacy organization, because nobody identifies as a member until the week they become one.

WHAT A STANDARD WOULD REQUIRE

None of this requires new legislation. It requires specification. Someone with defined competency in environmental and psychosocial assessment should be accountable for the determination and should document it, and the role should be named rather than assumed, which for most programs means a nurse or a care manager, though the licensure level that can carry the responsibility varies by state. A national standard should specify the competency and let states map it to their own scope-of-practice

rules, rather than naming a profession and creating fifty conflicts. The instrument itself doesn't need inventing, because programs are already asking these questions and writing the elements into a common form is a matter of collecting what exists. The assessment also belongs before transport rather than after, and where a pre-admission home evaluation isn't feasible, video assessment has already been studied in discharge planning and could be adapted rather than built from nothing.

What happens to the finding matters as much as who makes it. Every exclusion on nonclinical grounds is a fact about the American housing stock, and recording the reason costs almost nothing while producing the first real dataset on whether homes in this country can host acute care. That finding also needs somewhere to go. A patient turned away because a bathroom cannot be reached has not only received a clinical decision. She has generated a referral, and at present that referral goes nowhere.

THE PART THAT ISN'T CLINICAL

The first national practice standards for Hospital at Home were published in the Journal of the American Geriatrics Society in March 2025, and most programs met or exceeded them by their own assessment; the Users Group’s Practice Standards Council released an updated version, Practice Standards 2.0, in October 2025. The Users Group has since built a national quality registry, and its first benchmarking reports went out in January 2026 covering 46 hospitals across 18 health systems. As of July 2026, 365 hospitals across 137 health systems in 37 states had been approved to provide acute hospital care at home. So about one hospital in eight participates in external benchmarking, and the standards that exist are largely self-reported. That is not negligence. It is a young field building its own infrastructure faster than anyone required it to, which is to its credit.

But the housing determination is the piece that falls outside clinical governance entirely, and it is the one deciding who gets access. Five years of statutory certainty is enough time to specify it. The 2029 report is the deadline that already exists, and the data it will draw on is being created now, one screening at a time, by people whose judgment nobody has been asked to standardize.

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