Massachusetts Transitions from Acute Care to Post-Acute Care (TACPAC) Task Force

Established by Section 25 of Chapter 197 of the Acts of 2024

Submitted July 31, 2025

Table of Contents

I. Task Force: Purpose and Scope

The Transitions from Acute Care to Post-Acute Care (TACPAC) Task Force was established under Section 25 of Chapter 197 of the Acts of 2024 to study and propose recommendations to address acute care hospital throughput challenges and the impact of persistent delays in discharging patients from acute to post-acute care settings. The work of the Task Force focused on identifying system barriers, advancing innovative solutions, and promoting timely, appropriate care transitions.

Specifically, the Task Force was responsible for examining:

i.   hospital discharge planning and case management practices;

ii.   payer administrative barriers to discharge;

iii.   legal and regulatory barriers to discharge;

iv.   efforts to increase public awareness of health care proxies and the importance of designating a health care agent;

v.   post-acute care capacity constraints and additional opportunities to provide financial incentives to increase capacity;

vi.   administrative day rates and the cost to hospitals of discharge delays;

vii.   enhanced hospital case management practices and reimbursement for wraparound services;

viii.   the adequacy of post-acute care facility insurance networks and the establishment of an out-of-network rate for post-acute care facilities;

ix.   expanding MassHealth Limited coverage to include post-acute and long-term care services;

x.   the effectiveness of interagency coordination to resolve complex case discharges;

xi.   the adequacy of reimbursement rates of MassHealth and commercial carriers for nonemergency medical transportation;

xii.   opportunities to expand coverage and reimbursement for services delivered by mobile integrated health programs certified by the department of public health and by participating providers in the federal Centers for Medicare and Medicaid Services acute hospital care at home program;

xiii.   alternative transportation options for patients being discharged and transferred to post-acute care facilities or home health agencies; and

xiv.   the adequacy of state resources and infrastructure to place complex case discharges in appropriate post-acute care settings, including, but not limited to, patients with dementia diagnoses, geriatric patients with psychiatric diagnoses, patients with behavioral health diagnoses, patients with substance use disorder diagnoses, justice-involved patients and patients who have been unable to find an appropriate placement for post-acute care for 6 months or longer.

The Task Force was chaired by Executive Office of Health and Human Services Assistant Secretary Joanne Marqusee, acting as the designee of the Secretary of Health and Human Services, and was comprised of a diverse panel of public health professionals, experts in health care administration and finance, and legal and law enforcement professionals (see full list in Appendix B).

The Task Force met nine times from January through July 2025 and was required to submit its recommendations to the Clerks of the House of Representatives and Senate, the Joint Committee on Ways and Means, and the Joint Committee on Health Care Financing not later than July 31, 2025.

All meetings were subject to the Open Meeting Law and minutes were taken and approved for each meeting. All materials considered by the Task Force as well as minutes of the Task Force's meetings were posted on a publicly-available webpage: https://www.mass.gov/transitions-from-acute-care-to-post-acute-care-tacpac-task-force

II. The Landscape: Population and Providers

Improving hospital throughput and transitions to post-acute care requires a clear understanding of who is served by the Massachusetts healthcare system, which providers support their care journeys, and what systemic barriers contribute to persistent discharge delays. The Commonwealth's healthcare infrastructure serves a diverse and aging population with complex medical, behavioral, and social needs. Across this landscape, providers and payers face significant capacity constraints, administrative challenges, and workforce shortages that contribute to bottlenecks in care transitions.

This section summarizes the key populations affected, the providers involved, and the core problems that have led to thousands of patients remaining in acute care beds despite being medically ready for discharge.

The Population

Massachusetts health care system serves a diverse and aging population with increasing post-acute care needs. Of the 6.5 million insured residents in Massachusetts, approximately 23% are in fully-insured commercial insurance plans; 23% are covered by Medicaid; 18% are covered by Medicare; and 36% are covered by employer self-insured plans.[1][2]

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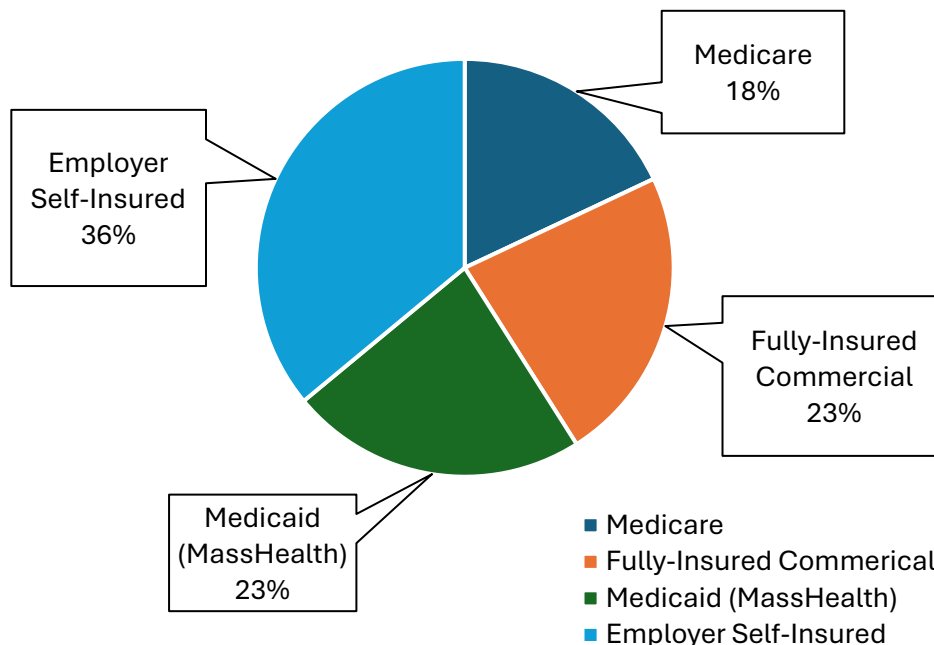
[1] Center for Health Information and Analysis. (2025, March 6). *Enrollment in health insurance: Enrollment trends (through September 2024)*. Commonwealth of Massachusetts. Retrieved June 30, 2025, from https://www.chiamass.gov/enrollment-in-health-insurance/#enrollment-trends-interactive

[2] Health care costs for uninsured residents, including those who may be justice-involved, are paid from the State's General Fund.

In thinking about the impact of recommendations that establish mandates on payers, it is relevant to note that state legislative or regulatory action on commercial insurance can only impact the fully-insured. Likewise, state legislative or regulatory action on public programs can only impact Medicaid. Thus, State mandates would at most apply to less than half of the insured population (i.e., 23% fully-insured and 23% Medicaid). To impact Medicare and/or self-insured plan policies would require federal action.

Key sub-populations facing prolonged discharge delays include individuals experiencing one or more of the following, which may individually or collectively be contributing to delayed discharges:

- Behavioral health needs
- Dementia and cognitive impairment
- Substance use disorders
- Homelessness or housing instability
- Justice involvement
- End-of-life care needs

The Providers

The Massachusetts care continuum supporting transitions from acute to post-acute care includes:
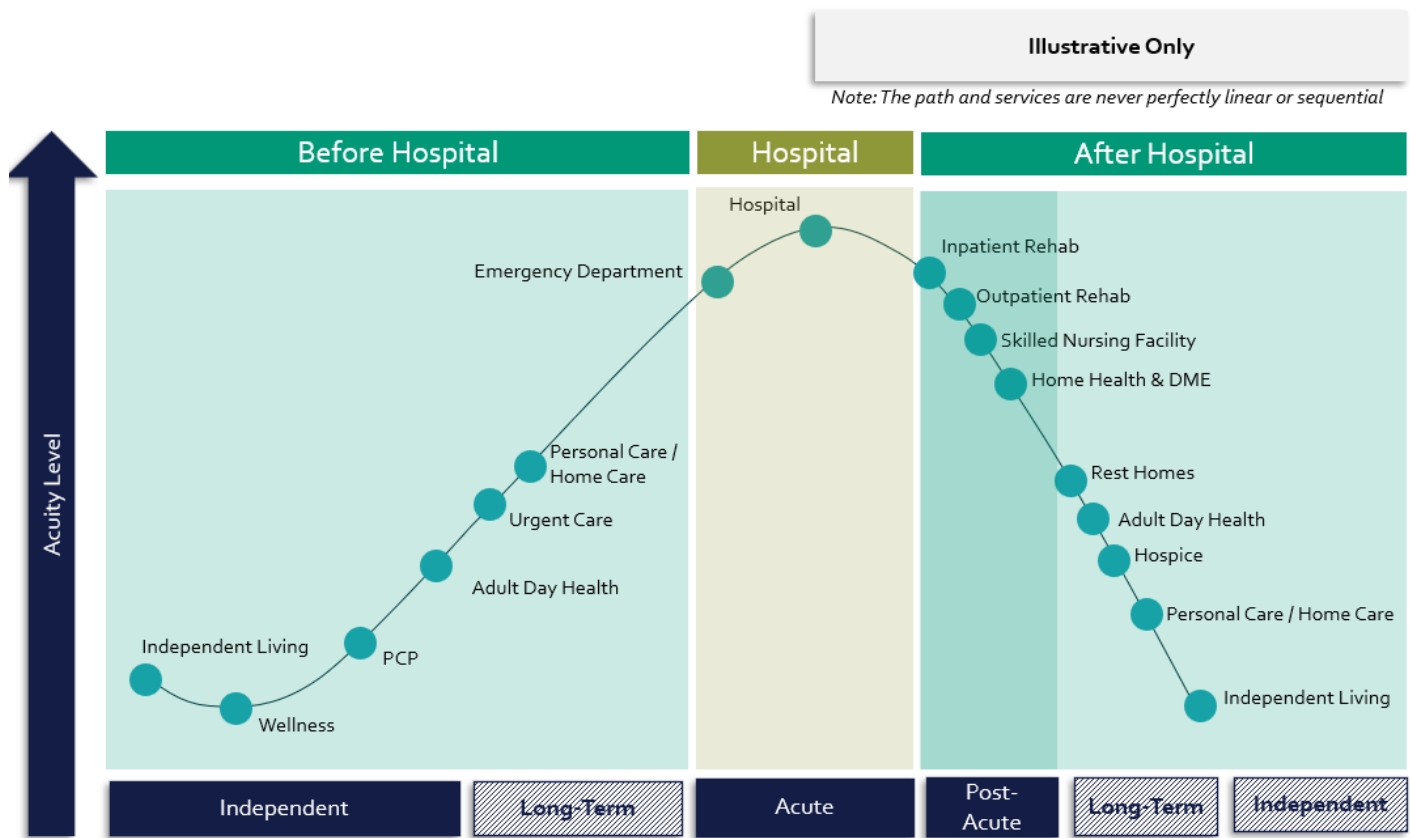
Acute Care

- Acute Care Hospitals: Facilities that provide short-term, intensive medical care for individuals experiencing serious or emergent health conditions. They serve as the entry point for many patients into the healthcare system and coordinate care transitions to post-acute and community-based settings.

Post-Acute Care

- Skilled Nursing Facilities (SNFs): Residential healthcare providers that deliver 24-hour nursing care, rehabilitation services, and support for individuals who require ongoing medical supervision and assistance with daily living after an acute hospital stay.
- Long-Term Acute Care Hospitals (LTACHs) and Inpatient Rehabilitation Facilities (IRFs): Specialized hospitals that offer extended medical care for patients with complex medical needs, such as prolonged ventilator use or intensive rehabilitation following serious injury, illness.
- Home Health Agencies and Community Providers: Organizations that deliver medical care, personal care, and supportive services directly in a patient's home or community, facilitating recovery and promoting independent living outside of institutional settings.

- Behavioral Health and Specialty Providers: Providers that offer targeted care for individuals with mental health conditions, substance use disorders, cognitive impairments, and other specialized medical needs. They play a critical role in managing complex, chronic, or co-occurring conditions.

Navigating the Health Care Continuum

Illustrative Only

Note: The path and services are never perfectly linear or sequential

Key Metrics:

- Massachusetts acute care hospitals oversee approximately 740,000 – 800,000 inpatient discharges annually, based on CHIA data through federal fiscal year (CY) 2023.[3]
- On average, more than 2,000 patients statewide remain hospitalized each day despite being medically ready for discharge.[4]
- Some patients experience discharge delays exceeding 30 days, particularly those with complex medical, behavioral, or social needs. Based on recent CHIA data, 9% of patients'

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[3] Center for Health Information and Analysis. (2025, February 27). *Massachusetts acute care hospital inpatient discharge reporting*. CHIA. https://www.chiamass.gov/massachusetts-acute-care-hospital-inpatient-discharge-reporting/#dashboard

[4] Massachusetts Health & Hospital Association. (n.d.). *Monthly throughput survey reports*. Retrieved June 30, 2025, from https://www.mhalink.org/throughputreports/

stays lasted 30 days or more and 2% lasted 120 days or more (double the comparable data in 2017).[5]

- Delays disproportionately affect individuals with complex care needs, behavioral health needs, dementia, substance use disorders, housing instability, justice involvement, or end-of-life care requirements. For example, of the 9% of patients' stays that lasted 30+ days, 3 of the 5 most common conditions impacting those stays were mental health-related.

- The problem is multi-faceted and often driven by one or more of the following: legal and decision-making challenges, post-acute care capacity constraints, payer-related complexities, fragmented care coordination, complex needs, and non-emergency transportation challenges.

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[5] Massachusetts Health Policy Commission (HPC). Health Care Cost Trends Hearing presentation (November 2024). Available on the HPC website: https://masshpc.gov/sites/default/files/2024-11/2024%20CTH%20Presentation.pdf

III. The Challenge: Bottlenecks Across the Continuum

Hospitals across Massachusetts are experiencing challenges discharging patients who are medically ready to transition to post-acute care (PAC) settings. These delays contribute to hospital crowding and suboptimal care transitions, underscoring the need for better coordination, infrastructure, and system accountability. Key barriers include:

1. Legal and Decision-Making Barriers

Many patients lack a legally authorized decision-maker—such as a Health Care Proxy (HCP) or other advance directive—which can delay care planning and discharge. When no proxy is available or activated, hospitals must often pursue time-consuming guardianship proceedings that vary by county. Additionally, the lack of a statutory "next of kin" surrogate decision-making authority and supported decision-making authority compound these delays.

2. Post-Acute Care Capacity Constraints

More than 2,000 individuals remain in acute settings daily despite being clinically ready for discharge, with some waiting over 30 days. Delays stem from workforce shortages in SNFs and HCBS settings, lack of weekend and off-hour discharge readiness, limited availability for patients with complex needs (e.g., high-acuity rehab, co-occurring behavioral and medical conditions, insurance complexity, coverage variability), and the need for more flexible service models such as Hospital-at-Home, mobile integrated health, remote patient monitoring, telehealth, or co-located care options.

3. Payer and Coverage Complexities

Discharge delays are also driven by payer-related challenges, including the administrative burden associated with prior authorizations, difficulties arranging timely out-of-network placements, and issues related to Medicaid long-term care (LTC) eligibility processing. Chapter 197 (2024) includes many important provisions aimed at addressing these challenges, and the Task Force identified other possible recommendations that could further mitigate challenges.

4. Fragmentation Across the Care Continuum

Transitions between hospitals, SNFs, and home- and community-based providers, and other post-acute settings are often hindered by program variability, lack of standardized tools, insurance complexity, coverage variability and unclear roles in discharge planning creating confusion and inefficiencies.

5. Delays for Individuals with Complex Needs

People experiencing behavioral health needs, homelessness, dementia, or justice involvement face additional obstacles due to limited availability of specialized programs like medical-psychiatric facilities, group living environments, bariatric equipment and training, and secure post-acute beds. Transportation bottlenecks, coordination breakdowns, and provider documentation that may include subjective or stigmatizing language can also contribute further extend the length of stay.

6. Non-Emergency Medical Transportation (NEMT) Arrangements

Even when a post-acute placement is secured, delays in arranging timely, reliable transportation—especially on weekends for behavioral health transfers or for complex transfers—can result in missed discharge windows and prolonged acute care hospital stays.

IV. Progress to Date: Ongoing and Emerging Efforts

Massachusetts agencies and partners have initiated several efforts to improve hospital discharge and transitions of care:

Effort	Description	Targeted Barrier
MHA / Honoring Choices Massachusetts / DPH "Simple Step" Campaign	• Promotes HCP completion across care settings.	Legal/Decision-Making Gaps
Chapter 197 of 2024 (Prior Authorization)	• Establishes a two-year pilot program that requires Group Insurance Commission (GIC) plans, MassHealth and fully-insured commercial plans licensed in Massachusetts to approve or deny requests for prior authorization for post-acute care services by the next business day following receipt by the payer of all necessary and complete information to establish the medical necessity of the requested post-acute care services (home care, SNF care, post-acute hospital care). • Directs the Division of Insurance to develop and implement a uniform prior authorization form for the admission of patients from an acute care hospital to post-acute care settings to be used by all insurers, including MassHealth. • Requires weekend approvals within one (1) calendar day or a waiver of prior authorization on weekends, with concurrent review beginning on the next business day.	Payer Admin
Chapter 197 of 2024 (MassHealth LTC Eligibility)	• Review and study improving the eligibility determination process, including establishing a rebuttable presumption of eligibility; guaranteeing payment for LTC services for up to one year while eligibility is resolved; expanding undue hardship waiver criteria to reduce financial barriers.	Payer Admin
Chapter 197 of 2024 (Public Guardianship Program)	• Requires DPH to study and report, by July 31, 2025, on the feasibility of having qualified professional guardians give informed medical consent for indigent persons and whether such guardians would reduce hospital discharge issues.	Legal/Decision-Making Gaps
Chapter 197 of 2024 (LTC Workforce Fund)	• Creates a fund to recruit and retain a dedicated long-term care workforce, including grants to develop new Certified Nursing Assistants (CNAs), career ladder grants for direct care workers to train to become	Workforce

Effort	Description	Targeted Barrier
	Licensed Practical Nurses (LPNs), along with leadership and supervisory training for nursing home leaders. However, to date, there has been no funding authorized for this account.	
Streamlining Nursing Facility Transitions	• Launch of DMH Nursing Facility Transition (NFT) Team to assist individuals able to transition to community settings. • Development by DMH of two Enhanced Medical Group Living Environments (EMGLE) to facilitate transitions to lower levels of care settings and prevent hospitalization or nursing facility admissions. • Creation of the Community Transition Liaison Program (CTLP) to support nursing-facility residents (age 22+) in returning to community living, regardless of insurance status.	Care Continuum Fragmentation
EOHHS Discharge Support	• A statewide resource launched in 2021 to assist hospitals with complex, delayed discharges. Discharge Support (DS) provides case-specific troubleshooting, identifies appropriate state agency contacts, and connects hospitals to resources not previously engaged in the discharge process. DS supports hospitals after all internal discharge efforts have been exhausted, and routinely collaborates with MassHealth, DMH, DDS, ASAPs, ILCs, the VA, and housing agencies. DS also addresses barriers for individuals facing homelessness, justice involvement, long-term care eligibility challenges, and multi-agency coordination delays.	Complex Cases
Integrate POLST Registry into EHRs	• Piloting ePOLST Registry integration into hospital EHRs by 2027 for automatic access to end-of-life orders.	Legal/Decision-Making Gaps
Improve Throughput and Access for Justice-Involved Patients Needing Inpatient Services	• Project was launched by the TACPAC Task Force to improve coordination among DPH, the Department of Correction (DOC) and Houses of Correction (HOC), as well as standardize operating procedures for admission requests to the Lemuel Shattuck Hospital for justice-involved patients requiring higher levels of care. It is anticipated that new processes, procedures, and communication approaches will be agreed to in summer 2025 and rolled out shortly thereafter.	Complex Cases

V. Bridging the Gaps: Recommendations for Consideration

The Task Force developed the following package of recommendations based on its deliberations, as well as the presentations and resources shared with the group. While efforts were made to reach broad consensus amongst the Task Force's membership, on one of the proposed recommendations below, the group was unable to reach full agreement and the varying opinions are noted.

As noted in several of the recommendations, there are legislative proposals in the 194th Massachusetts General Court that include provisions consistent with the recommendation(s). Appendix C includes the references to those legislative proposals. While the Task Force is not necessarily advocating for a specific legislative proposal, we wanted to share where our recommendations overlapped with provisions in legislative proposals that are being considered.

Additionally, it is important to note that the work of the Task Force was conducted prior to the passage of federal legislation signed into law on July 4, 2025, which includes certain provisions that may significantly impact access and barriers to healthcare, e.g., introducing penalties for insuring individuals with documentation issues, retroactively reducing coverage from 90 days to 60 days, etc. These federal changes are likely to exacerbate the problem of patients being delayed in transitioning from acute to post-acute care settings.

Recommendation	Action	Justification	Task Force Charge(s) Addressed
1. Legal & Decision-Making Considerations			
1.1 Advance "Next of Kin" or "Surrogate" Decision-Making legislation	• Support passage of legislation to establish a default surrogate hierarchy for patients lacking capacity and without an appointed Health Care Proxy (e.g., appointing surrogate vs. relying on highest-ranked available next of kin, clarify definitions, clarify scope and duration of next of kin/surrogate, address handling of family disagreement). The majority of these concepts are contained in provisions included in various bills currently under review; please see Appendix C. • Convene key stakeholders from the hospital, legal, and post-acute care communities to ensure that	Provides a legally recognized fallback decision-maker to prevent discharge delays, reduce emergency guardianship filings, and enable timely care decisions for incapacitated individuals.	iii, vi

Recommendation	Action	Justification	Task Force Charge(s) Addressed
	proposed and adopted statutory language includes the necessary clarifications and protections to effectively address the problem.		
1.2 Expand Health Care Proxy (HCP) education and execution	• Scale and routinize the MHA / Honoring Choices Massachusetts / DPH "Simple Step" Campaign statewide to increase awareness and completion rates with special focus on multilingual and culturally appropriate content. • Integrate HCP education and documentation into hospital intake, COAs, ASAPs, and PCP practices. • Endorse standard plain-language, multilingual HCP forms.	Reduces reliance on emergency guardianship, prevents discharge delays due to lack of legal decision-maker, increases early/timely planning especially for patients at risk of incapacity, reducing avoidable guardianship filings and institutional discharges.	i, iii, iv, v
1.3 Modify MGL 201D to Modernize Health Care Proxy Requirements	• Amend the law to require just one witness who may witness via audio-video and electronically sign the proxy document. • Statutorily change the law to make it clear that Advanced Practice Providers (APP) with proper training are authorized to make incapacity determinations and invoke health care proxies.	Streamlines the process of executing and activating health care proxies.	iii, vi
1.4 Explore hospital-based court liaison roles	• Assess feasibility and value of funding Court Navigator positions within hospital systems to manage and expedite guardianship / conservatorship filings and court communication.	Streamlines filing and communication with Probate and Family Courts, reduces variation in process across counties, and shortens legal wait times.	ii, iii, vi
1.5 Promote Supported Decision-Making	• Support legislation to establish legal recognition of Supported Decision-Making (SDM) in Massachusetts (reflected in provisions included in various bills currently under review; please see Appendix C).	Reduces need for guardianship; preserves autonomy while supporting timely discharge decisions for adults with retained decision-making capacity.	i, iii, v

Recommendation	Action	Justification	Task Force Charge(s) Addressed
	• Conduct statewide training for providers and families to ensure consistent understanding and application.		
1.6 Expand Public Guardian Programs and Volunteer Recruitment	• Support the expansion and funding of the Public Guardian Pilot Program and align with forthcoming Department of Public Health (DPH) recommendations to strengthen guardianship capacity statewide. • Support legislation that would fund public awareness campaigns to recruit retired healthcare providers and other qualified individuals to serve as volunteer guardians (reflected in provisions included in various bills currently under review; please see Appendix C).	Expanding public guardian programs and recruiting volunteers addresses the persistent shortage of available guardians, which contributes to discharge delays and prolonged hospital stays for individuals without decision-makers.	iii, vi
2. Post-Acute Capacity & Referral Pathways			
2.1 Program to Enhance Capacity of Skilled Nursing Facilities to Accept Long-Term Custodial Care Patients	• Through pilot programs and hospital-nursing home partnerships, investigate the feasibility, costs to nursing facilities and hospitals, and patient outcomes of programs to expand capacity for patients requiring long-term care custodial beds in skilled nursing facilities with appropriate workforce supports and investment, particularly for specialized populations.	Hospitals continue to have more than 340 patients per month who are waiting for long-term care beds in nursing homes; Increases capacity and throughput by freeing-up beds in hospitals and creating capacity for hospital-ready discharges.	v, xiv
2.2 Standardize discharge referral packets and promote virtual screening	• Convene key stakeholders representing hospital and post-acute care providers to explore impact of mandating uniform referral packets for hospital discharge and pre-admission clinical in-person or virtual	Reduces unnecessary delays caused by incomplete or inconsistent discharge documentation.	i, vii

Recommendation	Action	Justification	Task Force Charge(s) Addressed
	screenings and warm hand-offs to post-acute care providers.		
2.3 Develop a real-time post-acute care system dashboard	• Explore the feasibility and cost of developing, governing and maintaining a real-time statewide platform for post-acute care bed and service availability, referral, acceptance status, discharge delays, and real-time coordination tools.	Enables data-driven coordination and reduces inefficient referrals and delays.	i, v, vi
2.4 Promote accelerated discharge programs	• Establish hospital targets to initiate hospital transfers to post-acute care earlier in the day (8:00 a.m. to 11:00 a.m.). • Adopt and scale models like "10 Before 10" or similar discharge acceleration models in high-volume hospitals to encourage earlier discharge of patients requiring ambulance transfer to reduce constraints on ambulance capacity late in the day.	Initiating hospital transfers to post-acute care earlier in the day improves hospital throughput, reduces avoidable administrative days, allows for flattening of transportation demands, and enhances care continuity and patient safety by aligning discharge timing with PAC facility intake workflows, ambulance availability and care team coordination.	i, v, vi
2.5 Expand SNF weekend intake and transport readiness	• Improve weekend and off-hour transitions, piloting "weekend-ready" discharge programs including designated PAC signatory staff, standard weekend prior authorization rules across those insurance companies over which the state has regulatory authority, and dedicated transport slots, (e.g., pre-scheduled PT-1s with weekend overrides).	Unlocks hospital capacity and prevents weekend backlogs.	i, v, vi
2.6 Expedited Discharge for Hospice and End-of-Life Care	• Establish expedited pathways (including prior authorization) for hospital discharge and post-acute care coordination for hospice and end-of-life patients to minimize	Delays in discharge for hospice and end-of-life patients can cause avoidable suffering and misalignment with care	I, vi

Recommendation	Action	Justification	Task Force Charge(s) Addressed
	unnecessary delays, ensure timely access to appropriate care settings, and uphold patient dignity and care preferences at the end of life.	goals. Expedited processes are essential to support timely transitions that prioritize patient comfort and family needs.	
3. Payer & Coverage Administrative Considerations			
3.1 Monitor and evaluate prior authorization reforms under Chapter 197	• Monitor utilization and collect data on Chapter 197 (2024) requirement, including: 　○ Timeliness of prior authorization decisions, specifically the next business day response standard for post-acute care and transport authorizations; 　○ Utilization of the waiver provision for non-business day submissions; 　○ Voluntary efforts by commercial insurers, GIC plans, MassHealth, and Medicare Advantage to further waive or streamline prior authorization requirements; 　○ Reviewing prior authorization trends among commercial insurers licensed in the state compiled by the Division of Insurance; and 　○ Impact on hospital throughput, inappropriate placements, and member satisfaction. • Support the development of mutually agreed-upon minimum covered stay periods through private negotiation between health plans and post-acute care providers, informed by ongoing monitoring and evaluation, to help provide greater clarity and predictability around payment.	Ensures that administrative streamlining under Chapter 197 is properly implemented, consistently applied, and achieves the intended benefits without causing unintended consequences such as inappropriate admissions or member dissatisfaction.	ii, vii

Recommendation	Action	Justification	Task Force Charge(s) Addressed

	• The Task Force discussed minimum covered stay periods in post-acute settings to help facilitate faster discharges and decrease post-acute providers' risk of accepting patients without payor coverage. However, there were differences of opinion among Task Force members regarding the best approach.
	    ○ Providers suggest a standardized minimum stay coverage for all insurers over which the state has authority.
	    ○ Payors suggest development of mutually agreed-upon minimum covered stay periods through private negotiation between health plans and post-acute care providers.		

3.2 Advocate for Medicare Advantage Prior Authorization Alignment	• Partner with federal and state stakeholders to advocate for national alignment of prior authorization turn-around times to expedite post-acute care transitions. • Advocate for federal government to align Medicare and Medicare Advantage prior authorization response times for post-acute care services with recent Massachusetts standards.	Delays in Medicare Advantage prior authorization create discharge backlogs and care coordination challenges; aligning response times improves throughput and patient experience.	ii, vii
3.3 Explore out-of-network reimbursement processes	• Convene stakeholders to explore potential strategies to support timely access to care when no in-network provider is available. • Strategies may include—but are not limited to—streamlining out-of-network (OON) payment processes or developing shared	Support timely discharge and ensures member access to care when capacity is strained.	viii, vi

Recommendation	Action	Justification	Task Force Charge(s) Addressed
	• principles to guide timely negotiation in urgent situations. • Prioritize solutions that balance the need to expedite patient access, reduce discharge delays, preserve the ability for private negotiation, and promote insurer network adequacy and transparency.		
3.4 Explore Enhanced Hospital Case Management and Wrap-Around Service	• Evaluate the feasibility, billing operations, and cost-effectiveness of enhanced hospital-based case management and wrap-around service models (e.g., CHART-style teams) through pilot programs.	Support proactive discharge planning and social needs support to help reduce discharge delays, improve care transitions, and ensure home- and community-based services (HCBS) are in place to prevent readmissions.	
4. Home & Community-Based Supports (HCBS) Care Continuum			
4.1 Make Hospital to Home Partnership Program (HHPP) permanent	• Explore feasibility of making the Hospital to Home Partnership Program (HHPP) permanent, and based on feasibility encourage and fund programs that enable all hospitals to embed liaison roles from their local ASAPs for home and community-based care coordination.	Direct HCBS coordination at the point of care reduces unnecessary SNF placement and enables faster, safer discharges to the community.	i, iii, v
4.2 Develop an HCBS referral portal integrated with EMRs	• Explore feasibility of developing a universal hospital-to-HCBS broadcast referral tool to connect ASAPs, ILCs, and home care agencies through secure, automated platforms.	Reduces manual handoffs, ensures faster referrals, and improves visibility across providers and allows ASAPs to anticipate potential wrap-around services to support discharge to the community prior to discharge from SNF care.	i, ii

Recommendation	Action	Justification	Task Force Charge(s) Addressed
4.3 Expand Mobile Integrated Healthcare (MIH) and Hospital-at-Home models	• Expand reimbursement pathways for MIH through defining standardized billing codes for MIH and clarifying scope of practice and credentialing pathways for MIH (reflected in provisions included in various bills currently under review; see Appendix C). • Sustain CMS Hospital-at-Home waivers through federal legislation, 1115 waivers, state plan amendments, and/or state legislation (reflected in provisions included in various bills currently under review; see Appendix C). • Establish structured referral pathways with standardized protocols for hospital, ED, PCP, and 9-1-1 referrals to MIH providers. • Develop sustainable reimbursement models, including MassHealth adoption of community paramedicine CPT/HCPCS codes and transitioning current MIH coverage into the State Plan when federal waivers expire. • Invest in EMS workforce development, including expanded paramedic scope of practice, training in chronic disease management, and vehicle/staffing resources as programs scale. • Foster strong partnerships among primary ambulance services, ACOs, home-health agencies, ASAPs, and hospital leadership to integrate MIH into broader care networks and EMR systems.	CHIA's June 2025[6] review found that expanding MIH would have minimal insurance premium impact ($0.03–$0.12 PMPM) while reducing emergency use, hospital readmissions, and improving access and outcomes, especially for underserved populations. Expanding MIH and Hospital-at-Home programs enable earlier discharge, reduces hospital crowding, and maintains care quality in alternative care settings.	i, v, vi

[6] Massachusetts Center for Health Information and Analysis (CHIA), *Mandated Benefit Review of House Bill 1154 and Senate Bill 726: An Act Advancing Mobile Integrated Health and Emergency Response*, June 2025. Available at: https://www.chiamass.gov/assets/docs/r/pubs/mandates/Mobile-Integrated-Health-MBR.pdf.

Recommendation	Action	Justification	Task Force Charge(s) Addressed
4.4 Support workforce pipelines for PAC and HCBS	• Continue bolstering and providing funding for programs that create career ladders, as well as tuition support, credentialing tracks, and wage incentives for home care, SNF, and paramedicine workers.	Addresses the most cited cause of discharge delays: workforce shortages.	v, vi
4.5 Simplify and promote enhanced public education on HCBS and community resources	• Develop an easy-to-use, multilingual – ideally interactive – service guide and web portal (e.g., an enhanced MassOptions.org) to streamline referral for HCBS and community resources in an effort to demystify services, eligibility, referrals, coverage, and transitions for patients, families, hospitals, and providers. • Launch targeted education campaigns in multiple languages to strengthen education about community-based resources (ASAPs, SCO, PACE, OneCare) and develop targeted campaigns for healthcare providers, patients and caregivers.	Simplifies navigation across fragmented services, reduces confusion about eligibility and referrals, and helps reduce unnecessary institutional placements.	x, xiv
5. Complex Needs & Populations			
5.1 Explore discharge planning strategies for certain MassHealth populations	• Assess current barriers and identify existing community-based, charitable, safety net, or other supports and funding that could assist with post-acute care and discharge planning for individuals with no post-acute care coverage.	Supports timely discharge for individuals who are medically stable but face challenges due to limited coverage, without requiring benefit expansion.	i, ii, vi
5.2 Scale Enhanced Medical Group Living Environment (EMGLE) and Nursing Facility Transition (NFT) team models	• Explore the impact and value of supporting regional EMGLE programs. • Formalize NFT discharge protocols across hospitals, SNFs, IRFs/LTACHs, BH and group home providers including but not limited to patients with acute & traumatic	Facilitates discharge for complex behavioral and medical patients unsuited for SNFs.	i, iv, v, vii

Recommendation	Action	Justification	Task Force Charge(s) Addressed
	brain injuries, spinal cord injuries and quadriplegia.		
5.3 Develop clear referral pathways and procedures for discharges back to DMH & DDS group homes	• Develop standard discharge planning forms and referral protocols specific to DMH and DDS group home settings. • Explore or pilot a model that assists with patient discharges on Fridays, Saturdays and Sundays when group homes are not typically staffed with admissions nurses and the discharge is not medically complex.	Reduces discharge delays for returning to group homes, especially on weekends, and improves coordination between hospitals and state-operated or contracted residential settings.	i, iii, v
5.4 Develop Standard Operating Procedures (SOPs) for justice-involved patient supports and discharges	• Develop SOPs and/or clear referral pathways for hospitals discharging patients who are justice-involved or are on sex offender registries. • Develop clear referral pathways, eligibility criteria, and process ownership for hospital discharges to Department of Correction (DOC)-secured medical beds. • Develop clear referral pathways for access by DOC / House of Correction (HOC) to post-acute care beds.	Improves patient flow, reduces unnecessary hospitalizations, and enhances awareness of safe and appropriate discharge options.	i, iii, v
5.5 Explore co-located service models	• Expand existing and pilot new models like co-location and transport support utilizing telehealth and/or remote monitoring to meet patient needs, building a system that is more flexible and efficient (e.g., co-location of high-frequency services such as dialysis dens within SNF settings, methadone medication units, bariatric support, BH supports, etc.).	Supports timely access to care, reduces reliance on acute care settings, and addresses transportation and site-of-care barriers for medically complex patients.	i, ii, v, vi
5.6 Enhance supports for	• Develop and standardize statewide policies and procedures regarding equipment (e.g.,	Building consistent SNF bariatric care capacity will help reduce discharge	xiv

Recommendation	Action	Justification	Task Force Charge(s) Addressed
bariatric population	bariatric beds, lifts, and mobility supports) and staffing for safely supporting residents with bariatric care needs at SNFs.	delays, improve access to appropriate care, and enhance resident safety and quality.	
6. Non-Emergency Medical Transportation (NEMT)			
6.1 Require early PT-1 submission in discharge workflows	• Mandate documentation of transport needs and PT-1 submission during discharge order entry.	Eliminates last-minute delays caused by uncoordinated or late-arranged NEMT.	i, ii, vi
6.2 Create regional discharge and transport coordination portals	• Explore feasibility, governance and cost of developing real-time coordination tools, like statewide or regional "Open Table" transportation coordination tool that could integrate PT-1 status, post-acute care, facility or service capacity, and transport availability in one shared tool.	Enables real-time matching and proactive problem-solving in discharge planning.	i, v, vii
6.3 Explore Behavioral Health Transportation Models	• Explore feasibility and funding for implementation of alternative behavioral health transportation models, including studying models in place in Colorado and Virginia (reflected in provisions included in various bills currently under review). • Promote piloting BH transportation alternatives focused on safety, patient-centered care, and cost-effectiveness. • Develop monitoring and evaluation frameworks for new transportation models.	Expands transportation options for individuals in behavioral health crisis, reducing reliance on police or ambulance transport, improving patient experience, and enhancing safety.	i, v, vi

VI. A Path Forward: Strategic Alignment and Accountability

Massachusetts has launched a range of promising efforts to improve hospital throughput and transitions to post-acute care. Building on this momentum will require a trained, skilled workforce and deliberate alignment across agencies, providers, and payers to ensure these efforts translate into sustained, system-level change.

To move forward effectively, state partners can:

- **Scale what works.** Time-limited pilots and embedded staffing models are already showing value. Promising innovations should be assessed for long-term sustainability and opportunities to support statewide adoption.

- **Strengthen infrastructure for coordination.** Durable tools, workflows, and data systems that support real-time discharge planning, referral management, and transport readiness can help streamline transitions and reduce delays across the continuum.

- **Clarify roles and accountability.** Shared expectations, standard operating procedures, and clear lines of responsibility—across hospitals, post-acute providers, transportation brokers, and community-based organizations—can reduce fragmentation and improve outcomes.

- **Ensure ongoing performance monitoring.** Implementation of recent reforms, including those under Chapter 197 of 2024, should be closely monitored to ensure intended outcomes and to identify opportunities for course correction.

- **Advance equity.** Populations with complex needs—including those with behavioral health conditions, disabilities, or limited insurance coverage—continue to face disproportionate discharge delays. Targeted strategies must ensure equitable access to timely, appropriate care transitions.

VII. Appendices

Appendix A – Full Text of the Task Force's Charge

Link: https://malegislature.gov/Laws/SessionLaws/Acts/2024/Chapter197

CHAPTER 197, SECTION 25

(a) There shall be a task force to study and propose recommendations to address acute care hospital throughput challenges and the impact of persistent delays in discharging patients from acute to post-acute care settings. The task force shall examine: (i) hospital discharge planning and case management practices; (ii) payer administrative barriers to discharge; (iii) legal and regulatory barriers to discharge; (iv) efforts to increase public awareness of health care proxies and the importance of designating a health care agent; (v) post-acute care capacity constraints and additional opportunities to provide financial incentives to increase capacity; (vi) administrative day rates and the cost to hospitals of discharge delays; (vii) enhanced hospital case management practices and reimbursement for wraparound services; (viii) the adequacy of post-acute care facility insurance networks and the establishment of an out-of-network rate for post-acute care facilities; (ix) expanding MassHealth Limited coverage to include post-acute and long-term care services; (x) the effectiveness of interagency coordination to resolve complex case discharges; (xi) the adequacy of reimbursement rates of MassHealth and commercial carriers for nonemergency medical transportation; (xii) opportunities to expand coverage and reimbursement for services delivered by mobile integrated health programs certified by the department of public health and by participating providers in the federal Centers for Medicare and Medicaid Services acute hospital care at home program; (xiii) alternative transportation options for patients being discharged and transferred to post-acute care facilities or home health agencies; and (xiv) the adequacy of state resources and infrastructure to place complex case discharges in appropriate post-acute care settings, including, but not limited to, patients with dementia diagnoses, geriatric patients with psychiatric diagnoses, patients with behavioral health diagnoses, patients with substance use disorder diagnoses, justice-involved patients and patients who have been unable to find an appropriate placement for post-acute care for 6 months or longer.

(b) The task force shall consist of: the secretary of health and human services, or a designee, who shall serve as chair; the assistant secretary for MassHealth, or a designee; the commissioner of mental health, or a designee; the attorney general, or a designee; the commissioner of correction, or a designee; 1 sheriff appointed by the Massachusetts Sheriffs' Association, Inc.; 1 member representing the division of the probate and family court department of the trial court to be appointed by the chief justice of said division; and 10 members to be appointed by the chair, 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts Senior Care Association, Inc., 1 of whom shall be a

representative of the Home Care Alliance of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Academy of Elder Law Attorneys, 1 of whom shall be a representative from the Massachusetts Ambulance Association, Incorporated, 1 of whom shall be a representative from the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative from Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative from an academic medical center located in Worcester county, 1 of whom shall be a representative of an acute care hospital located in Suffolk county and 1 of whom shall be a representative from an acute care hospital designated by the health policy commission as an independent community hospital for the purposes of 105 CMR 100.715(B)(2)(b).

(c) Not later than July 31, 2025, the task force shall submit its report, including its recommendations or any proposed legislation necessary to carry out its recommendations, to the clerks of the house of representatives and the senate, the house and senate committees on ways and means and the joint committee on health care financing.

Appendix B – List of Task Force Members

Name	Seat
Joanne Marqusee	Chair and Designee of the Secretary of Health and Human Services
Carminda Andrade	Designee of the Commissioner of the Department of Mental Health (DMH)
Donna Buckley	Appointee of the Massachusetts Sheriffs' Association
Samantha Canica	Appointee of the Chief Justice of the Trial Court representing the Division of the Probate and Family Court Department
Leslie Darcy	Designee of the Assistant Secretary for MassHealth
Adam Delmolino	Appointee of the Chair, representing the Massachusetts Health & Hospital Association (MHA)
Shauna Dube	Appointee of the Chair, representing an academic medical center located in Worcester County (UMass Memorial Medical Center)
Jeff Fisher	Designee of the Commissioner of the Department of Correction (DOC)
Valerie Frias	Designee of the Attorney General
Tara Gregorio	Appointee of the Chair, representing the Massachusetts Senior Care Association (MSCA)
Jake Krilovich	Appointee of the Chair, representing the Home Care Alliance of Massachusetts
Liz Leahy	Appointee of the Chair, representing the Massachusetts Association of Health Plans (MAHP)
Tracy Lee	Appointee of the Chair, representing an acute care hospital located in Suffolk County (Beth Israel Deaconess Medical Center)
Mary McClintock	Appointee of the Chair, representing an acute care hospital designated by the Health Policy Commission as an independent community hospital (South Shore Hospital)
Richard Raymond	Appointee of the Chair, representing the Massachusetts Ambulance Association
Clarence Richardson	Appointee of the Chair, representing the Massachusetts Chapter of the National Academy of Elder Law Attorneys
Deborah Vona	Appointee of the Chair, representing Blue Cross and Blue Shield of Massachusetts

Appendix C – Relevant State Legislation Currently Under Review

State Legislation Currently Under Review (by Task Force Recommendation)

1.1 Advance "Next of Kin" or "Surrogate" Decision-Making Legislation
- HB 1692 / HB 1874 / SB 1047

1.5 Promote Supported Decision-Making
- HB 261 / HB 264 / SB 155

1.6 Expand Public Guardian Programs and Volunteer Recruitment
- HB1412 / SB903

4.3 Expand Mobile Integrated Healthcare (MIH) and Hospital-at-Home models
- HB 1154 / SB 726 – Mobile Integrated Health
- HB 1141 / SB 806 – Hospital at Home

6.3 Explore Behavioral Health Transportation Models
- HB 2234 / SB 1397