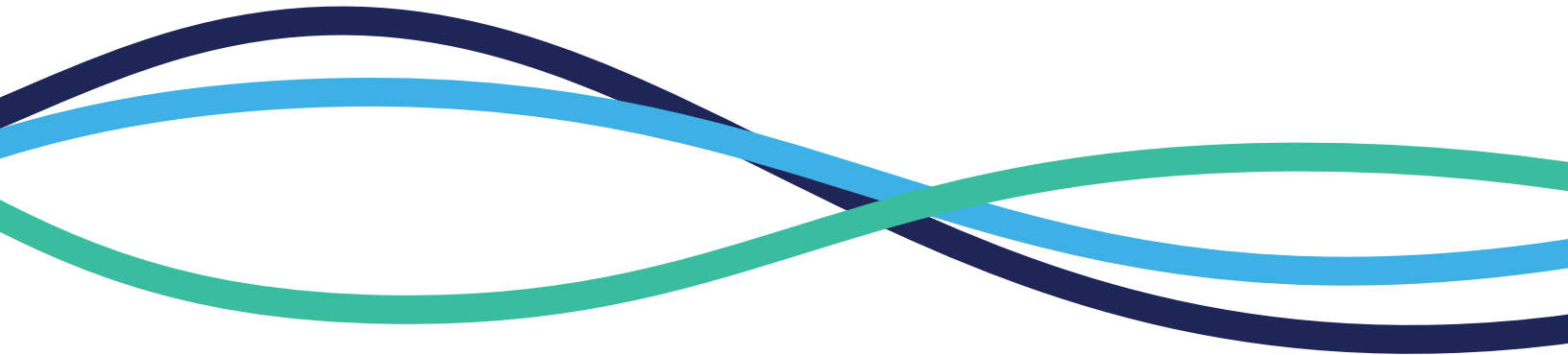




After the Hospital:

A Guide to Post-Acute Care



MASSACHUSETTS
Health & Hospital
ASSOCIATION

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Acknowledgments

The Continuum of Care Council (CCC) is an advisory council of the Massachusetts Health & Hospital Association (MHA), established with the goals to optimize patient care, experiences, and clinical and economic outcomes through population health strategies. It provides a forum for members to engage in cross-continuum collaboration to address regulatory and clinical barriers that impede caregivers' vital work.

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**We hope that this guide will help many patients and families
in making the best decisions about their post-acute care needs.**



Section 1. Introduction

The Massachusetts Health & Hospital Association (MHA) prepared this guide to support you and your family to make the best decisions about your post-acute care options. The information in this guide can help you to make these healthcare choices confidently.

Many people need medical care after a health event to recover from an injury, illness, surgery, and/or hospitalization. For example, some people may need rehabilitation; comfort care that focuses on providing relief from pain and other symptoms of a serious illness; or end-of-life care. All of this care provided outside of the traditional hospital setting is referred to as “post-acute care.” It is very important that you receive the right care, at the right time, and in the right place to meet your individual goals and needs and to support your quality of life. For the best outcomes, it is also critical that you receive care from providers who can meet your needs in a culturally competent way.

Your healthcare team may recommend post-acute care (PAC) for you.

Most people have never heard of the term “post-acute care.” Some people use the term PAC instead of using post-acute care. The word “acute” means a sudden and intense new situation.

This guide explains your options for care after a major change in your health.

How Can Post-Acute Care Help Me?



Post-Acute Care Can:

- ✓ Support recovery after a health event, usually for a limited-time period
- ✓ Help restore function and improve your quality of life
- ✓ Provide therapy such as physical, occupational, and speech therapy
- ✓ Provide intravenous (IV) therapy such as antibiotics or fluid
- ✓ Provide wound care
- ✓ Provide services to address mental health or substance use disorder needs
- ✓ Provide education about disease management
- ✓ Provide comfort care, palliative care (care that focuses on providing relief from pain and other symptoms of a serious illness), or end-of-life care
- ✓ Be provided at home by community service professionals
- ✓ Be provided in outpatient clinics or doctors' offices
- ✓ Be provided at a facility such as a skilled nursing facility (SNF), nursing home, long-term acute care hospital, or inpatient rehabilitation facility
- ✓ Be provided through virtual telehealth appointments or other services using technology, including SNF-at-home or mobile integrated health

OVERVIEW OF POST-ACUTE CARE SERVICES

Post-acute care (PAC) includes a range of services to address your goals and needs. PAC services can be provided at home, in an outpatient setting in your local community like a doctor's office or hospital clinic, or at a facility for a short-term stay like a nursing home (see Figure 1). You should work with your provider to ensure that the care planning process meets the care goals that you and your family/caregiver have set and that they are addressed in a comprehensive way. The PAC planning process should also address any behavioral health needs you have for mental health and/or substance use disorder services. Always check with your health plan or insurance company to ensure that the services that you need are covered.

Figure 1. Post-acute care services





Section 2. Your Roadmap to Making the Best Choices

We know that finding the right post-acute care at a time of stress and uncertainty can be hard for you and your family.

To make this process easier for you, this guide gives you five steps to follow.

Step 1. Understand Your Care Needs

Step 2. Learn About Services that Meet Your Needs

Step 3. Talk to Your Health Insurance Company or Health Plan

Step 4. Find Out More About Your Providers

Step 5. Make the Choice that is Right for You

Step 1. Understand Your Care Needs

It is important to understand your specific needs for post-acute care services. Understanding your needs will help you have a successful care experience. A successful care experience is critical to your recovery. For anticipated events, such as a scheduled surgery, many people have a plan of care in advance of the surgery.

POST-ACUTE CARE PLAN

- **Yes – I have a plan for post-acute care.** For planned events, such as scheduled surgery for a hip or knee replacement, many people will have a plan for post-acute care in advance of the event. You should review this plan with your healthcare provider to make sure that it is still the best plan for you.
- **No – I need a plan for post-acute care.** Some events are not planned. Some needs may not be known until your hospital stay. This is especially true for unanticipated events, such as a stroke. In these types of circumstances, the planning process often occurs in the hospital. You will need the support of your healthcare team. You may also want to check with your health plan or health insurer to confirm coverage of needed medications, therapies, in-patient care at a rehabilitation facility, long-term acute care hospital, nursing home, or assisted living residence, and any other care or services that may be needed.

COMMON EXAMPLES OF POST-ACUTE CARE NEEDS

- Help with eating, bathing, getting dressed, and toileting
- Help with meals to meet nutritional requirements
- Assistance getting around your home
- Assistance with grocery shopping, light housekeeping, and laundry
- Companionship to enhance wellbeing and prevent loneliness
- Assistance with connecting with family and friends
- Help monitoring your temperature, blood pressure, heart rate, comfort level, and weight
- Assistance with medications
- Education about medications and potential side effects
- Therapy needs, such as physical therapy, occupational therapy, speech therapy, cognitive therapy
- Skilled nursing care, wound care, and intravenous (IV) medications
- Help using medical equipment and supplies such as home oxygen or nebulizers
- Accessing transportation for follow-up medical appointments or dialysis
- Accessing technology, such as telehealth
- Pain management
- Comfort care, palliative care, serious illness management, and end-of-life support
- Help caring for your pet



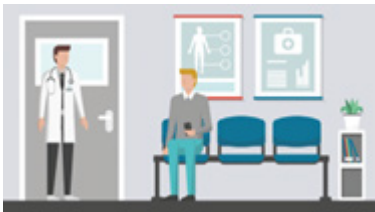
ADVANCED CARE PLANNING

Planning for your future care can include planning for the unexpected, as well. If you have not already done so, it is recommended that you designate a healthcare agent and complete a signed "Health Care Proxy" to make decisions about your care should you not be able to do so. If you or a family member has a serious advancing illness or medical frailty, adults can choose to complete a POLST form (Portable Medical Orders for Life Sustaining Treatment) with your physician, nurse practitioner, or physician assistant. Talk to your clinician about your prognosis, treatment options, and the care you want / do not want. Your clinician will transfer your choices to the POLST form, which is followed by every clinician across all care settings. Honoring Choices MA provides up-to-date healthcare planning information, no-cost Massachusetts planning documents, and many resources for adults, families, and caregivers. Its network of Community Partners can help you get connected to care in your community as well. **Please note:** the current MOLST system is transitioning to the digitally-based POLST system in the summer of 2024 and you may see these terms used interchangeably. See resources and links to MOLST/POLST forms later in this guide.

CARE AT HOME, IN A FACILITY, OR AS AN OUTPATIENT



Home-based care. Many people receive post-acute care at home. For example, you might need help with health-related care, such as skilled nursing care and physical therapy. You might also need personal care, such as help bathing, dressing, and going to the bathroom. You might also require assistance with transportation to and from medical appointments.



Outpatient-based care. Many people receive rehabilitation services or intravenous medications at an outpatient clinic. You might need to go to a provider several times per week for medical or therapy treatments.



Facility-based care. Some people receive care in a facility for a short-term stay. Depending upon your individual post-acute care needs, you might benefit from receiving around-the-clock care in a facility to meet your post-acute care needs. While in the facility, you may also need a plan to manage things at home and stay connected to loved ones.

The Care Transition Process for Post-Acute Care Services

A care transition takes place every time you move from one setting to another.

You may experience a wide variety of care transitions when you receive PAC services. For example, you might move from hospital to home, from home to the hospital, and from the hospital to a skilled nursing or rehabilitation facility. After you leave the facility, you may continue to receive post-acute care at home. Your home could be a private residence or an assisted living community. You may also receive care in an outpatient clinic that supports your rehabilitation and recovery after a hospital stay.

The care transition process is equally important for behavioral health conditions, including mental health and substance use disorders.

A smooth care transition process is important to your recovery.

It is best to work closely with your healthcare team, which may include a physician, nurse, case manager, social worker, and your primary care provider to make sure your care transition goes smoothly. If the care transition was not planned before hospitalization, then the transition plan should begin right after your admission to the hospital.

- 1. Know what care you will be receiving and for how long.** Make sure you have all the information you need about where you are going and what type of care you'll receive. Are you going home or to a facility? If you have different options, where would you most prefer to receive care? What kind of care do you need? What kind of care is offered at each facility?
- 2. Designate a family caregiver.** Be familiar with the CARE Act (Caregiver, Advise, Record, Enable). This act, which was signed into law in Massachusetts in 2017, requires that a designated family member's or friend's name be recorded at the time of a hospital admission so that your hospital providers know who to talk to about your care transition. This act also requires that patients and designated family members or friends receive advance notice prior to your discharge to your home or other care facility so that they are aware of when you will be transferred. Clear instructions on home care tasks, especially medically related ones, must be given to this person (and demonstrated) before you leave the hospital – particularly if you are being discharged home.
- 3. Understand your care goals and needs.** Make sure that you can answer these questions: What is the primary goal of treatment? Will your functioning improve? If so, by how much? Will you fully recover? Will you need additional care? What type of additional care might you need and for how long?
- 4. Work with your hospital case manager (registered nurse, social worker) and insurer representative (as needed) for support.** You, your family members, and community providers should be partners in your care transition, whether you are going home or to another facility.
- 5. Address the issues one by one.** This can help you to manage your expectations and recovery.

If you are leaving the hospital or any other facility, make sure to:

1. Get a customized discharge plan based on your specific needs, including a list of medications and instructions on how and when to take them, and an explanation of any other specific care instructions.
2. Schedule timely follow-up care with healthcare providers as recommended.
3. Be sure you have a hospital contact name and phone number for questions, concerns, and follow-up instructions.

Step 2. Learn About Services that Meet Your Needs

It is important to understand the range of services that are available to meet your care needs. You can do this with the support of your healthcare team and health insurance company. You may also want to consider what type of non-medical support you might receive from family, friends, and neighbors.

Post-acute care services are available in three types of settings:

At home

At an outpatient clinic in your local community

At a facility such as a skilled nursing facility, an inpatient rehabilitation facility, or a long-term acute care hospital

Post-acute care services that address specific behavioral health conditions can include:

Social supports such as club houses

Recovery groups such as Alcoholic Anonymous, Narcotics Anonymous, or recovery learning communities

Other types of peer groups for mental health and substance use disorder conditions

Residential treatment facilities



The Choice of Home or Facility

You may prefer to receive post-acute care in your home. Care at home may be optimal depending on your care needs. In Massachusetts, some Medicaid and/or Medicare health plans are flexible in providing care to you in your home or community. The [One Care program](#), [Senior Care Options \(SCO\)](#), [home care organizations](#), and the [Program-of-All-Inclusive Care for the Elderly](#) (also called the PACE program) are generally flexible. In addition, some medical professionals can provide virtual telehealth appointments using personal computers, tablets, smartphones, telephones, and other devices. It is important to understand your healthcare team's recommendation for post-acute care and find the service and setting that provides the best care experience. You should also ask your insurer for any guidelines that can help you make the best possible decisions.

SERVICES IN YOUR HOME

Most people go home after a hospitalization. Home may be in a private residence or an assisted living community. Going home will require advance planning to put the right services and supports in place to meet your care needs. Every patient must have an individualized plan of care based upon a full assessment of their needs. The plan of care will also detail your expected recovery timeline. Home health providers should deliver care in your home in accordance with your plan of care. As a reminder, not all insurance plans cover all home care services, so be sure to check with your insurer before scheduling services.

SERVICES IN YOUR LOCAL COMMUNITY

Many people go home after the hospital and have ongoing care needs met through outpatient appointments with local providers. For example, following major surgery, a patient may need to go to a physical therapist several times a week for a couple of months. Treatments like this are referred to as “outpatient” services.

As part of the discharge process, you may need access to common outpatient services such as:

- Therapy, including physical therapy, occupational therapy, or speech therapy
- Rehabilitation including cardiac rehabilitation
- Behavioral health services, including mental health services and substance use disorder treatment
- Doctor/specialist follow-up visits
- Lab work and medical imaging

Home healthcare services may include:

- Post-surgical nursing care, such as wound care
- Rehabilitative nursing after a stroke or cardiac event
- Pulmonary care
- Therapy, including physical therapy, occupational therapy, and speech therapy
- Medication management and administration
- Wound care
- Intravenous therapy
- Personal care services to help you with bathing, dressing, and toileting
- Assistance with walking, mobility, and transfers
- Assistance in monitoring your health status, reducing the need for office visits for routine checks
- Monitoring your temperature, pulse, respiration, blood pressure, and weight
- Communicating with your provider and healthcare team
- Palliative care services for serious illness management and hospice care for comfort care and end-of-life support
- Behavioral health services, including mental health services and substance use disorder treatment
- Case management
- Assistance with meal preparation and eating
- Assistance with household tasks, such as laundry, light housecleaning, grocery shopping, and errands
- Companionship and socialization
- Caregiver support

SERVICES IN A SPECIALIZED CARE FACILITY

Some people have care needs that vary in intensity and specialty and that require around-the-clock care in a facility. There are three common types of facilities for this type of care:

<p>Skilled Nursing Facility (SNF)</p>	<p>Some people need skilled nursing care after a hospitalization. This type of facility is also called a SNF.</p> <p>SNFs are also known as nursing homes and provide short-term care (up to 100 days if necessary, depending on your needs). Short-term rehabilitation patients are usually separated from long-term stay residents (who are residents of the SNF).</p> <p>Services include skilled nursing care, physician supervision, physical therapy, occupational therapy, speech-language therapy, social services, meals, dietary counseling, medical monitoring, administering oral and IV medications, wound care, and managing medical supplies and equipment used in the facility.</p> <p>In a SNF, you'll receive one or more therapies for an average of one to two hours per day. Medicare typically covers skilled nursing facility care only if a patient has been admitted to a hospital for three consecutive midnights. Be sure to confirm with the hospital that your stay in a skilled nursing facility will be covered by Medicare.</p>
<p>Inpatient Rehabilitation Facility (IRF)</p>	<p>Some people need to go to an inpatient rehabilitation facility after hospitalization. This type of facility is also called an IRF.</p> <p>IRFs are rehabilitation hospitals that provide intensive rehabilitation therapy, physician supervision, and nursing care, with physicians, nurses, and therapists coordinating care.</p> <p>To be in an IRF, patients must require both physician oversight for their medical care and therapy to improve function. Because IRFs provide hospital-level care, you do not need a hospital stay to qualify for admission. You can be admitted from home or directly from the emergency department if you meet IRF admission criteria and your insurance approves your stay.</p> <p>Services include physician services (5-7 times per week), physical therapy, respiratory therapy, occupational therapy, speech pathology, nursing services (24/7), medication monitoring, and managing other services and supplies.</p> <p>The amount of daily rehabilitative therapy in an IRF is more intensive than a SNF. In an IRF, you will receive three hours of therapy five days per week, or a total of 15 hours of therapy over a seven-day period.</p>
<p>Long-Term Acute Care Hospital (LTACH)</p>	<p>Long-term acute care hospitals serve patients with more complex needs than patients who go to SNFs and IRFs. They require longer hospital stays (often more than 25 days) and require prolonged, highly specialized care. This type of facility is also called a LTACH.</p> <p>Patients who are on life-sustaining equipment such as machines to assist you in breathing, or who need 24/7 medical and nursing management, may be referred to an LTACH after acute care hospitalization.</p> <p>LTACHs provide a much higher level of care than SNFs and specialize in treating patients who may have more than one serious condition.</p> <p>Services include inpatient hospital services and supplies, meals, nursing care, medications administered during the stay, rehabilitation services, pain management, and intensive respiratory therapy.</p>

Assisted Living Residence (ALR)

Assisted living residences (ALRs) emphasize aging with dignity and choice, while offering a high-quality lifestyle in a home-like supportive, non-clinical environment. Residents transitioning from living independently in their home often choose assisted living for a variety of reasons. Most residents receive support with certain activities of basic daily living, such as bathing, dressing, grooming, or mobility, and may receive limited assistance with medications. Residents also benefit from activities and programs tailored to meet their needs that focus on health, exercise, socialization, recreation, and wellness. Some of these individuals live in special memory care units that support those living with Alzheimer's disease or other dementias. Assisted living may be a good shorter-term option if someone is not ready to be home alone after a hospitalization and needs support with activities of daily living. Regardless of need or ability, every resident can benefit from the community atmosphere of assisted living. The services that would typically be provided in a private residence can also be provided in the assisted living setting, such as physical therapy, home care services, hospice, and other care as needed.

Services in a Facility for Behavioral Health Conditions

Behavioral health conditions include both mental health and substance use disorder conditions. Although this guide does not cover the range of facilities that provide post-acute care for people with behavioral health conditions, you should know that there are facility-based care options for people with behavioral health conditions. Two examples are:

Partial Hospital Programs operate for six hours a day and are often used as "step-down" programs to help facilitate timely discharges. This may be appropriate for individuals who are trying to cope with psychiatric issues, such as mood disorders, anxiety, and post-traumatic stress disorder. This program can also help those with co-occurring substance use disorder issues. Individuals attend a partial hospital program after an inpatient psychiatric hospital stay or to prevent further worsening of symptoms that would require hospitalization.

Residential Treatment Facilities can be appropriate for individuals to address mental health and/or substance use disorder needs.

To learn more about your options for facility-based or community-based options, you should speak to your provider and specialists.

PALLIATIVE CARE

According to the [Center to Advance Palliative Care](#) (CAPC), palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a specially trained team of physicians, nurses, and other specialists, who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.

Understanding Palliative Care: Palliative Care Improves Quality of Life and Lowers Symptom Burden.

"Palliative care specialists improve the quality of life for patients whose needs are most complex. Working in partnership with the primary care physician, the palliative care team provides: (1) time to devote to intensive family meetings and patient/family counseling; (2) skilled communication about what to expect in the future in order to ensure that care is matched to the goals and priorities of the patient and the family; (3) expert management of complex physical and emotional symptoms, including complex pain, depression, anxiety, fatigue, shortness of breath, constipation, nausea, loss of appetite, and difficulty sleeping; and, (4) coordination and communication of care plans among all providers and across all settings." Source: The Center to Advance Palliative Care (CAPC).

HOSPICE SERVICES

When the goal of treatment begins to shift from curing illness to providing comfort as a patient is reaching the end of their life, hospice care is a common choice. This decision is a very personal one and directly involves the patient, family, physician, and any loved ones who may serve as caregivers. The patient's wishes are always the priority.

Hospice care is provided by a team of healthcare professionals, who work with the patient and their family to design and implement a plan of care unique to the patient's diagnosis.

In addition, hospice provides all medications, services, and equipment related to a patient's terminal illness. Hospice care ensures they receive state-of-the-art pain control and symptom management. It is a philosophy of care that

focuses on quality of life and the whole person – body, mind, and spirit.

Hospice care enables patients to focus on living their remaining days fully, among friends and "family." "Family" is uniquely defined by each patient and includes those individuals chosen to support the patient during this time of life.

Most patients receive hospice care in their home, but hospice care may also be provided in freestanding hospice facilities, hospitals, SNFs, and other care facilities such as an assisted-living residence.

Hospice care provides:

- Specialized nursing and medical care, pain management, and emotional and spiritual support based on the patient's needs and wishes
- Support for the patient's chosen family
- Caring, not curing

Understanding Hospice Care: The Level and Location of Hospice Care

The type and amount or level of hospice care needed will vary across patients and conditions. If you or a loved one are exploring the option of hospice care, it is best to talk with your primary care provider to understand what options may be available. It is important to note that not all options are covered by all insurers; it is recommended that you check with your health insurance company or Medicare to ensure that the recommended hospice services are covered. The National Hospice and Palliative Care Organization is a great resource to begin exploring hospice care options and find care near you or a loved one: <https://www.nhpco.org/>.

Routine Hospice Care	This level of care is the most common level of hospice care. With this type of care, an individual has usually elected to receive hospice care at their home residence.
Continuous Home Care (CHC)	This level of care is provided for between 8 and 24 hours a day to manage pain and other acute medical symptoms. CHC services must be predominately nursing care, supplemented with caregiver and hospice aide services. CHC services are intended to maintain the patient at home during a pain- or symptom-related crisis.
Inpatient Respite Care (IRC)	This level of care is available to provide temporary relief to the patient's primary caregiver. Respite care is provided in a hospital, hospice facility, or a long-term care facility that has sufficient 24-hour nursing personnel present.
General Inpatient Care (GIP)	This level of care is provided for pain control or other acute symptom management. GIP begins when other efforts to manage symptoms are not sufficient. GIP can be provided in a Medicare-certified hospital, hospice inpatient facility, or nursing facility that has a registered nurse available 24 hours a day to provide direct patient care. This is a short-term benefit. Once symptoms are under control, the goal is for the patient to return to the previous setting.

Step 3. Talk to Your Health Insurance Company or Health Plan

The best way to find out what your health insurance will cover is to contact your insurer's customer service staff. Most insurers will pay for post-acute care, but health plans vary in what services they will cover and which providers may deliver the services. If you have a case manager at the hospital, they may be able to assist you with this process.

Always check with your insurer to verify the specifics around your coverage and benefits. Ask them what is covered based upon your healthcare needs and who can provide the service. Ask your plan what services are not covered and what you might be expected to pay.

If you are returning home from the hospital, you will want to work closely with your insurer to ensure that your needs are met. [This guide from the Massachusetts Division of Insurance \(DOI\)](#) is a helpful resource for patients.

HEALTH INSURANCE COVERAGE

Health insurers will vary in what they cover.

- Medicare, including original Medicare and Medicare Advantage
- MassHealth, including managed care and integrated care plans
- Commercial (health plans offered through an employer)
- Tricare (military benefits)
- Veterans Benefits Administration

QUESTIONS TO ASK YOUR HEALTH INSURER OR HEALTH PLAN

Take the time to ask your health insurer these types of questions.

- What is my post-acute care coverage?
- What is my coverage for care at home?
- What is my coverage for care in a facility?
- Does my coverage limit which facilities I can go to?
- What will these services cost me?
- Are there any restrictions on coverage for this service?
- Are there any limits on how long insurance will pay for this service?

MASSHEALTH AND MEDICARE COVERAGE FOR POST-ACUTE CARE

Medicaid (MassHealth)

MassHealth, under certain programs, can be more flexible than other insurers in providing coverage for care and services at home. For example, if you are enrolled in a One Care plan through the MassHealth One Care program, a plan through the Senior Care Options (SCO) program, or a PACE program through the Program of All-Inclusive Care for the Elderly (PACE), you may have coverage to receive your post-acute care needs at home. You will also want to ask your MassHealth insurer and/or health plan for the list of facilities with which they contract.

Medicare

Medicare has multiple coverage options, including traditional Medicare, Medicare Advantage plans, and Medicare supplemental plans. Medicare Advantage plans may include more services than traditional Medicare. However, Medicare Advantage plans may also require “prior authorization” (or insurance approval) for certain services, and you may be limited to network providers. Medicare supplemental plans help fill the gaps that are not covered by [Medicare Parts A \(for hospital-related care\) and Part B \(for other medical care\)](#). [This bulletin from the Massachusetts Division of Insurance](#) is a useful tool to explain the differences in Medicare options.

Each year, patients should assess their current coverage to see if it is best meeting their needs, and whether they have or need Medicare Part D (coverage for prescription drugs). With Medicare Advantage plans, a patient could see changes in the doctors, hospitals, nursing homes, and home care providers included in their networks from year to year. One portion of their expenses will be the monthly premium costs; this is when Medicare Advantage can look inexpensive. Patients also need to also consider their co-payments, co-insurance and any percentages of their total bills that they may be responsible for. They should examine their benefits statements and medical bills for the past year and add up what they paid in deductibles and copays to get a sense of the true costs of their plan. Then consider what you might pay the following year, especially if you need any major medical care or may need treatment at a rehabilitation facility.

If patients need assistance identifying appropriate insurance coverage, the state program Serving the Health Insurance Needs of Everyone (SHINE) provides free health insurance information, counseling, and assistance to people who are eligible for Medicare – as well as their caregivers. Certified trained counselors work with participants to help explore Medicare plan options.

More information about SHINE and its local offices [is available here](#) or at 1-800-243-4636.

COVERAGE FOR BEHAVIORAL HEALTH UNDER MASSHEALTH

According to experts, post-acute coverage for people with behavioral health needs, including mental health and substance use, is critically important. You will also want to ask your insurer and/or health plan for the list of facilities with which they contract.

For example, many people under MassHealth may be eligible to receive post-acute care behavioral health services through the Massachusetts Behavioral Health Partnership (MBHP). MBHP manages a variety of services in multiple settings to meet the needs of patients and promote the principles of rehabilitation, recovery, and resiliency. Services include outpatient mental health services, outpatient substance use disorder services, emergency services, and inpatient services.

[Visit here to learn more.](#)

Step 4: Find Out More About Your Providers



SAFETY

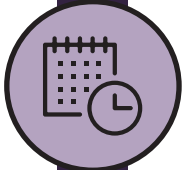
Ask your provider(s) to learn more about their safety protocols, emergency preparedness plans, and infection control policies and procedures. Safety questions and concerns should apply to all types of providers, from nursing homes to community providers such as home health providers.



QUALITY

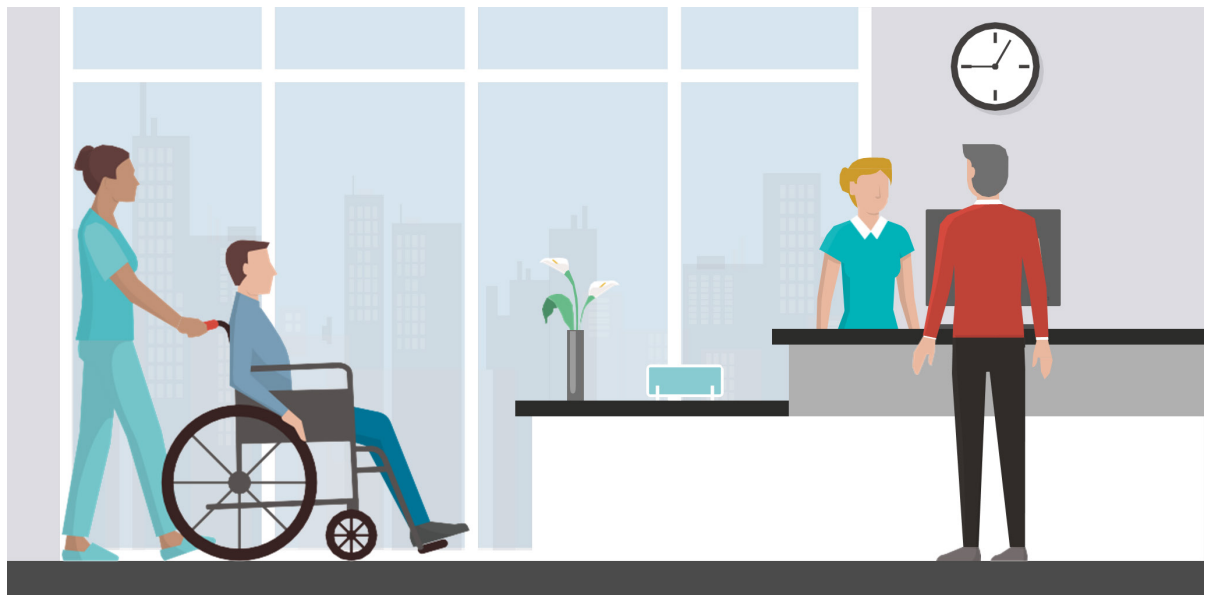
Patients and their families should collect information on the quality of home health agencies and facilities (see resources below). Patients should also find out how the facility communicates and shares important information with primary care providers.

Patients should review the list of resources below. It is important to note, however, that this list of resources is not comprehensive. The information on provider quality is limited in nature.



CONVENIENCE

Patients should take into consideration travel time and how convenient the facility is for family members and friends to visit. Patients and families should ask about visiting hours and policies as well as potential restrictions. Keep in mind that the most convenient option may not always be the best option, depending on quality, safety, and availability of services.



RESOURCES

The best way to learn more about quality and to pick a facility is to do some homework. Be sure to find out if your primary care provider or health insurance plan has an affiliation or agreement with the facility.

- Tour the facility and talk with residents, families, and staff – if that's possible
- Observe the facility's cleanliness
- Gather information on quality and discharge success

There are several resources that can help you learn more about the quality of a facility or agency.

Please note that depending on a variety of factors, including but not limited to bed availability, insurance coverage, and your specific care needs, you may not be able to be admitted at your facility of choice.

The Nursing Home Survey Performance Tool.

The Massachusetts Department of Public Health has developed the Nursing Home Survey Performance Tool. This tool provides information about individual nursing homes in Massachusetts to serve as a resource for consumers who are making decisions about their healthcare.

The Nursing Home Survey Performance Tool is available at:

<https://www.mass.gov/guides/nursing-home-survey-performance-tool>

Five-Star Nursing Home Quality Rating System.

The Centers for Medicare and Medicaid Services (CMS) has the Five-Star Nursing Home Quality Rating System. This system gives nursing facilities ratings for: (1) health inspections, based upon outcomes from state health inspection surveys; (2) staffing, based upon comparative staffing levels; and (3) quality, based upon resident-level quality measures. Nursing homes receive ratings based on how they compare to each other. Nursing homes also receive an overall star rating from one to five (five being the top score). The overall rating reflects a nursing home's performance on three sources: health inspections, staffing, and quality of resident care measures.

Five-Star Nursing Home Quality Rating System is available at:

<https://www.medicare.gov/care-compare/?providerType=NursingHome&redirect=true>

Medicare.gov. Find Healthcare Providers: Compare Care Near You.

Find Medicare-approved providers near you and compare care quality for doctors, hospitals, dialysis facilities, hospice centers, and more. The below site contains information on home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term acute care hospitals. For example, for inpatient rehabilitation facilities, you can find out how the facility scores along several key indicators. Indicators include complications, results of care, infection control, readmissions, and successful return to home and community.

Compare Care is available at:

<https://www.medicare.gov/care-compare/>

Veterans Administration's Community Living Center (CLC) Compare Report.

The Veterans Administration (VA) has also developed tools to report on quality. This tool provides information on the quality of care provided in nursing homes. This includes information about the VA Community Living Centers and private sector nursing homes with whom the VA contracts. The VA's system is called the VA's Community Living Center (CLC) Compare Report. This report features a star rating system adapted from Medicare's Five Star Rating Methodology. The CLC ratings are based on health surveys, staffing, and quality of resident care measures.

The VA's Compare Report is available at:

<https://www.accesstocare.va.gov/CNH/FindCommunityNursingHomes?LocationText=02465&SortOrder=0&Radius=50&UserLatitude=-1&UserLongitude=-1>

Ombudsman Programs.

An ombudsman is an advocate. The ombudsman service in Massachusetts offers a free service for older adults to voice their complaints and have concerns addressed so they can live with dignity and respect. These programs serve individuals in assisted living residences, home health care agencies, and long-term care facilities like nursing homes and rest homes.

Ombudsman information available at:

<https://www.mass.gov/service-details/ombudsman-programs>

Mass.gov. Checklists for deciding on a Long-Term Care Nursing Facility and Rest Home.

Some people will need longer-term stays. This site contains many helpful questions and guidance.

Checklists are available at:

<https://www.mass.gov/info-details/checklists-for-deciding-on-a-long-term-care-nursing-facility-and-rest-home>

RESOURCES FOR BEHAVIORAL HEALTH AND RELATED SOCIAL SERVICES

The Massachusetts Behavioral Health Helpline (BHHL) has a searchable online collection of more than 6500 mental health, substance use, and support services in Massachusetts. You can filter results based on your location and needs.

https://www.treatmentconnection.com/search-treatment-facilities?page=1&limit=25&stateCode=Massachusetts&lat=42.358670324&long=-71.718185&limit_to_state=false&distance=250

Community Behavioral Health Centers (CBHCs) are located across Massachusetts, and provide a wide range of mental and substance use services and treatment both in-person and via telehealth. For more information and to locate your nearest CBHC use this link:

<https://www.mass.gov/community-behavioral-health-centers>

If you are struggling with mental health or substance use, there are 24/7 crisis services available through the following help lines:

The Massachusetts Behavioral Health Helpline is a 24/7 helpline to connect individuals and families to the full range of treatment services for mental health and substance use:

<https://www.masshelpline.com/>

The Massachusetts Substance Use Helpline is a 24/7 helpline to navigate substance use treatment and recovery services:

<https://helplinema.org/about/about-the-helpline>

Example Questions to Ask When Selecting a Nursing Home for a Short-Term Rehabilitation Stay

- Does the facility score high on inspection reports?
- Are services licensed or accredited?
- What areas have they identified for improvement?
- What type of infection control measures are in place?
- Is the place clean and well-maintained?
- Is the building easily accessible indoors and outdoors?
- Does the facility conduct patient/family satisfaction surveys?
- What specialized services are available?
- How much therapy do patients receive?
- What is the number of staff caring for each patient?
- What types of treatment team members will be active with my recovery?
- What can be expected about the transition from hospital to rehabilitation?
- What items should you bring and what is provided?
- How do family members participate in care planning meetings?
- What is the process for helping set up in-home services if needed after the stay?
- Are there suggested/recommended visitation hours for families and friends?

Example Questions to Ask When Selecting A Home Care Agency

- Does the agency have literature describing its services, fees, and billing?
If so, will they send you copies?
- Does the agency work with the client to develop a written plan of care or service contract?
If so, how often is this plan updated?
- Does the agency directly employ its workers or are they independent contractors?
(They should be directly employed.)
- Does the agency provide a written list of client and family rights?
- Will the agency provide interpreter services, if needed?
- How does the agency screen and evaluate their employees?
- Are caregivers, supervisors, and backup available 24/7/365?
- How does the agency investigate complaints and/or resolve conflicts between its staff and clients?
- Can the agency document that it carries professional and general liability insurance?
- Will the agency provide a list of local references?



Step 5. Make the Choice that is Right for You

Six Tips for Patients and Families in Finding Post-Acute Care

Tip #1. Make sure your care plan meets your goals. You will need to tell your healthcare team about your personal goals and needs so that they understand what is important to you. Your healthcare team includes your family and providers involved in your care. This could include your primary care provider, your specialist, case manager, or a care coordinator through your health insurer. They can help by discussing options that align with your goals.

Tip #2. Collect information on health insurance coverage and costs. You will want to contact your health insurer using the number on your insurance card. You will want to understand what your out-of-pocket costs will be with different care options.

Tip #3. Collect information about your provider options. You will want to learn about the quality and safety of the service provider, using trusted local, state, and federal information sources. There are resources in this guide to help you find this information.

Tip #4. Ask someone to be your “eyes and ears” for any care transitions. If possible, include someone who can serve as your care partner. You might want a trusted family member or friend to accompany you during transfers from one setting to another. This person can keep track of paperwork, discharge instructions, or other communications while you move from one setting to another.

Tip #5. Seek answers. Don't be afraid to ask questions. Some of the information may be new to you. The information can be confusing. Make sure your healthcare professional provides clear information and instructions about your post-acute care plan and follow up needs.

Tip #6. Designate a healthcare proxy and complete advance directives. Planning for your future care can include planning for the unexpected, as well. If you have not already done so, it is recommended that you designate a healthcare agent and sign a “Health Care Proxy” form so that someone can make decisions about your care should you not be able to do so. If you or a family member has a serious advancing illness or medical frailty, adults can choose to complete a POLST form (Portable Orders for Life Sustaining Treatment) with your physician, nurse practitioner or physician's assistant. Talk to your clinician about your prognosis, treatment options, and the care you want/do not want. Your clinician will transfer your choices to the POLST form, which is followed by every clinician across all care settings. [Honoring Choices MA](#) provides up-to-date healthcare planning information, no-cost Massachusetts planning documents, and many resources for adults, families, and caregivers. Its network of Community Partners can help you get connected to care in your community as well. Note: the state is switching this system to a digitally-based “POLST” system in summer of 2024 and the rollout will continue into 2025.

Key Community Organizations to Support Patients

Massachusetts has many types of community organizations that can help you in your recovery.

Aging Service Access Points (ASAPs) provide the following direct and protective services: information and referral; interdisciplinary case management; intake and assessment; development and implementation of service plans; monitoring of service plans; reassessment of needs; and investigations of abuse and neglect of elders.

More information is available at:

<https://www.mass.gov/service-details/aging-services-access-points-asap>

Note: Some Area Agencies on Aging (AAAs) are also ASAPs. AAA offices provide many different services to Massachusetts residents that are 60 years of age and older. The AAAs can assist and offer guidance on nutrition, caregiver support, assistance programs and referrals, ombudsmen assistance, insurance counseling, and even transportation.

Independent Living Centers (ILCs) are private, nonprofit, consumer-controlled organizations providing services and advocacy by and for people with all types of disabilities. They create opportunities and help you achieve your greatest level of independent living within your family or community.

More information is available at:

<https://www.mass.gov/independent-living-centers-0?>

Recovery Learning Communities (RLCs) are consumer-run networks of self-help/peer support, information and referral, advocacy, and training activities. Training in recovery concepts and tools, advocacy forums, and social and recreational events are all part of what goes on in an RLC. The doors are open to all individuals with a serious mental illness. RLCs work collaboratively with mental health providers, other human service agencies, and the community at large to forward the mission of community integration and respect for people with mental health conditions. RLC activities are designed to appeal to the range of people in the community, including people of all racial and ethnic backgrounds, and people of all co-occurring disabilities. RLCs are for everyone.

More information is available at:

<https://www.mass.gov/service-details/recovery-learning-communities>

Massachusetts Clubhouse Coalition (MCC). The Massachusetts Clubhouse Coalition is dedicated to expanding employment, housing, educational, social, and leadership opportunities available to Massachusetts residents who have a mental illness. The MCC was organized to uphold and promote the values, principles, and financial integrity of the international clubhouse model toward the empowerment of people with mental health needs. Toward this purpose, the MCC will take action, advocate, provide support, and offer opportunities to network and educate itself and the community while working as an organization to remove barriers to successful community integration. The Massachusetts Clubhouse Coalition is committed to helping clubhouses and individual clubhouse members reach their full potential.

More information about clubhouses:

<https://www.massclubs.org/massachusetts-clubhouses>

<https://www.massclubs.org/contact>



Section 3. Helpful Resources

Community Organizations

Aging Service Access Points (ASAPs)

<http://masshomecare.info/wp/wp-content/uploads/downloads/2015/03/ASAP-AAAs-by-City-Town-2014-10-14.pdf>
<https://www.mass.gov/service-details/aging-services-access-points-asap>

ASAPs provide the following direct and protective services: information and referral; interdisciplinary case management; intake and assessment; development and implementation of service plans; monitoring of service plans; reassessment of needs; and investigations of abuse and neglect of elders.

Independent Living Centers (ILCs)

https://www.mass.gov/independent-living-centers-0?_

If you have a disability, an Independent Living Center (ILC) can help you live on your own or be more independent while living with others.

Recovery Learning Communities (RLCs)

<https://www.mass.gov/service-details/recovery-learning-communities>

Recovery Learning Communities (RLCs) are consumer-run networks of self-help/peer support, information and referral, advocacy, and training activities. Training in recovery concepts and tools, advocacy forums, and social and recreational events are all part of what goes on in an RLC.

Massachusetts Clubhouse Coalition (MCC)

<https://www.massclubs.org/massachusetts-clubhouses>

MCC is dedicated to assisting adults with major mental illness to live full, productive, stable lives in the community. There are 36 community-based vocational and social rehabilitation centers, called "clubhouses." Membership in the MCC is awarded to clubhouses (and their members and staff) which achieve certification from the International Center for Clubhouse Development (ICCD) ensuring the quality of services provided by these rehabilitation centers.

Honoring Choices, MA

<https://www.honoringchoicesmass.com/>

Honoring Choices Massachusetts is a consumer-oriented, non-profit organization focused on the rights of every adult to direct their healthcare choices and to make a plan to receive the best possible care that honors their values and choices all through their lives.

Professional Organizations

Association for Behavioral Healthcare (ABH)

<https://www.abhmass.org/>

The Association for Behavioral Healthcare promotes and advocates for community-based mental health and addiction treatment services.

Home Care Alliance of Massachusetts (HCA of MA)

<https://www.thinkhomecare.org/page/about>

The alliance can provide a comprehensive list of home health and home care agencies searchable by geography or service. This is a trade association of home care agencies that promotes home care as an integral part of the healthcare delivery system; it provides essential and timely information and learning opportunities to members.

Hospice and Palliative Care Federation of Massachusetts (HPCFM)

<https://www.hospicefed.org/>

This is a professional membership organization for hospice and palliative care providers. This federation provides resources and referrals to patients and families.

LeadingAge Massachusetts

<https://www.leadingagemma.org/>

This is a membership organization supporting not-for-profit aging service providers offering tools, resources, and advocacy and education to members. In addition, LeadingAge of Massachusetts provides information and resources for consumers.

Massachusetts Association of Behavioral Health Systems (MABHS)

<https://www.mabhs.org/contact.htm>

The Massachusetts Association of Behavioral Health Systems (MABHS) is the only trade association in Massachusetts whose central mission is to focus on inpatient psychiatric and substance use issues. Originally founded in 1989 by the freestanding psychiatric hospitals, the MABHS has grown over the years and now consists of 50 inpatient facilities statewide, from the Berkshires to Cape Cod. Its member facilities have more than 2,000 beds, and admit more than 60,000 patients on an annual basis.

Massachusetts Assisted Living Association (Mass-ALA)

<https://www.mass-ala.org/>

This is a trade association providing information, education, and advocacy on behalf of assisted living communities in Massachusetts.

At the beginning of each year, Mass-ALA publishes an Assisted Living Resource Guide. It serves as a user-friendly list of certified Massachusetts assisted living residences that are part of Mass-ALA's membership. The guide includes useful information on selecting an assisted living community, as well as frequently asked questions, financing information, a consumer checklist, and additional information that can help individuals make an informed decision.

Massachusetts Health & Hospital Association (MHA)

<https://www.mhalink.org/>

The mission of the Massachusetts Health & Hospital Association is to advance the health of individuals and communities by serving as the leading voice for all Massachusetts hospitals, healthcare systems, and other care providers to help them provide high-quality, cost-effective, and equitable healthcare.

Massachusetts Senior Care Association

<https://www.maseniorcare.org/about-massachusetts-senior-care-association>

This is a membership organization that represents a wide range of providers and services that meet the needs of older adults and people with disabilities. In addition to providing advocacy and educational programs for care providers, the association offers information and referral services to consumers.

Massachusetts Organization for Addiction Recovery (MOAR)

<https://www.moar-recovery.org/resources>

This is an organization providing support to recovering individuals, families, and friends recovering from alcohol and other addictions.

Insurance Coverage

Massachusetts Division of Insurance (DOI)

<https://www.mass.gov/info-details/consumer-guide-to-understanding-health-insurance>

The DOI provides information on insurance requirements in Massachusetts and available options for coverage.

MassHealth

<https://www.mass.gov/topics/masshealth>

MassHealth can provide information about Medicaid, CHIP, and long-term care coverage for MassHealth applicants, members, and providers.

MassHealth Accountable Care Organizations (ACOs) and Managed Care Organizations (MCOs)

<https://www.mass.gov/service-details/full-list-of-masshealth-acos-and-mcos>

This website lists all MassHealth ACOs and MCOs.

MassHealth Long Term Services and Supports (LTSS)

<https://www.mass.gov/doc/powerpoint-an-introduction-to-masshealth-long-term-services-and-supports-for-acos-mcos-cps/download>

This is a guide that provides basic information about the range of state LTSS and other covered services through MassHealth for providers within ACOs.

MassHealth One Care Program

<https://www.mass.gov/one-care>

The One Care program is a way to get your MassHealth and Medicare benefits together. One Care offers services that you cannot get when your MassHealth and Medicare benefits are separate. With One Care, you have one plan, one card, and one person to coordinate your care.

MassHealth Senior Care Options (SCO)

<https://www.mass.gov/senior-care-options-sco>

Senior Care Options (SCO) is a comprehensive health plan that covers all services normally paid for through Medicare and MassHealth. This plan provides services to members through a senior care organization and its network of providers. It combines health services with social support services by coordinating care and specialized geriatric support services, along with respite care for families and caregivers. SCO offers an important advantage for eligible members over traditional fee-for-service care. There are no co-pays for enrolled members.

MassHealth Program of All-Inclusive Care for the Elderly (PACE)

<https://www.mass.gov/program-of-all-inclusive-care-for-the-elderly-pace>

The Program of All-inclusive Care for the Elderly (PACE) is administered by MassHealth and Medicare to provide a wide range of medical, social, recreational, and wellness services to eligible participants. You do not need to be on MassHealth to enroll in PACE. However, if you meet the income and asset guidelines, you may be eligible for MassHealth and MassHealth may pay your PACE premium.

Medicare Coverage

<https://www.medicare.gov/>

This website includes information about Medicare costs, coverage, and plans.

Medicare Appeals

<https://www.medicare.gov/claims-appeals/how-do-i-file-an-appeal>

This page has information about filing an appeal for a Medicare denial.

Medicare Hospice Benefits

<https://www.medicare.gov/Pubs/pdf/02154-medicare-hospice-benefits.pdf>

This website includes the Centers for Medicare & Medicaid Services' official booklet about Medicare hospice benefits, including eligibility, services, and local hospice providers.

Medicare Mental Health Resources

<https://www.cms.gov/files/document/medicare-mental-health.pdf>

This website includes the Centers for Medicare & Medicaid Services booklet about Medicare mental health benefits, including covered services, inpatient and outpatient treatment options, and opioid use disorder treatment programs.

Prescription Drug Assistance

<https://www.mass.gov/prescription-drug-assistance>

Prescription Advantage is a state-sponsored prescription drug program for seniors and people with disabilities. It provides financial assistance to lower prescription drug costs and fill gaps in coverage.

SHINE Program (health insurance counseling)

<https://www.mass.gov/health-insurance-counseling>

This program provides free Medicare health insurance information, counseling, and education to Massachusetts residents with Medicare and their caregivers.

Conditions

Alcoholics Anonymous (AA)

<https://www.aa.org/find-aa>

AA Massachusetts is a state-wide recovery resource devoted to supporting individuals in Massachusetts. AA Massachusetts helps individuals struggling with alcoholism find the help they need on a local basis. There are AA meetings per county or city, to help people to take the next step to overcome alcohol addiction.

Bureau of Substance Addiction Services (BSAS)

<https://www.mass.gov/orgs/bureau-of-substance-addiction-services>

BSAS oversees the statewide system of prevention, intervention, treatment, and recovery support services for individuals, families, and communities affected by gambling and substance addiction.

Brain Injury Association

<http://www.biama.org/>

The Brain Injury Association of Massachusetts provides support, information and resources to survivors, families, and medical professionals about brain injury.

Helpline Substance Use Disorder Treatment Hotline

<https://helplinema.org/>

The Helpline is the only statewide, public resource for finding licensed and approved substance use treatment and recovery services. 1-800-327-5050

Advocacy and Legal

Center for Public Representation (CPR)

<https://www.centerforpublicrep.org/>

CPR is dedicated to enforcing and expanding the rights of people with disabilities and others who are in segregated settings. CPR uses legal strategies, advocacy, and policy to design and implement systemic reform initiatives to promote their integration and full community participation. Working on state, national, and international levels, CPR is committed to equality, diversity, and social justice in all its activities.

Disability Law Center (DLC)

<https://www.dlc-ma.org/>

The Disability Law Center (DLC) is the federally mandated protection and advocacy (P&A) agency for Massachusetts. The P&A system is a national network of disability rights agencies investigating abuse and neglect and providing legal representation and other advocacy services to people with disabilities. To aid P&A systems in fulfilling their mandate, Congress gave them extensive access authority.

Health Care for All (HCFA)

<https://hcfama.org/>

Health Care For All advocates for health justice in Massachusetts by working to promote health equity and ensure coverage and access for all.

Health Law Advocates (HLA)

<https://www.healthlawadvocates.org/>

Health Law Advocates (HLA) is a 501(c)(3) public interest law firm whose mission is to provide pro bono legal representation to low-income residents experiencing difficulty accessing or paying for needed medical services. HLA is committed to ensuring universal access to quality health care in Massachusetts, particularly for those who are most at risk due to such factors as race, gender, disability, age, or geographic location. With its partner organization, Health Care For All, HLA combines legal expertise with grassroots organizing and policy reform to advance the statewide movement for universal healthcare access.

Mental Health Legal Advisors Corporation (MHLAC)

<https://mhlac.org/what-we-do/>

MHLAC provides legal and policy advocacy for people with mental health challenges throughout the Commonwealth of Massachusetts. A state agency, its central priority is to address those concerns that are most closely related to clients' ability to live full and independent lives. Like other legal services offices, MHLAC focuses on combating poverty, which is often characterized as a "social determinant" of mental illness. When clients are put in institutional settings, MHLAC seeks to protect them from abusive treatment that can often wreak permanent damage.

MOLST-to-POLST Transition: Medical Orders for Life-Sustaining Treatment (MOLST) to Portable Orders for Life-Sustaining Treatment (POLST)

<https://shorturl.at/iMChd>

The Massachusetts POLST program helps people living with serious illness and advancing frailty engage in care planning conversations with their clinicians and care teams to ensure that their treatment preferences are understood and honored across all care settings. The longstanding MOLST program is being transitioned to a digitally-based POLST starting in the summer of 2024.

Ombudsman Programs

<https://www.mass.gov/service-details/ombudsman-programs>

These programs help elders and their caregivers to resolve and address concerns with nursing homes, home healthcare agencies, MassHealth-funded home care, and assisted living communities.

Medicare Rights Center

<https://www.medicarerights.org/>

This is an independent source of Medicare information and assistance that provides counseling, advocacy, and education to help consumers and professionals understand and navigate Medicare.

The National Alliance on Mental Illness of Massachusetts (NAMI)

<https://namimass.org/>

The National Alliance on Mental Illness of Massachusetts (NAMI Massachusetts) is the state's voice on mental illness. The mission of NAMI Massachusetts is to improve the quality of life for people diagnosed with mental health conditions and their families. It seeks to improve the public's awareness and understanding of mental health conditions and ensure that all people affected by a mental health condition receive the support they need in a timely fashion.

Office of Patient Protection

<https://masshpc.gov/opp>

The Office of Patient Protection safeguards the rights of health insurance consumers by regulating the internal appeal process and administering external reviews for consumers with fully insured Massachusetts health insurance.

Parent/ Professional Advocacy League (PPAL)

<https://ppal.net/>

The Parent/Professional Advocacy League (PPAL) is a statewide family organization dedicated to improving the mental health and well-being of children, youth, and families through education, advocacy, and partnership.



Frequently Asked Questions (FAQs)

QUESTION 1. WHAT IS POST-ACUTE CARE?

- PAC is the abbreviation for "post-acute care"
- It's important for many people to get post-acute care (PAC) after a health event
- Health events may include an illness, injury, surgery, or hospitalization
- PAC services include home health, skilled nursing care, therapy, and rehabilitation services
- PAC can support your continued recovery, improve your overall functioning, and optimize your quality of life
- PAC services can provide you with comfort care or end-of-life care

QUESTION 2. WHAT SHOULD I KNOW ABOUT POST-ACUTE CARE?

- It's important that you receive the right post-acute care (PAC), at the right time, and in the right place to meet your individual goals and needs that account for your life circumstances
- PAC can be provided at home, in an outpatient clinic, or in a facility such as a skilled nursing facility (SNF)
- PAC must be provided in a manner that is culturally competent for best outcomes
- PAC services are different in their intensity and type of care
- PAC transitions from one setting to another setting, such as from the hospital to home, are a crucial part of the process for best outcomes and to prevent a readmission to a hospital

QUESTION 3. DOES HEALTH INSURANCE COVER POST-ACUTE CARE?

- It's important to find out how your health insurance covers post-acute care (PAC)
- Depending upon your care needs and health insurance coverage, you may be able to choose between care at home or at a facility
- Most health insurance and health plans cover PAC, but coverage will vary by insurer
- Some health insurers are more flexible about paying for care at home
- Check with your health insurer and/or plan to find out what they will cover

QUESTION 4. HOW DO I LEARN MORE ABOUT QUALITY?

- Ask your healthcare team, your health plan, and your family/friends for information about quality. Care Compare is a resource available to the public that provides information on the quality of care, as well as other information on cost, and volume of services.

Visit: <https://www.medicare.gov/care-compare/>

A POST-ACUTE CARE GUIDE FOR PROVIDERS AND CLINICIANS

What You Need to Know About Post-Acute Care (PAC) Services to Support the Needs and Goals of Your Patients and Their Families

Table of Contents

- Section 1** Introduction
- Section 2** The Essential Elements of a Successful Process
- Section 3** The Range of Post-Acute Care Services
- Section 4** Provider Checklists to Support Care Transitions
- Section 5** Key Terms and Concepts





Section 1. Introduction

The Massachusetts Health & Hospital Association (MHA) prepared this guide to assist providers and clinicians in making the best recommendations to their patients about the care that they may need following a health event.

Many people need care after a health event to recover from an injury, illness, surgery, and/or hospitalization. Some people may need comfort care or end-of-life care. It is very important that your patients receive care that will meet their individual needs. We hope this guide helps you to make the best recommendations for your patients.

This guide provides the following information:

- The essential elements of a successful process
- The range of post-acute care (PAC) services
- Three provider checklists to support your patient's care transition process
- A list of key terms and concepts to build into your understanding of PAC

Post-Acute Care

Post-acute care services play an important role in our healthcare delivery system. Health insurers often refer to these services as "PAC" services.

Many people may require continued post-acute care to support recovery and improve functional status following an illness, injury, surgery, or hospitalization, and to meet their hospice and palliative care needs.

Massachusetts has many options for post-acute care. Services range in focus from recuperation, rehabilitation, chronic disease management, skilled nursing, and end-of-life care.

Services may be provided at home, in an outpatient clinic, or in a facility such as a skilled nursing facility (SNF). Services may be provided via telehealth. Services should be consistent with the needs and goals of the patient and recognize their social determinants of health.

Section 2. The Essential Elements of a Successful Process

In this section, we have outlined a handful of key goals and some of the essential elements for providers and clinicians to consider in making the best recommendations for their patients.

Key Goals for Providers and Clinicians

- Support patients on their path to optimizing quality of life
- Understand patient and family goals and needs
- Engage with patients consistently; be available and committed
- Evaluate decisions through the lens of health equity
- Practice effective communication, ask questions, and listen carefully
- Provide education to patients and families, with clear explanations
- Ensure the right services and supports are in place for patients going home
- Address underlying concerns and help patients/families feel confident about care transitions



Essential Elements

Element 1. Find out about the patient's goals and life context. Providers should seek information from patients and families about the context for care, such as personal goals; social and cultural backgrounds; health beliefs and attitudes; advanced care directives, such as a Medical Orders for Life Sustaining Treatment (MOLST) form; living environment; lifestyle; socioeconomic status; insurance coverage; degree of family and social supports; and other relevant factors. Providers should understand what matters most to the patient. This process should involve the patient's care partner or designated caregiver, if one is available. This approach will help to ensure that providers make the best recommendations for additional treatment and/or support, based on the patient's needs, preferences, values, and expectations. Consider The Joint Commission's (TJC) Health-Related Social Needs when completing this assessment, which explores patients' access to transportation, difficulty paying for prescriptions or medical bills, education and literacy, food insecurity, housing insecurity, and access to high-speed broadband services in their residence.

Note: the state is transitioning the MOLST system to the digitally-based POLST (Portable Medical Orders for Life-Sustaining Treatment) in summer of 2024, with rollout continuing into 2025. For more information on transition from MOLST to POLST, [click here](#).

Element 2. Inform your patients about post-acute care services. The post-acute care (PAC) landscape can be fragmented and confusing for patients and family members, and for providers. Communicating specific information about the range of PAC services will help patients make the most informed choices possible. For each PAC service, it's important to understand clinical

indicators and qualifying criteria, intensity, duration, level of care provided, and associated costs and insurance coverage. PAC plays a vital role in the healthcare continuum; it is positioned between acute care and long-term services and supports. Explore the services available for your patient if they are enrolled in managed, integrated, or accountable care programs. These programs may offer benefits of care coordination as well as more options for home-based support.

Element 3. Work together as a team and speak with one voice. Working collaboratively as an integrated team will help healthcare and social service professionals arrive at a consensus about post-acute care (PAC) planning. In relatively straightforward cases, one team member, such as a case manager or care coordinator, may recommend a choice of PAC to patients and family members as a matter of course. Sometimes, there is disagreement. When there are different perspectives on PAC planning between patients and families, it is important for providers to bring a clear and simple explanation to patients and families to help them understand the differences between services.

Element 4. Make the care transition process a smooth one. The transition from hospital to post-acute care (PAC) often begins right after a patient is admitted to the hospital or healthcare facility. PAC providers are essential but often untapped partners within the healthcare system. The ideal process includes tight communication and effective collaboration between hospitals and PAC providers working together and in partnership with community organizations. The goal is to deliver the greatest value to patients and minimize care disruptions and readmissions. The ideal process should bring together patients and their family members and healthcare providers across the continuum of care to set the patient up for the best possible outcome.

Providers May Want to Present PAC Options to Patients

Once patients and family members have a basic understanding of the condition and PAC options, providers may want to begin framing the goals early in the discharge planning process. Consider presenting a range of possibilities with contingencies and the best option to the patient. Patients may only qualify for certain levels of PAC based on their needs.

"Given our clinical experience and your home situation and preferences, we think the best PAC option may be _____."

In clinically complex patients or those with complicated living situations, it may be ideal to schedule a family meeting to discuss options as a large group. The role of team members in such a meeting is to present their clinical observations and rationales for recommendations. (For a more detailed discussion about running a family meeting, please see: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3681449/>.)

Providers don't necessarily have to agree with the PAC choice a patient makes. They should respect them, however, and provide the information and resources and support to maximize the chances of their success.



Section 3. The Range of Post-Acute Care Services

Post-acute care services refer to a range of healthcare services to support a patient's recovery and maximize their functioning, often following a hospitalization. PAC services can offer comfort care or end-of-life care to a patient.

Key Facts to Consider

- Post-acute care is often referred to as "PAC"
- PAC services can address many different clinical scenarios
- PAC services can either be provided at home, in an outpatient clinic, or in a facility
- Patients' individual goals, needs, and preferences are critical to understand
- Most patients receive home health services at home to support their recovery
- Some patients live in an assisted living community where they can receive PAC services
- Health insurers vary in how they cover PAC and what they will cover
- Treatment options and services differ from patient to patient
- Factors to consider include length of stay, hours of therapy, diagnosis, treatment plan
- Community social services and supports are critical to supporting the patient and family
- Long-term services and supports (LTSS) overlap with PAC services to support patients

Post-Acute Care

- Post-acute care services include home health services; medical services; therapy services, including occupational therapy, physical therapy, and speech therapy; nursing care; hospice and palliative care services; telehealth; behavioral health therapy; and recovery supports.
- PAC services can be provided at home, in an assisted living residence, in an outpatient setting, skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term acute care hospital (LTACH).
- The chart on the following page presents examples of the most common types of facility-based care (the chart does not present examples of PAC services for behavioral health conditions, including mental health and/or substance use disorder treatment services).

Setting	Services
Outpatient Rehabilitation	
Clinical indications	Sports medicine injuries, loss of physical function, loss of balance, cognition, speech impairments, pain, loss of function
Types of care	Orthopedic injuries, amputee care, post-concussion treatment, stroke recovery, task management, speech
Skilled Nursing Facility (SNF)	
Clinical indications	Nursing therapy and medical needs, after a hospital stay
Types of care	Stroke care, cancer care, orthopedic recovery, wound care, cardiac and pulmonary recovery
Inpatient Rehabilitation Facility (IRF)	
Clinical indications	Intensive therapy (3 hours/day), nursing and medical needs for significant injury or illness after hospital stay
Types of care	Aggressive rehabilitation for spinal cord injuries, brain injuries, trauma injuries, stroke, amputee
Long-Term Acute Care Hospital (LTACH)	
Clinical indications	Intensive medical, nursing needs, and therapy care.
Types of care	Recovery for ventilator weaning, wound care, organ transplant, cardiopulmonary disease, cancer

Other Services and Supports for Patients

Community-Based Social Services and Supports

- Social services and supports, including meals, food, housing supports, transportation, broadband access, and non-medical transportation

Long-Term Care Services and Supports

- Long-term care services and supports (LTSS), including home and community-based services (HCBS) and facility-based services for those with long-term needs
- LTSS services include unskilled home care, personal care attendant services, transportation, durable medical equipment, and many other services

Section 4. Provider Checklists to Support Care Transitions

The purpose of this checklist is to give providers and clinicians a simple way to confirm that you have considered the key issues affecting patient success during care transitions, prior to discharging patients from the hospital to home or hospital to facility-based care.

The Care Transition Process

Care transitions are the most important part of the process, yet often the most difficult part of the process for patients. When patients move from one environment to another environment, they are exposed to new risks. The checklist is intended to mitigate these risks.

#	Questions to Consider When Patient is Going from Hospital to Home	Check
1	Is discharge from the hospital premature?	<input type="checkbox"/>
2	What are the patient's individual needs and goals?	<input type="checkbox"/>
3	Who is in charge during the care transition process?	<input type="checkbox"/>
4	Does your patient understand your instructions for discharge?	<input type="checkbox"/>
5	Does your patient have a loved one who will be there on the day of transfer? Who is going to be your patient's "eyes and ears" on Day 1 of your patient's transfer? Is this person available for the entire day?	<input type="checkbox"/>
6	Are services in place for discharge?	<input type="checkbox"/>
7	Does your patient have what they need at home to be successful? Does the patient have enough help at home? Does the patient have enough food at home?	<input type="checkbox"/>
8	Does your patient have enough money to fill prescribed medications? Does your patient have someone who will fill their medications? Does your patient understand your medication instructions?	<input type="checkbox"/>
9	Does your patient have transportation to follow up appointments? Does your patient need to have a follow-up appointment scheduled before discharge?	<input type="checkbox"/>
10	Does your patient need medical equipment or remote patient monitoring technology at home?	<input type="checkbox"/>
11	Does the patient have access to broadband services and devices at home?	<input type="checkbox"/>

#	Questions: When Patient is Going from the Hospital to a Facility	Check
1	Is discharge from the hospital premature?	<input type="checkbox"/>
2	What are the patient's individual needs and goals?	<input type="checkbox"/>
3	Does the patient have a signed Health Care Proxy and/or POLST form? Have the documents been shared with the facility? Is it in their electronic medical record?	<input type="checkbox"/>
4	Are facility staff ready to care for the patient? Has transportation been arranged?	<input type="checkbox"/>
5	Do facility staff have complete clinical information on the patient? Do facility staff understand functional status and cognitive needs of the patient?	<input type="checkbox"/>
6	Does your patient meet the qualifying hospital stay requirements for a facility?	<input type="checkbox"/>
7	Have you spoken to admissions staff at the facility to ensure that the facility has received all necessary information and paperwork? Have you provided the information? Is a call warranted? Has a nurse-to-nurse report been completed?	<input type="checkbox"/>
8	Will your patient need post-acute care upon discharge from the facility?	<input type="checkbox"/>

PAC Planning Process

The purpose of this checklist is to provide providers with a simple checklist to support the best post-acute care planning process.

#	Questions to Consider During the Planning Process	Check
1	Has the team established a person-centered care planning process?	<input type="checkbox"/>
2	What are the patient's needs and goals? Does the team understand the patient's goals, needs, values, and social needs and family context? Does the patient have an advanced care directive (POLST form), and is it up to date?	<input type="checkbox"/>
3	Has the team discussed the options for PAC services?	<input type="checkbox"/>
4	Does the patient understand the full range of PAC options?	<input type="checkbox"/>
5	Has the team reached internal consensus about the PAC recommendation?	<input type="checkbox"/>
6	Has the patient been engaged throughout the process?	<input type="checkbox"/>
7	Has the team discussed time frames, duration of care, and potential obstacles with the patient and family?	<input type="checkbox"/>
8	What will the patient's insurance cover in terms of services and costs?	<input type="checkbox"/>
9	Is the family caregiver aware of and in agreement with the plan for PAC?	<input type="checkbox"/>
10	Does the patient know who to contact for follow up questions or concerns?	<input type="checkbox"/>



Section 5. Key Terms and Concepts

Providers and clinicians will want to be familiar with these concepts and build them into their decision-making relationships with patients. Follow the links to learn more about each concept.

- **Ableism.**
<http://cdrnys.org/blog/uncategorized/ableism/>
- **“Dignity of risk.”**
https://www.resourcesforintegratedcare.com/physical_disability/dcc/webinars/dignity1
- **Disability.**
<https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html>
- **Health equity.**
<https://www.cdc.gov/chronicdisease/healthequity/index.htm>
- **Health-Related Social Needs (HRSNs)**
<https://www.cdc.gov/health-equity-chronic-disease/social-determinants-of-health-and-chronic-disease/index.html>
- **Independent living philosophy.**
<https://ncil.org/about/aboutil/>
- **Integrated care.**
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5354214/>
- **Long-term services and supports.**
<https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>
- **Lived experience of disability.**
https://www.resourcesforintegratedcare.com/physical_disabilities/disability_competent_care/webinar/webinar2/lived_experience/2013
- **Patient-centered care.**
<https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559>
- **Person-centered care.**
<https://www.cms.gov/priorities/innovation/key-concepts/person-centered-care#:~:text=Person%2DCentered%20Care%3A%20Integrated%20health,make%20effective%20care%20plans%20together.>
- **Recovery model.**
<https://namitm.org/mhr/10fcr/>
- **Social determinants of health.**
<https://health.gov/healthypeople/priority-areas/social-determinants-health>
- **Social services and supports.**
<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.0170>
- **Supported Decision Making.**
<http://www.supporteddecisionmaking.org/>
<http://www.supporteddecisionmaking.org/state-review/massachusetts>

POST-ACUTE CARE RESOURCES

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- Section 1** Learn More About Post-Acute Care (PAC)
- Section 2** PAC Services and Settings
- Section 3** Health Insurance Coverage for PAC Services





SECTION 1. LEARN MORE ABOUT POST-ACUTE CARE

Services

Post-acute care (PAC) includes a range of services that can be provided in a variety of settings. Settings may include home, an outpatient clinic, a skilled nursing facility, or a short-term rehabilitation facility or healthcare facility. Across the different settings, there are six main types of services: (1) home health in a private home or assisted living residence; (2) outpatient rehabilitation centers; (3) skilled-nursing facilities (SNFs), also called nursing homes; (4) inpatient rehabilitation facilities (IRFs); (5) long-term acute care hospitals (LTACHs); and (6) hospice and/or palliative care. Many people know about home health and nursing home care, but are less familiar with other services such as IRFs and LTACHs. PAC services are typically provided following discharge from an acute-care hospital or rehabilitation facility. In some cases, however, post-acute care can be provided to people who have medical needs that do not require hospitalization. Several factors will determine the best option for post-acute care. The key factors are the intensity of care needs to best support recovery, patient preference, and insurance coverage.

Patient Goals for Recovery

Post-acute care is designed to support the patient's recovery and wellness, to improve or regain functional status, to effectively manage a chronic illness or disability, or to provide comfort care or end-of-life care. It is critically important that patients be matched with the right PAC service to maximize recovery and restore function. PAC is also designed to provide end-of-life care and support.

Patient Illnesses and Conditions

Post-acute care services address a wide range of patient care needs and conditions. Conditions include orthopedic conditions, such as hip and knee replacements; neurological events, such as stroke and spinal cord injury; debilitating illnesses, such as cancer; and behavioral health conditions, such as mental illness and substance use disorders. PAC services can also address end-of-life needs too.

Patient and Family Concerns

Post-acute care decisions can be very stressful for a variety of reasons. Depending upon the severity of the injury, illness, surgery, or hospitalization, patients and their families may worry about a range of issues. Key issues include taking care of themselves, family members, and their pets; paying for the cost of care and being able to pay bills; being a burden on family; and getting transferred to an unfamiliar care setting. Frequently, patients worry about whether they will recover fully, or be able to live independently again.

Home-Based Services

Home healthcare services are provided by skilled healthcare professionals such as licensed nurses, physical therapists, occupational therapists, and speech therapists for patients who need ongoing post-acute care and are considered to be homebound. You are considered homebound if it is a taxing effort for you to leave your home and/or you need assistance to leave your home. Outpatient rehabilitation centers are provided to patients living at home and in assisted living residences, who may not need or be eligible for home healthcare. Many experts in Massachusetts believe that "home" should be the default for post-acute care to align with the care goals and preferences of patients who prefer to receive care at home. Many patients enrolled in a health plan such as a managed care plan, an integrated program of care, or an accountable care organization may have greater access to PAC services at home. Many health plans assume full financial accountability for the continuum of care needs of their patients, and are also incentivized to provide care at home.

"Safe and Ready" for Discharge from the Hospital

Patients who require post-acute care services must be deemed "safe and ready" for discharge from the hospital to home or to a post-acute facility. In making this decision, providers and patients must consider a range of factors, including a patient's cognitive status, overall functioning, living situation, and support network. Providers don't necessarily have to agree with the PAC choice a patient makes. They should respect them, however, and provide the information and resources and support to maximize the chances of their success.

Addressing the patient's needs for social services and supports prior to discharge may enhance recovery, improve outcomes, and prevent avoidable hospitalizations. These social service needs are often related to the patient's health-related social needs, which are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred

to as "place." (Source: Healthy People.gov) There are many questions to consider related to the safety and readiness of the patient to be discharged from the hospital to home or a post-acute care facility.

Example questions:

- Is the patient's home safe and suitable for recovery?
- Are there stairs or potential fall risks in the home that need to be addressed?
- Does the patient have support from family, neighbors, or friends?
- Are social isolation and loneliness risk factors?
- Does the patient need help managing medications and preparing meals?
- Is there transportation available for follow-up appointments?

Person-Centered Planning

Post-acute care options must reflect what the patient needs and wants in a holistic sense. A person-centered process is one that accounts for the whole person, not just the patient. A person-centered planning process provides the patient with an opportunity to identify their goals, needs, social determinants of health, and life context. Many aspects of the person's life are important to develop the right plan of care, including: the person's living situation (home, assisted living, nursing home), race, ethnicity, language and culture, gender, sexual orientation, disabilities (including persons who can live independently or semi-independently), and personal preferences.

Care Transitions

Care transitions are a crucial component of the post-acute care planning process. Care transitions have the potential to affect a patient's experience and recovery positively or negatively. Care transitions take place at any point when the patient is being moved from one place to another. For example, care transitions can happen from hospital to home, from hospital to a PAC facility, and from a PAC facility to home. Patients are at greater risk during transitions of care. This is especially true if information is not shared seamlessly and communication breaks down. Collaboration across the healthcare continuum is critically important to create a smooth care transition and prevent and reduce hospital admissions and readmissions.

“Dignity of Risk”

Post-acute care can help to support patients and their right to choose where they want to receive post-acute care services, and, if necessary, their right to take reasonable risks. “Dignity of risk” refers to the concept of affording a person the right (or dignity) to take reasonable risks. Ignoring this right can impede personal growth and negatively affect self-esteem and overall quality of life. This term was first coined in 1972 by Robert Perske in relation to people living with disabilities (and further expanded in Wolpert’s 1980 “The Dignity of Risk” paper). It was a reaction to over-protective safeguards and a paternalistic approach to care decisions, which they argued, was patronizing and diminished a person’s freedoms and self-esteem.

Source: <https://www.ausmed.com/cpd/articles/dignity-of-risk>

Long-Term Services and Support

Post-acute care services and long-term care services and supports (LTSS) or long-term care (LTC) services are different, although there is considerable overlap between PAC services and LTC services. Post-acute care is focused on providing medical care for discrete time periods and is complementary to the acute care received in a hospital setting. Long-term care is mostly non-medical care and focused on helping individuals with activities of daily living (ADLs). Key needs to address ADLs include bathing, eating, dressing, and using the toilet on an ongoing basis. Long-term services and support (LTSS) may often be added to the post-acute care plan. This will vary based upon health insurance coverage. Many managed care health plans and integrated programs of care can augment the post-acute care services with LTSS to address the patients at home holistically, or support end-of-life care or comfort care which focuses on pain and symptom management.

Behavioral Health Care and Wellbeing

Behavioral health refers to the connection between body and mind and focuses on how a person’s behavior affects the overall health and wellbeing. It includes mental health services and treatment of substance

use disorders typically provided by psychiatrists, psychologists, social workers, counselors, and addiction specialists. Since the onset of COVID-19, an estimated 50 percent of Americans report that the pandemic has led to emotional distress and negatively affected their mental health. Incorporating behavioral health services into a post-acute care plan is crucial in helping patients address these concerns. This may include follow up with a mental health professional, treatment for substance use disorders, and access to resources to help manage stress-related conditions.

Community Resources

Post-acute care outcomes for patients can be enhanced by connecting patients with resources in the community. Several community organizations including Aging Services Access Points, (ASAPs), Independent Living Centers (ILCs), and Recovery Learning Communities (RLCs) can be helpful to patients in supporting their post-acute care needs and recovery goals.

Knowledge Gaps

Many patients have never heard of post-acute care, even though many people have some knowledge of home health care and outpatient therapies, for example. As a result, patients may make decisions about PAC services based upon location, service availability, and cost, rather than on what is best for recovery. When providers are not able to offer clear descriptions of PAC services, this can result in a disconnect between patient and family expectations and actual care delivered.

Understanding the Independent Living Philosophy and Recovery Model

Patients and providers are encouraged to read more about the independent living philosophy and the recovery model, available at: <https://www.mass.gov/doc/an-introduction-to-masshealth-long-term-services-and-supports-and-other-covered-services/download>

Patient Scenarios

The patient's journey through post-acute care may differ due to the type and severity of condition. Other key factors affecting the patient's needs are life context and health insurance coverage. Patients with the same conditions, for example, may have very different journeys.

Patient	Condition	PAC Services and Setting and Outcome
Patient A	Lives at home, suffers a minor injury, develops a wound that won't heal	Patient receives complex wound care from a home health nurse but does not need to be hospitalized
Patient B	Lives at home, has a urinary tract infection (UTI)	Patient admitted to the hospital for UTI, and returned home with home health supports
Patient C	Lives at home, has a planned surgery	Patient admitted to the hospital for planned surgery, transferred to a skilled nursing facility (SNF), and returns home with home health services
Patient D	Lives at home, has an accident	Patient admitted to the hospital, transferred to a skilled nursing facility or an inpatient rehabilitation facility, returns home with home health services

TERMS AT-A-GLANCE	LINKS
Area Agencies on Aging (AAAs)	https://www.agingcare.com/local/massachusetts-executive-office-of-elder-affairs-boston-area-agency-on-aging-ma
Accountable Care Organization (ACO), (in context of Massachusetts)	https://www.mass.gov/masshealth-innovations
Acute	https://medlineplus.gov/ency/imagepages/18126.htm
Aging Services Access Points (ASAPs)	https://www.mass.gov/service-details/aging-services-access-points-asap
Assisted Living	https://www.mass.gov/topics/assisted-living
Behavioral Health (BH)	https://www.samhsa.gov/find-help/treatment
Capitation (capitated)	https://www.bluecrossmafoundation.org/publication/primer-medicare-managed-care-capitation-rates-understanding-how-masshealth-pays-mcos
Centers for Disease Control and Prevention (CDC)	https://www.cdc.gov/
Centers for Medicare and Medicaid Services (CMS)	https://www.cms.gov/
Compare Care	https://www.medicare.gov/care-compare/
Chronic	https://medlineplus.gov/ency/imagepages/18126.htm
Fee-For-Service (FFS)	https://www.healthcare.gov/glossary/fee-for-service/
Functional (definition, measures)	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Functional-Measures-
Group Insurance Commission	https://www.mass.gov/orgs/group-insurance-commission
Health Equity	https://www.cdc.gov/chronicdisease/healthequity/index.htm
Home Care (Home Care Alliance)	https://www.thinkhomecare.org/
Honoring Choices	https://www.honoringchoicesmass.com/
Hospice	https://www.hospicefed.org/page/fivews
Independent Living	https://acl.gov/programs/aging-and-disability-networks/centers-independent-living https://ncil.org/about/aboutil/
Independent Living Center (ILC)	https://www.mass.gov/independent-living-centers-0?_
Inpatient Rehabilitation Facility	https://amrpa.org/For-Patients/What-is-Post-Acute-Care
Long-Term Acute Care Hospitals (LTACHs, or LTCHs)	https://medicareadvocacy.org/medicare-info/long-term-care-hospitals/
Long-Term Care	https://www.nia.nih.gov/health/long-term-care/what-long-term-care
Long-Term Services and Supports	https://www.medicaid.gov/medicaid/long-term-services-supports/index.html
MassHealth	https://www.mass.gov/topics/masshealth
Medicare	https://www.medicare.gov/

TERMS AT-A-GLANCE	LINKS
Managed Care (MassHealth context)	https://www.mass.gov/service-details/managed-care-organization-mco-plan
Medicare Advantage	https://www.medicare.gov/health-drug-plans/health-plans
MassHealth Choices	https://www.masshealthchoices.com/en
Ombudsman (programs in Massachusetts)	https://www.mass.gov/service-details/ombudsman-programs
One Care	https://www.mass.gov/one-care
Options Counseling Program	https://www.mass.gov/service-details/options-counseling-program
Outpatient Rehabilitation	https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/outpatient-rehabilitation
Palliative Care	https://www.hospicefed.org/page/palliative_care
Portable Orders for Life-Sustaining Treatment (POLST)	https://www.mass.gov/info-details/molst-transition-to-polst
Post-Acute Care	https://www.aha.org/advocacy/long-term-care-and-rehabilitation
Program of All-Inclusive Care for the Elderly (PACE)	https://www.mass.gov/program-of-all-inclusive-care-for-the-elderly-pace https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PACE/PACE
Recovery Model	https://www.samhsa.gov/find-help/recovery
Recovery Learning Community (RLC)	https://www.mass.gov/service-details/recovery-learning-communities
Senior Care Option (SCO)	https://www.mass.gov/senior-care-options-sco
Social Determinants of Health (SDOH)	https://health.gov/healthypeople/priority-areas/social-determinants-health
Social Services and Supports	https://www.hhs.gov/programs/social-services/index.html https://www.mass.gov/topics/health-social-services
Skilled Nursing Facility (SNF)	https://www.mass.gov/nursing-home-consumer-information
Telehealth	https://telehealth.hhs.gov/patients/understanding-telehealth/
TRICARE	https://www.tricare.mil/
Veterans Affairs	https://www.va.gov/

SECTION 2. PAC SERVICES AND SETTINGS

Many patients receive PAC services after a stay in an acute-care hospital, or instead of a stay in an acute-care hospital. Several factors will influence what types of PAC services are needed.

Among the many factors are patient goals and preferences of the patient, where they live, what they need in terms of level and intensity of care needs, safety concerns, service availability, and insurance coverage.

What is the difference between post-acute care and long-term care?

It's important to note that post-acute care services are not long-term care services and supports. The goals are different. Post-acute care services are medical services that are provided to support a patient's continued recovery from illness, injury, or surgery, or management of a chronic illness or disability. Long-term services and supports (LTSS) or long-term care (LTC) are different. LTSS or LTC address the chronic care needs of older adults and people with disabilities to promote independence, support their lives in the community, and improve overall quality of life.

The table below provides a basic overview of the types of post-acute care settings and services that patients may need to recover from an acute episode and to restore functions. The types of services provided across settings may vary based upon the patient's insurance coverage and plan.

Detailed service descriptions provided on the following pages.

Setting: Home	Setting: Community Clinic or Facility
Private Home	Outpatient
Rest Home Independent Living Assisted Living	Skilled Nursing Facility (SNF) Inpatient Rehabilitation Facility (IRF) Long-Term Acute Care Hospital (LTACH)

Note: Readers should be aware that this service directory does not address post-acute care services to address behavioral conditions, including mental health and substance use needs.



HOME-BASED CARE	HOME HEALTH SERVICES
Primary purpose	To support recovery
Service description	Home-based care for patients recovering from a serious surgery, illness, or injury provided in their home, including an assisted living facility. Home health can include home health agencies, private duty nursing services, hospice, infusion services, clinician home visit programs, hospital-at-home, and telemedicine. Home health services can include skilled nursing care, nursing visits, home health aide services, physical therapy, occupational therapy, speech pathology services, medical social services, part-time (intermittent) home health aide services, medical supplies, and durable medical equipment. Home health agency services must be ordered by a physician who certifies that services are medically necessary and establishes an individual plan of care. This level of care is delivered to patients in their own homes by caregivers, aides, nurses, and physical or occupational therapists. Home health can be augmented by specialized remote patient monitoring.
Providers involved	Home health agencies, licensed professionals such as nurses, physical therapists, occupational therapists, speech therapists, social workers, home health aides, dietitians
Patients who might benefit	Patients who need skilled services from a licensed nurse or therapist to support their ability to reside in the community.
Finding out about quality	Ask your doctor, ask your health plan, and visit these links: https://www.seniorcare.com/home-care/resources/medicare-quality-data/ https://www.medicare.gov/care-compare/
Tips for patients	Increasingly people want to age in place and receive care at home; this is especially true due to the 2020 COVID-19 pandemic
Other names used	Home health, home healthcare
Relevant resources	https://www.seniorcare.com/home-care/ https://www.seniorcare.com/home-care/resources/home-health-care-services/ https://www.thinkhomecare.org/



FACILITY-BASED CARE	OUTPATIENT THERAPY SERVICES
Primary purpose	To support recovery
Service description	Therapy services, including diagnostic evaluation and therapeutic intervention, are designed to improve, develop, correct, rehabilitate, and to maintain function, or to prevent the worsening of functions that have been lost, impaired, or reduced because of acute or chronic medical conditions, congenital anomalies, or injuries.
Providers involved	Independent therapists, rehabilitation centers, or speech and hearing centers deliver Physical Therapy (PT), Occupational Therapy (OT), and Speech/Language Pathologist (SLP).
Patients who might benefit	Patients with physical therapy, occupational therapy, speech therapy needs, and other types of needs who live at home
Finding out about quality	No standardized reporting on quality
Tips for patients	Ask your physician, ask your health plan
Other names used	OT, PT, SLP

FACILITY-BASED CARE	NURSING FACILITY
Primary purpose	To improve, develop, correct, rehabilitate, and to maintain function, or to prevent the worsening of functions that have been lost or impaired.
Service description	Patients who need skilled services performed by or under the supervision of a registered nurse (RN) or therapist (e.g., intravenous feeding, observation and evaluation of an unstable medical condition, positioning in bed or a chair as part of the care plan, or administration of medication) can receive these services in a nursing facility, on a short-term basis. The length of time will vary from patient to patient. For example, some patients can't go home after surgery for a hip replacement and may spend 7-10 days in a nursing facility, before going home.
Patients who might benefit from this service	Patients with debilitating illnesses or orthopedic conditions, such as major joint replacement. Patients who require a nursing facility level of care and choose a facility setting. Most stays are for fewer than 30 days, after which the patient usually returns home. This kind of care can be beneficial after a surgery or a prolonged hospitalization, or for rehabilitation following a stroke or other serious medical event. Patients who have had a knee replacement, hip replacement, shoulder replacement, or a specific acute trauma. For patients who have had a stroke, and need to regain motor skills and speech function; therapy is provided for physical, speech, and/or occupational therapy.

FACILITY-BASED CARE	NURSING FACILITY
Providers involved	Short-term skilled nursing care; rehabilitation services; independent therapists, rehabilitation centers, or speech and hearing centers deliver Physical Therapy (PT), Occupational Therapy (OT), and Speech/Language Therapy (ST). Physical therapists , occupational therapists , and speech language pathologists , among other licensed professionals who serve the residents within skilled nursing facilities.
Finding out about quality	Find & compare nursing homes, hospitals & other providers: https://www.medicare.gov/care-compare/
Tips for patients	<p>To qualify for Medicare coverage in these facilities, patients must have a “qualifying event” that includes a three-night inpatient hospital stay and must require skilled nursing or rehabilitation for at least one hour daily five days a week. Medicare SNF benefits last 100 days without a new qualifying event. Medicare covers the first 20 days of the SNF stay and then, beginning on day 21, a patient has a 20% copay.</p> <p>Medicare has certain criteria regarding observation services and readmissions that warrant particular attention. See this information from Medicare: https://www.medicare.gov/what-medicare-covers/skilled-nursing-facility-snf-situations.</p> <p>Medicare has a number of demonstration programs that have waived the requirement for a three-night hospital stay: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/SNF-Waiver-Guidance.pdf</p>
Other names used	Skilled nursing facilities (SNFs); nursing home; nursing facility
Relevant resources	<p>Massachusetts Nursing Homes https://www.mass.gov/nursing-home-consumer-information</p> <p>Massachusetts Senior Care Association https://www.maseniorcare.org/</p> <p>LeadingAge Massachusetts https://www.leadingagemass.org/</p>



FACILITY-BASED CARE	INPATIENT REHABILITATION FACILITIES (IRFs)
Primary purpose	To regain independence; to improve functional abilities (the ability to perform activities of daily living, including bathing, dressing, and other independent living skills, such as shopping and housework).
Service description	IRFs care for patients recovering from a serious surgery, illness, or injury who need intensive rehabilitation therapy, physician supervision, and coordination of care. People who go to short-term inpatient rehabilitation facilities typically receive three hours of therapy five days/week. IRFs provide regular and intensive treatment, with medical and nursing support, as required, and 24-hour nursing care. Rehabilitative care includes physical, occupational, speech, and respiratory therapy. IRFs also assist with personal care such as eating, dressing, toileting, and bathing. Patients will have a personalized treatment plan with goals and an intensive therapy schedule, a dedicated care manager, and routine visits from a physician. Most stays are under 30 days. Patients usually return home. Rehabilitation services typically include semi-private rooms, meals, nursing services, drugs, other hospital services and supplies.
Providers involved	Physical therapists, occupational therapists, speech language pathologists, respiratory therapists, care managers, physicians
Patients who might benefit	Patients who have had a stroke, other neurological conditions, brain disease or condition (non-traumatic), brain injury (traumatic), hip or femur fracture, hip or knee replacement, amputation or other bone or joint condition, spinal cord disease or condition (non-traumatic), spinal cord injury (traumatic), other serious medical event, pulmonary or physical medicine, rehabilitation.
Finding out about quality	Find and compare nursing homes, hospitals and other providers: https://www.medicare.gov/care-compare/
Tips for patients	Some IRFs specialize in treating patients with certain medical conditions, like patients with a spinal cord injury.
Other names used	Rehabilitation care hospitals



FACILITY-BASED CARE	LONG-TERM ACUTE CARE HOSPITALS (LTACHs)
Primary purpose	To improve functional abilities
Service description	<p>Long-term acute care hospitals (LTACHs) specialize in providing intensive, rehabilitative, and therapeutic care. LTACHs treat patients hospitalized for more than 25 days who may need a longer hospital stay to get well. LTACHs often care for patients who have more than one serious condition, but who may improve with time and ultimately return home. Patients must require multidisciplinary therapy (e.g., physical therapy, occupational therapy, speech therapy, orthotic or prosthetic services) and be able to participate in intensive treatment. This level of care is for medically fragile patients who need a high level of care over the long term, often more than four weeks. LTACH facilities treat patients with high-acuity conditions including pulmonary failure, respiratory failure, or head trauma.</p>
Providers involved	24-hour in-house physician coverage, nurse practitioners and physical medicine consultants; specialty consultants, including those in the fields of cardiology, pulmonary medicine, oncology, infectious disease, and nephrology.
Patients who might benefit	<p>Patients who require daily monitoring and complex medical interventions. This may include patients with complex wounds, chest tubes, ventilatory dependency, or multi-organ failure. Patients who are medically fragile and who are dependent on medical care for which daily skilled nursing intervention is medically necessary. This includes high-acuity conditions such as pulmonary failure, respiratory failure, or head trauma.</p>
Finding out about quality	<p>Find and compare nursing homes, hospitals and other providers: https://www.medicare.gov/care-compare/</p>
Tips for patients	If the plan is for you to move from an LTACH to an IRF, find a facility that offers both services.
Other names used	LTACHs, LTACs, Long-Term Care Hospitals, Chronic Care Hospitals, Chronic Disease & Rehabilitation Hospitals, CDRHs



SERVICE	PALLIATIVE CARE
Primary purpose	To improve the quality of life for people with serious or life-altering illnesses; to manage chronic conditions of a patient with the goal of providing comfort and the highest quality of life possible; provided any time regardless of the stage of the illness or life expectancy.
Service description	Palliative care services may be provided at any time. Palliative care is based upon an individual's needs. Care plans may focus on one or several goals, including managing symptoms, including side effects of treatment, and improving understanding of illness and its progression. Palliative care can be provided along with curative treatment and does not depend on prognosis.
Providers involved	Palliative care is provided by a specially trained team of doctors, nurses, and other specialists who work together with a patient's other doctors to provide an extra layer of support.
Patients who might benefit	Palliative care is available for a wide range of diseases. The majority of adults in need of palliative care have chronic diseases such as cardiovascular diseases (38.5%), cancer (34%), chronic respiratory diseases (10.3%), AIDS (5.7%) and diabetes (4.6%). Many other conditions may require palliative care, including kidney failure, chronic liver disease, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, neurological disease, dementia, congenital anomalies, and drug-resistant tuberculosis.
Other names used	Supportive care; Comfort care, Serious Illness Care
Relevant resources	Hospice & Palliative Care Federation of Massachusetts: https://www.hospicefed.org/ Center to Advance Palliative Care: https://www.capc.org



HOME OR FACILITY	HOSPICE CARE
Primary purpose	To improve quality of life, provide comfort and pain control, provided at the end of life, when an illness no longer responds to treatment
Service description	Hospice care is considered the model for quality compassionate care for people facing a life-limiting illness. Hospice provides expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's family as well. Hospice focuses on caring, not curing.
Providers involved	Hospice service team of healthcare professionals, including nursing, counseling, spiritual care, and volunteers. Hospice may be provided in any setting: home, hospitals, nursing homes, hospice care facilities, assisted living facilities, and group homes.
Patients who might benefit	Patients at end of life with diagnoses such as cancer, neurological conditions, heart/circulatory, COPD.
Notes to patients	To qualify for hospice care, life expectancy is six months or less, which can be difficult to determine. Choosing to enter a hospice program is voluntary. Patients may choose to resume curative care or life-prolonging treatments at any time.
Finding out about quality	Find and compare nursing homes, hospitals, hospice other providers: https://www.medicare.gov/care-compare/
Other names used	Compassionate care; end-of-life care
Relevant resources	Hospice & Palliative Care Federation of Massachusetts: https://www.hospicefed.org/ National Hospice & Palliative Care Organization: https://www.nhpco.org Center to Advance Palliative Care: https://www.capc.org

SECTION 3. HEALTH INSURANCE COVERAGE

Health insurance usually covers post-acute care services. It is important to understand benefits since health insurance coverage will vary based on whether you have Medicare, MassHealth, commercial coverage, or some other form of insurance coverage.

Note: Readers should be aware that this overview of health insurance coverage does not address post-acute care services to address behavioral conditions, including mental health and substance use disorder needs.

In this section, you will find information about coverage under:

Medicare

**MassHealth
(Medicaid)**

Commercial

TRICARE

Veterans

MEDICARE

Basic Information

The Medicare program is a federally funded health insurance program. The Medicare program covers people ages 65 and older and under age 65 with certain disabilities. The Centers for Medicare and Medicaid Services (CMS) administers the Medicare programs and refers to people on Medicare as “beneficiaries.” The Medicare program has four different parts: Medicare Part A covers hospitalizations, home care, hospice, and skilled nursing home care but only temporarily and, in some cases, after a qualifying hospital stay; Medicare Part B covers physician services and therapies; Medicare Part C refers to Medicare Advantage (MA) plan; and Medicare Part D covers drugs and vaccines. Some people receive their coverage for services under the original Medicare program. Some people receive their coverage for services through a Medicare Advantage plan with prescription drug coverage.

Post-Acute Care Coverage

The Medicare program covers post-acute care. Medicare is also the primary payer of post-acute care in the country. Medicare beneficiaries can access Medicare benefits through the original Medicare program or through a Medicare Advantage (MA) plan. Medicare beneficiaries enrolled in a Medicare Advantage plan will receive at a minimum the same benefits that are available to beneficiaries that participate in the original Medicare program.

- Original Medicare: Medicare Parts A, B, D
- Medicare Advantage: Medicare Part C - Managed Care Plans

To learn more about the Medicare program, the Kaiser Family Foundation produces a basic resource, available at: https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/?gclid=EAlaIQobChMlrlvCilet7QIVivOzCh3zDgloEAAYAiAAEgKsU_D_BwE

MEDICARE COVERAGE FOR POST-ACUTE CARE (CALENDAR YEAR 2021)		
SERVICE	ORIGINAL MEDICARE	MEDICARE ADVANTAGE (MA)
Coverage	<p>Original Medicare, also known as traditional Medicare, covers post-acute care hospital-based and skilled nursing services (Medicare Part A services) as well as outpatient and professional services (Medicare Part B)</p> <p>As a fee-for-service benefit, beneficiaries can receive care from any doctor or hospital that accepts Medicare reimbursement rates, anywhere in the United States, and Medicare will pay its share of the bill for any Medicare-covered service it covers</p> <p>Cost-sharing varies by type of service</p>	<p>Medicare Advantage Plans are another way to get your Medicare Part A and Part B coverage</p> <p>Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by Medicare-approved private companies that must follow rules set by Medicare</p> <p>Most Medicare Advantage Plans include drug coverage (Part D)</p> <p>MA plans must cover all services covered by Original Medicare, but are not required to follow the beneficiary cost-sharing levels of Original Medicare</p>
Home Health Care	<p>Covered</p> <p>20 percent co-insurance for all durable medical equipment</p>	<p>Covered</p> <p>Cost-sharing depending on Medicare Advantage plan</p>
Physical Therapy, Occupational Therapy, and Speech Pathology Services	<p>Covered</p> <p>20 percent co-insurance</p>	<p>Covered</p> <p>Cost-sharing depending on Medicare Advantage plan</p>
Outpatient Mental Health Services and Substance Use Disorder Services	<p>Covered (includes partial hospitalization programs)</p> <p>No cost sharing for annual depression screening</p> <p>20 percent co-insurance for all other services</p>	<p>Covered</p> <p>Cost-sharing depending on Medicare Advantage plan</p>
Skilled Nursing Facility (SNF)	<p>Coverage for first 100 days</p> <p>Days 1-20: \$0 for each benefit period</p> <p>Days 21-100: \$185.50 coinsurance per day of each benefit period</p> <p>Days 101 and beyond: all costs</p> <p>Requires a qualifying 3-day inpatient hospital stay preceding SNF care</p>	<p>Coverage for first 100 days</p> <p>Cost sharing may vary by Medicare Advantage plan</p> <p>Depending on Medicare Advantage plan, may not require a preceding 3-day inpatient hospital stay</p>

MEDICARE COVERAGE FOR POST-ACUTE CARE (CALENDAR YEAR 2021)		
SERVICE	ORIGINAL MEDICARE	MEDICARE ADVANTAGE (MA)
Inpatient Rehabilitation Facility (IRF)	Covered No deductible if transferred from another hospital in the same benefit period; otherwise \$1,484 deductible	Covered Cost-sharing depending on MA plan
	90 days of inpatient hospital care per benefit period: \$0 per day (days 0-60), \$371 per day (days 61-90)	
	60 "lifetime reserve days" for use beyond the 90 days of inpatient coverage: \$742 per day (days 91+) For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance After lifetime reserve days are exhausted: all costs	
Long-Term Acute Care Hospital	Covered No deductible if transferred from another hospital in the same benefit period; otherwise \$1,484 deductible	Covered Cost-sharing depending on MA plan
	90 days of inpatient hospital care per benefit period: \$0 per day (days 0-60), \$371 per day (days 61-90)	
	60 "lifetime reserve days" for use beyond the 90 days of inpatient coverage: \$742 per day (days 91+) For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance After lifetime reserve days are exhausted: all costs	
Hospice	Covered Cost-sharing = \$0 copay	Covered under Original Medicare Cost-sharing = \$0 copay
Palliative Care	Covered	Covered under Original Medicare
Assisted Living	Not Covered	Not Covered



MASSHEALTH

Basic Information

The MassHealth program is a state-administered program, for which the state and the federal government jointly pay. MassHealth is the name for the commonwealth's Medicaid program. MassHealth is the primary source of health insurance coverage for about more than 2 million people of all ages in the state. This includes about 180,000 persons 65 years of age and older or 17% of all MassHealth "members." MassHealth calls its enrollees "members." People 65 years of age are sometimes called seniors or older adults.

Some MassHealth members also have Medicare too. About 1 in 4, or 25% of all Medicare beneficiaries in the commonwealth are also eligible for MassHealth (or 1 in 6 of all MassHealth members). These individuals with coverage under Medicare and MassHealth are called dually eligible beneficiaries. They have Medicare plus MassHealth. Among those who are dually eligible persons, about 50% are 65 and older and about 50% are under age 65. It is important to note that for dually eligible beneficiaries, the Medicare and MassHealth programs work together to expand coverage for the person. Each program plays a role in providing coverage: (1) Medicare is the primary source of insurance; and (2) MassHealth is the secondary source of insurance, wrapping around the Medicare benefit, plus covering specific benefits offered under the MassHealth program that are not covered under Medicare.

In general, MassHealth's coverage is similar to coverage under commercial insurance. However, MassHealth also covers additional benefits such as long-term services and supports (LTSS) that are important to older adults and persons with disabilities.

MassHealth has many approaches and programs for receiving coverage. With six plan options, coverage for specific services varies considerably type. You can learn more about coverage provided under each plan option on the MassHealth website: <https://www.mass.gov/masshealth-plans-and-enrollment-guide>.

Some MassHealth members receive coverage directly from a provider on a fee-for-service (FFS) basis. This provides MassHealth members with access to services that are covered under MassHealth from providers that participate in MassHealth's traditional FFS program.

Most MassHealth members receive coverage through a managed care health plan or managed care program. MassHealth members can enroll in an accountable care organization (ACOs), a managed care organization (MCO), a One Care plan, a Program of All-Inclusive Care for the Elderly (PACE), or a Senior Care Options (SCO) plan.

Post-Acute Care Coverage

The MassHealth program covers post-acute care services for MassHealth members, in accordance with the services that are covered under the MassHealth program on a fee-for-service (FFS) basis.

Members who are enrolled in a managed care health plan or managed care program receive at least what other MassHealth members receive on a fee-for-service basis. Since MassHealth has several coverage types, it is best to check with MassHealth, your provider, or plan, to ensure that your MassHealth coverage covers the post-acute care service that you need.

By design, managed care plans can be more flexible in providing MassHealth coverage and offer post-acute care to MassHealth members in new and innovative ways to meet needs of the person in a person-centered way. The One Care program, the SCO program, and the PACE program generally offer enhanced benefits above Medicare and MassHealth. Patients in need of PAC services should contact their plan. Individuals at a facility level of care may be able to access additional services provided through home and community-based service waivers. Eligibility varies by age, clinical needs, and community versus long-term residence in a long-term care facility. Individuals covered under the Senior Care Options (SCO) program may be able to access the Frail Elder Waiver services through the SCO program.

To learn more about the MassHealth program, the Blue Cross Blue Shield Foundation of Massachusetts produces a basic resource, available at:

<https://www.bluecrossmafoundation.org/publication/masshealth-basics-facts-and-trends-october-2023>

MASSEALTH COVERAGE FOR POST-ACUTE CARE

MassHealth pays for many important healthcare services, including doctor visits, hospital stays, rehabilitation and therapeutic services, and behavioral health and substance use disorder services.

MassHealth pays for post-acute care services

Information is available at: <https://www.mass.gov/service-details/covered-services>

Coverage	MassHealth coverage varies by coverage type
	<p><u>Coverage type: MassHealth Standard</u> Community-based LTSS covered</p> <p><u>Coverage type: MassHealth CommonHealth</u> Community-based LTSS covered</p> <p><u>Coverage type: MassHealth Family Assistance</u> Community-based LTSS not covered</p> <p><u>Coverage type: MassHealth Care Plus</u> Community-based LTSS not covered</p>
Long-Term Services and Supports	<p>https://www.mass.gov/doc/an-introduction-to-masshealth-long-term-services-and-supports-and-other-covered-services/download</p>
Community-Based LTSS	<p>Adult Day Health, Adult Foster Care, Continuous Skilled Nursing (may be provided by Independent Nurses or Home Health Agencies), Day Habilitation, Group Adult Foster Care, and Personal Care Attendant Program (PCA). Nursing Facility (over 100 days)</p>
Facility-Based LTSS	<p>Nursing Facility (over 100 days) and Chronic Disease</p>
Other LTSS Services	<p>Rehabilitation Hospital Services (over 100 days)</p> <p>Home Health Agency</p> <p>Outpatient therapies (PT, OT, SLP)</p> <p>Nursing Facility (under 100 days)</p> <p>Chronic disease and rehabilitation services (under 100 days)</p> <p>Hospice</p>

MASHEALTH COVERAGE UNDER MANAGED CARE

Coverage under Managed Care Organizations (MCOs) and Accountable Care Organizations (ACOs)

Coverage under programs:
Senior Care Options (SCO) program,
the One Care program,
the Program-of-All-Inclusive Care for the Elderly (PACE)

MCOs and ACOs cover most services directly; however, MassHealth covers some services directly

SCO Program

This program is for persons with coverage under MassHealth or MassHealth coverage plus coverage under Medicare

<https://www.mass.gov/senior-care-options-sco>

<https://www.mass.gov/service-details/enrolling-and-receiving-care-under-senior-care-options-sco>

One Care Program

This program is for persons with coverage under MassHealth plus coverage under Medicare

<https://www.mass.gov/one-care>

<https://www.mass.gov/service-details/one-care-plans>

PACE Program

This program is for persons with coverage under MassHealth or MassHealth plus coverage under Medicare

<https://www.mass.gov/program-of-all-inclusive-care-for-the-elderly-pace>



COMMERCIAL COVERAGE

Basic Information

Private companies or non-governmental organizations issue commercial health insurance. There are many different types of commercial health insurance and they each are likely to have different benefit structures. Some of the most common types of commercial health insurance include health maintenance organizations, preferred provider organizations, exclusive provider organizations, point-of-service plans, and private fee-for-service, and high-deductible health plans.

Post-Acute Care Coverage

Commercial insurance plans vary widely in their coverage and policies for post-acute care services. Most plans typically provide some sort of coverage for short stays in post-acute care, skilled nursing facilities, and home healthcare if the services are necessary following a hospital stay. Commercial insurers often require members to use in-network post-acute care providers. Some plans will cover services from providers that are "out-of-network," but they usually do not cover as much of the cost and can leave patients with additional out-of-pocket costs. Commercial plans often cover inpatient post-acute care stays if patients obtain prior authorization from the plan and member cost sharing for these services are often like the cost-sharing for inpatient acute care hospital stays. Commercial plans may be less likely than other payers to cover palliative care and community-based services and supports.

TRICARE

Basic Information

TRICARE is the healthcare program for uniformed service members, retirees, and their families located within the United States and internationally. TRICARE provides comprehensive coverage to all beneficiaries. TRICARE includes health plans, special programs, prescription coverage, and dental coverage. Most TRICARE health plans meet the requirements for minimum essential coverage under the Affordable Care Act. TRICARE is managed by the Defense Health Agency under leadership of the Assistant Secretary of Defense (Health Affairs).

Learn more: <https://tricare.mil/CoveredServices/IsItCovered>

Post-Acute Care Coverage

TRICARE offers several services under its basic benefit for beneficiaries with special needs for post-acute care. These services include home healthcare, hospice care, and skilled nursing facility care.

- **Home healthcare:** TRICARE covers part-time and intermittent skilled nursing care, home health aide services, physical, speech and occupational therapy, and medical social services. Members must obtain prior authorization for home healthcare. The services covered under TRICARE are the same as those covered by Medicare. As a part of this benefit, home healthcare must be provided by a participating home health agency, and is only available in the U.S., D.C., and U.S. Territories.
- **Skilled nursing facilities:** Members qualify for SNF care if they are treated in a hospital for at least three consecutive days, not including the day of discharge, and they enter the skilled nursing facility within 30 days of the hospital discharge. There is no day limit, assuming care is medically necessary. Prior authorization is not required, except for active-duty service members and Medicare-eligible beneficiaries after the first 100 days. Covered skilled nursing services includes a semi-private room; regular nursing services; meals (including special diets); physical, occupational and speech therapy; drugs provided by the facility; and medical supplies and appliances.
- **Hospice services:** Patients qualify for hospice care when the patient, primary care physician, or authorized family initiates hospice care. The benefit covers supportive services, including pain control and counseling services, home health aide services, and personal comfort items. TRICARE doesn't cover room and board unless respite care is required. TRICARE provides hospice care in three successive benefit periods: the first 90 days, the second 90 days, and unlimited 60-day periods. The patient requires pre-authorization for each benefit period.
- **Custodial care:** TRICARE covers non-skilled, personal care for basic day-to-day tasks in an institution or at home for seriously ill or injured service members. This includes help with eating, dressing, getting in or out of a bed or chair, moving around, and using the bathroom. Some aspects of care may be covered for all other beneficiaries. This includes limited specific skilled nursing services (one hour per day), prescription medicines, up to 12 physician visits per calendar year, and medically necessary care for inpatient care in an acute care hospital.
- **Assisted living:** Not covered
- **Long-term care:** Not covered

TRICARE also has several special programs that provide services beyond the basic benefit for beneficiaries with special needs. For example, the Extended Care Health Option (ECHO) provides financial assistance to beneficiaries with special needs for an integrated set of services and supplies.

VETERANS ADMINISTRATION (VA)

Basic Information

The Veterans Health Administration (VHA) is America's largest integrated healthcare system, providing care at 1,255 healthcare facilities, including 170 medical centers and 1,074 outpatient sites of care of varying complexity, serving 9 million enrolled veterans each year. To qualify for VHA health care benefits, patients must have served in the active military, naval or air service and are separated under any condition other than dishonorable. The VHA health benefits package includes all the necessary inpatient hospital care and outpatient services. Care is provided through VHA Medical Centers, which provide a wide range of services including traditional hospital-based services such as surgery, critical care, mental health, orthopedics, pharmacy, radiology, and physical therapy. Veterans may be eligible for care through a non-VHA provider in their local community depending on their healthcare needs or circumstances, and if they meet specific eligibility criteria. Veterans with other forms of healthcare coverage, such as a private insurance plans, Medicare, Medicaid/MassHealth, or TRICARE, can continue to use VHA along with these plans.

Post-Acute Care Coverage

VHA benefits include a wide variety of post-acute and long-term care services.

- **VA Nursing Home Care:** Veterans may qualify for indefinite Community Living Center (formerly known as nursing home care) services; other veterans may qualify for a limited time period.
- **Domiciliary Care:** Rehabilitative and long-term health maintenance care for veterans who require some medical care but do not require all the services provided in nursing homes. Domiciliary care emphasizes rehabilitation and a return to the community.
- **Medical Foster Homes:** Private homes in which a trained caregiver provides services to a few individuals.
- **State Veterans Homes:** Facilities that provide nursing home, domiciliary or adult day care. Each state establishes eligibility and admission criteria for its homes.
- **Adult Day Healthcare:** Day programs for veterans who need skilled services, case management, and help with activities of daily living (such as bathing, getting dressed, and preparing meals).
- **Home Healthcare:** The VA offers three types of home healthcare: Skilled Home Healthcare Services (SHHC), Homemaker and Home Health Aide Services (H/HHA), and a Family Caregivers Program. In addition, the VA offers a Home Telehealth program whereby clinicians monitor patients through use of remote patient monitoring programs.
- **Hospice:** Comfort-based care for veterans who have a terminal condition with six months or less to live. VA Hospice also provides grief counseling to your family.
- **Long-Term Care Services:** Covered

Learn more: https://www.va.gov/healthbenefits/resources/publications/hbco/hbco_medical_benefits_package.asp



Care After the Hospital: Guide to Post-Acute Care

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