



Executive Office of Elder Affairs

RESPECT INDEPENDENCE INCLUSION

Community Transition Liaison Program (CTLP) Network Training (Waiver, MFP & MRC)

August 24, 2023

10:00 a.m. – 12:00 p.m.

For ASAP Utilization Only - Do Not Distribute




Agenda (120 minutes)

- Welcome (10 minutes)
- Introduction to MassHealth Waiver Team (5 min)
- MassHealth Waiver Programs & Questions (45 min)
- Introduction to MRC Team (5 min)
- Mass Rehabilitation Commission Programs & Questions (45 min)
- What's Next? (10 minutes)
- Appendix

MassHealth Home and Community Based Services Waivers and Money Follows the Person Demonstration

Executive Office of Health and Human Services

Community Transition Liaison Program – 8/24/23

Topics for Today:

1. Home and Community Based Services (HCBS) 1915(c) Waivers
2. Money Follows the Person Demonstration (MFP Demo)
3. How to access the HCBS Waivers and MFP Demonstration

Home and Community Based Services (HCBS) Waivers

Alternative Long-Term Services and Supports (LTSS) programs for individuals who otherwise require care in a facility

HCBS / 1915(c) Waivers

- States can develop home and community-based services waivers (HCBS) waivers to meet the needs of people who prefer to get long-term care services and supports in their **home or community**, rather than in an institutional setting.
- Eligible individuals must demonstrate the need for a **Level of Care** that would meet the state's eligibility requirements for services in an institutional setting.
- State must show **cost neutrality** in order to be approved for a waiver, demonstrating that providing waiver services won't cost more than providing these services in an institution.

HCBS / 1915(c) Waivers

CMS can **waive certain requirements** that otherwise apply to the Medicaid program, giving the state flexibility to define:

- The **target group** of Medicaid beneficiaries to be served, subject to certain requirements.
- The **maximum number** of participants who may be served in a given HCBS waiver program.
- The **services** available to the waiver target group (in addition to what is already available through MassHealth).
- The **income and asset rules** that usually apply to eligibility for community Medicaid.

Massachusetts' HCBS Waivers

- There are 10 HCBS waivers in Massachusetts.
- MassHealth administers these waivers, in partnership with a state operating agency.

Agency Acronyms	
ASAPs	Aging Services Access Points
DDS	Department of Developmental Services
EOEA	Executive Office of Elder Affairs
MRC	Massachusetts Rehabilitation Commission

Massachusetts Operates 10 HCBS Waivers

Waiver	Operating Agency	Target Population
Adult Supports (AS)	DDS	Adults with intellectual disabilities (22+)
Community Living (CL)		
Intensive Supports (IS)		
Frail Elder	EOEA	Older adults (60+)
Traumatic Brain Injury (TBI)	MRC	Adults with TBI (18+)
Children's Autism	DDS	Children with autism (up to age 9)
Acquired Brain Injury – Non-Residential Habilitation (ABI-N)	MRC	Adults with ABI sustained at age 22+
Acquired Brain Injury – Residential Habilitation (ABI-RH)	DDS	
Moving Forward Plan – Community Living (MFP-CL)	MRC	Adults who are disabled or seniors (18+)
Moving Forward Plan – Residential Supports (MFP-RS)	DDS	

Roles: MassHealth v. Operating Agencies

- MassHealth provides administration and oversight
  - Negotiating with CMS to meet 1915(c) requirements.
  - Renewing the waivers every 5 years.
  - Amending the waivers (to add a service, add slots, expand eligibility, etc.).
  - Overseeing the state agencies to make sure waiver operation complies with CMS rules.
  - Submitting quality reports to CMS.

- Sister state agencies (DDS, MRC, and EOEA) operate the waivers
  - Providing case management to waiver recipients.
  - Providing waiver services – managing providers and claiming processes.
  - Oversee day-to-day operation of the waiver and conduct quality oversight.

Required Elements for all HCBS Waivers

- Waiver participants must be financially eligible and

  - require a facility level of care (LOC);
  - have an ongoing need for, and receive waiver services at least once a month;
  - be able to be safely served in the community with available waiver and MassHealth services.

- All waiver participants must have a waiver case manager.

Waiver Plan of Care (POC)

- After an individual is found eligible for a waiver, they work with a waiver case manager in a person-centered planning process to develop a waiver Plan of Care (POC) that:
  - acts as the **authorization** for waiver services (analogous to Prior Authorizations for MassHealth LTSS).
  - specifies **amount, frequency, and type of provider** for each waiver service the participant will receive.
- POCs must be reviewed and updated at least annually, and whenever necessary due to a change in the participant's needs or circumstances.

Waiver Eligibility

- Two parts to waiver eligibility
  - **Clinical eligibility** is determined by the waiver operating agency or its agent
  - **Financial eligibility** is always determined by MassHealth
- **Both types** of eligibility must be reviewed annually

Clinical Eligibility Determinations	
Waiver(s)	**Agency/Agent**
DDS Adult ID Waivers	DDS
Children's Autism Waiver	DDS
TBI Waiver	MRC
Frail Elder Waiver	ASAPs
ABI Waivers	UMass
MFP Waivers	UMass

Waiver Financial Eligibility

- HCBS Waiver participants must be eligible for MassHealth Standard in the community.
- Special financial eligibility rules for adult HCBS waiver applicants/participants:

1. Applicant's income ≤ 300% SSI Federal Benefit Rate (the SSI FBR for 2023 is now $914, so 300% is $2,742.)
2. Asset test requirement for applicant (≤ $2,000)
3. Countable asset limit on applicant's spouse (limit for 2023 is ≤ $148,620.)

* FBR and spousal asset limit subject to change on annual basis.

Managed Care

Most (roughly two-thirds) of MassHealth members are enrolled in a managed care plan:

- Accountable Care Partnership Plans (ACO-A plans)
- Primary Care ACOs (ACO-B plans)
- MassHealth managed care organizations (MCOs)
- MassHealth Primary Care Clinician (PCC) Plan
- One Care Plans
- Senior Care Options (SCO) Plans

HCBS Waivers and Managed Care

Population	Managed Care Rules
Waiver participants under 65 with MassHealth only	Required to enroll in an MCO, ACO, or PCC Plan
Waiver participants under 65 with MassHealth and Medicare (duals)	Must remain in Fee for Service. Can't be in a waiver **and** enrolled in One Care or PACE*.
Waiver participants under 65 with MassHealth and commercial insurance	Must remain in Fee for Service. Individuals with MassHealth secondary to commercial insurance are not eligible for MassHealth managed care.
Waiver participants 65+ with • MassHealth and Medicare (duals) • MassHealth and no Medicare	Must remain in Fee for Service. Can't be in a waiver **and** enrolled in SCO or PACE. EXCEPTION: FEW participants 65+ may enroll in SCO plans, and the SCO must provide all state-plan and waiver services.

Acquired Brain Injury (ABI), Moving Forward Plan (MFP), and Frail Elder Waivers

Acquired Brain Injury (ABI) Waivers

- For individuals 22+ who are disabled, or age 65+, with an acquired brain injury that was sustained at age 22 or older.
  - Examples of ABIs that qualify include brain injuries resulting from stroke, brain trauma, infection of the brain, brain tumor, or anoxia (also includes traumatic brain injury).

- To qualify for the waiver, **a person must apply while they are living in a facility, and their facility stay must be at least 90 days before discharge.**

- Two ABI waivers – differ by individual's need:

  1. ABI-RH (Residential Habilitation): For participants who need 24-hour supervision and staffing in a provider-operated and staffed setting such as a residential habilitation group home. DDS provides case management.

  2. ABI-N (Non-Residential Habilitation): For participants who do not need 24 hour supports or supervision, and can live in their own home/apt, family home, or Adult Foster Care. MRC provides case management.

Moving Forward Plan (MFP) Waivers

- For individuals who are 18 or older and disabled or age 65+.

- To qualify for the waiver, **a person must apply while they are living in a facility, and their facility stay must be at least 90 days before discharge.**

- Two MFP waivers – differ by individual's need:

    1. MFP-RS (Residential Supports): For participants who need 24-hour supervision and staffing in a provider-operated and staffed setting such as a residential habilitation group home. DDS provides case management.

    2. MFP-CL (Community Living): For participants who do not need 24 hour supports or supervision, and can live in their own home/apt, family home, or Adult Foster Care. MRC provides case management.

Frail Elder Waiver (FEW)

- For individuals age 60 and older
- Participants can live in their own home/apartment, family home, or Adult Foster Care (AFC).
- Provides a range of in-home support services, transportation, and family support to maximize independence and assist participants to remain in their homes.
- EOEA is operating agency. Aging Services Access Points (ASAPs) make clinical eligibility determinations and provide waiver case management.
- Participants age 65+ have the option to enroll in Senior Care Options (SCO) plans to receive their waiver services.

ABI, MFP, and Frail Elder Waivers

Eligible Population Criteria	ABI-Non Residential	ABI-Residential	MFP-Community Living	MFP-Residential Supports	Frail Elder
Minimum age	22	22	18	18	60
Must have been living in a facility for at least 90 days	Yes	Yes	Yes	Yes	No
Acquired brain injury (ABI) required	Yes	Yes	No	No	No

Waiver services are available in addition to other MassHealth benefits

- HCBS Waivers provide a layered benefit package that supplements traditional Medicaid benefits available to MassHealth Standard-eligible individuals.

- Waiver services cannot duplicate other available services.

- Each waiver has a different set of services, targeted to meet the needs of the waiver population.

- Some examples of waiver services include Transitional Assistance, Residential Supports, Home Modifications, Home Health Aide, Home Delivered Meals, Adult Companion, Homemaker, Day Services, Supported Employment, Non-Medical Transportation.

Money Follows the Person Demonstration (MFP Demo)

MFP Demo – Overview

- Money Follows the Person is a Demonstration Grant from Centers for Medicare & Medicaid Services (CMS).

- The original Massachusetts Money Follows the Person Demonstration (MFP Demo) ran from April 2011 through June 2018.

  – Over 3,100 individuals signed up for the MFP Demo.

  – 2,151 individuals successfully transitioned to the community.

- The goal of the MFP Demo is to “rebalance” funding from facility-based settings to home and community-based settings.

MFP Demo – How does it work?

- Using our existing waiver outreach and enrollment mechanisms, we will enroll individuals who are eligible for **MassHealth Standard or CommonHealth** in the MFP Demo after a facility stay of **60+** days.
  - We may also identify individuals who are **expected to** have a facility stay of 60+ days and educate them about the MFP Demo.

- We can serve individuals in the MFP Demo who are not eligible for waivers and offer them services they would not otherwise have access to, such as transitional assistance and home modifications.

- We may also enroll waiver-eligible individuals in the MFP Demo, in order to take advantage of the additional federal funding associated with the MFP Demo. In these cases, the individual is enrolled in both a waiver and the MFP Demo.

MFP Demo target populations

CMS establishes broad target populations* for the MFP Demo:

- Elders
- Individuals with Intellectual/Developmental Disabilities (ID/DD)
- Individuals with Physical Disabilities
- Individuals with Mental Illness

* These are the terms that CMS uses for these populations.

MFP Demo Qualifying Criteria

To qualify for the MFP Demo, an individual must:

- be living in a qualified nursing facility or long-stay hospital for at least **60 consecutive days, including Medicare rehabilitation days**;
- be 18 years old or older and be disabled (disabled as defined in Title XVI of the Social Security Act and MassHealth regulation 130 CMR 501.000), **OR** be age 65 or older;
- be eligible for MassHealth Standard or CommonHealth and whose last day in the facility is a Medicaid-paid inpatient day;
- be a resident of Massachusetts;
- have signed the Informed Consent Form; and
- transition to an MFP Demo qualified residence in the community.

Counting Days for MFP Demo Qualification

- Applicants must be living in a nursing home or long-stay hospital for at least **60** consecutive days.
- Applicants can move between qualified settings as long as they do discharge to the community between facility settings.
- Medicare rehabilitation days (Physical, Occupational and Speech Therapy) **may be included** in the 60 day count.
- If an applicant goes into an acute care hospital, those days may count toward the 60 day count, as long as the applicant returns to an MFP Demo qualified facility and transitions from there.

What are MFP Demo Qualified Facilities?

- Department of Public Health (DPH) licensed and Medicaid certified nursing facilities
- Chronic Disease and Rehabilitation Hospitals
- DPH Hospitals
- Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/ID)
- Psychiatric Hospitals including both public and private (also referred to as Institutions for mental disease or IMDs) - excludes individuals aged 22 – 64 in IMDs.

MFP Demonstration - Workflow

MFP Demo Qualified Facilities

- Nursing Facilities
- Rehab & Chronic Hospitals
- ICF-ID
- DPH Hospitals
- Psychiatric Hospitals - with some exceptions

MFP Demo transition services & supports

MFP Demo Qualified Residences

- Individual's/ Family's Home
- Individual's Leased Apartment
- Community Residential Setting (Max 4 Individuals)
- Assisted Living Residences

MFP Demo participants may access services in the community through:

- HCBS Waivers (ABI/MFP, Frail Elder, DDS ID)
- One Care/SCO/PACE
- MassHealth State Plan services

MFP Demo Qualified Community Residences

- A home owned or leased by the individual or a family member (with no limit on number of family members)
- An apartment with an individual lease
- A community-based residential setting in which no more than 4 unrelated individuals reside (tenants must have a lease, lockable entrance/egress, control over sleeping/bathing/cooking space)
- Adult Foster Care or Shared Living caregiver's home

MFP Demo Qualified Assisted Living Residences

- Assisted Living Residences may not be located on a campus that includes a medical facility such as a nursing facility or hospital.
- Apartments must have separate living, sleeping, bathing and cooking areas (based on the participant's needs and with their agreement, units with only a microwave and no cooktop are acceptable).
- Unit must have lockable access and egress.
- Cannot require that services must be provided as a condition of tenancy.
- Must not require notification of absences from the residence.
- Leases may not reserve the right to assign or change apartments.

MFP Demo – Participation

- Participation is voluntary.
- An individual may remain enrolled in the MFP Demo for a period of 365 days post discharge. After that time, the individual's MFP Demo enrollment and services end. The individual will continue to receive MassHealth State Plan, HCBS Waiver services, and/or State Home Care if eligible.
- Case management services will be provided by the following:
  - ASAP for those eligible for Frail Elder Waiver (FEW) or State Home Care
  - DDS for those eligible for ABI/MFP residential waivers, ID waivers or DDS funded services
  - MRC for those eligible for ABI/MFP community waivers, State Plan, and all others

Additional Information

How to Access the HCBS Waivers

- **Adult ID Waivers**
  - For information about the 3 waivers and application forms, go to:

    HCBS Waivers for Adults with Intellectual Disabilities: Information for Individuals & Families | Mass.gov

    To locate the closest DDS Area Office, go to:

    DDS Area Office Locator Lookup - DDS Area Online Locator (state.ma.us)

- **Children's Autism Waiver**
  - For information about the Children's Autism Waiver and the annual "open interest" period, go to:

    DDS Children's Autism Waiver Service Program Overview | Mass.gov

- **TBI Waiver**
  - The MRC Connect portal is an entry point for all MRC programs, including the TBI Waiver: MRC Connect | Mass.gov

How to Access the HCBS Waivers

- **Frail Elder Waiver**
  - For questions about Frail Elder Waiver eligibility or the application process, go to MassOptions or call 1-800-243-4636.
  - Identify and call the ASAP in the individual's geographic area:

    Aging Services Access Points (ASAPs) in Massachusetts | Mass.gov

- **ABI/MFP Waivers**
  - For ABI/MFP outreach to individuals in nursing facilities, call MRC at 617-204-3747
  - For questions about ABI/MFP eligibility or the application process, call UMMS at 855-499-5109

Links to application forms for ABI and MFP Waivers	
ABI-RH: English / Spanish	ABI-N: English / Spanish
MFP-RS: English / Spanish	MFP-CL: English / Spanish

Helpful Links

- MFP Demo homepage:
  Money Follows the Person Demonstration | Mass.gov

- ABI and MFP Waivers homepage:
  Acquired Brain Injury (ABI) and Moving Forward Plan (MFP) Waivers | Mass.gov

- HCBS Waiver Participant videos:
  Mass Rehabilitation Commission - YouTube

Appendix

Other HCBS Waivers

Waivers for Adults with Intellectual Disability

For adults with intellectual disability age 22 and older who are at an ICF-ID (Intermediate Care Facility for Individuals with Intellectual Disabilities) Level of Care

- DDS is operating agency and provides case management
- Three ID waivers – differ by individual's need:

1. Intensive Supports Waiver: For participants with intensive need for supports due to severity of their functional limitations, behavioral and/or medical needs

2. Community Living Waiver: For participants with moderate level of support needs; i.e., less than 24-hour supervision or support per day

3. Adults Supports Waiver: For participants with lower intensity need for supports

Traumatic Brain Injury Waiver

For individuals with a TBI age 18 and older who are at a nursing facility or hospital Level of Care

- MRC is operating agency and provides case management.
- Participants must have a traumatic brain injury (i.e., a brain injury caused by external force).
- Includes both residential and non-residential services.

Children's Autism Waiver

For children birth through age 8 with autism spectrum disorders who are at an ICF-ID Level of Care

- DDS is operating agency and provides case management.
- Waiver provides intensive supports to children with autism spectrum disorders (ASD) and their families to help ensure that they can remain in their homes and actively participate with their families and community.
- Serves a complex population that includes families with multiple siblings on the Autism Spectrum, families whose primary language is one other than English, and children who have experienced multiple adverse childhood events, among other factors.

Introduction to MassHealth Waiver Team

Questions?

Massachusetts Rehabilitation Commission (MRC) Team

Massachusetts Rehabilitation Commission
CL Overview

Community Living Programs & Services

To be covered today

- Statewide Head Injury Program (SHIP)
- Supported Living Programs (SL)
- Assistive Technology
- Vehicle Modifications/Home Modifications
- Home Care Assistance Program (HCAP)
- Independent Living Centers (ILC)

Not covered today

- Vocational Rehabilitation
- MFP & ABI waiver, MFP demo
- Chapter 688
- Transition to Adulthood (TAP)
- Youth Leadership Forum (YLF)
- Young Leaders Rising (YLR)
- Youth Leadership Network (YLN)

MRC Connect

The purpose of MRC Connect is to improve the experience for people with disabilities and allow them to access and benefit from an array of MRC services. If you have a disability, MRC Connect can help you fill out an online application to match your needs to available MRC programs you may be eligible for.

Apply for these programs through MRC Connect:

- Vocational Rehabilitation (VR)
- Statewide Head Injury Program (SHIP)
- Home Care Assistance Program (HCAP)
- Supported Living (SL)
- Chapter 688
- https://www.mass.gov/mrc-connect

Eligibility determined outside of MRC Connect: Disability Determination services and Waiver services.

Statewide Head Injury Program (SHIP)

Established in 1985, SHIP supports individuals with traumatic brain injury and their families to access services in the community that maintain or enhance independence in the home, community or at work

- Funds for SHIP services come from several different sources
  - State Appropriation
  - Trust Fund
  - DUI Surcharge
  - Speeding Ticket Surcharge

Traumatic Brain Injury Waiver

- Provides supplemental funding for 100 individuals within SHIP who meet clinical and financial eligibility requirements, and who are at risk of institutionalization without funding

Statewide Head Injury Program (SHIP)

Residents of Massachusetts, **regardless of age**, with:

A documented externally caused traumatic brain injury (TBI) that has affected the ability of the individual to manage at pre-injury level of functioning

+

Significant impairments of behavioral, cognitive, and/or physical functioning resulting primarily from the externally caused TBI

+

Ability and willingness to participate in community-based services.

There is no financial eligibility criteria for SHIP.

Statewide Head Injury Program (SHIP)

SHIP supports individuals with traumatic brain injury and their families by funding services in the community that maintain or enhance independence in the home, community or at work.

Services Include:

- Skills Training
- Residential Services
- Shared Living
- Adult Companions
- Regional Service Centers
- Worcester Community Center
- Social/Recreational Programs
- Respite Services
- Family Assistance Program
- Substance Use Services
- Technical Assistance regarding TBI

Supported Living

What is Supported Living?

- The Supported Living Program provides **ongoing** case coordination for anyone one year out from graduating high school or turning 22 years of age to end of life, to live independently in the community.
- The program is built on the independent living philosophy which empowers consumers to make their own decisions about their lives, based on informed choice.

Services include:

- Finding accessible housing
- Managing:
    - PCA program
    - Medication
    - Health
    - Finances
    - Household
    - Transportation
- Requesting adaptive equipment Accessing educational, vocational, social & recreational opportunities
- Self-advocacy

For more information go to:

HTTPS://WWW.MASS.GOV/SERVICE-DETAILS/MRC-SUPPORTED-LIVING-PROGRAMS

Supported Living (SL) Expansion Program vs. SL

Program	Supported Living	Supported Living Expansion
Eligibility	-MA residents age 17 - end of life -Who are their own guardians and can direct their care -living with a primary severe physical disability and any additional impairment	-MA residents age 18+ end of life -Who are their own guardians and can direct their care -living with co-occurring conditions/behavioral health -People screening negative on Level II PASRR.
Application	MRC Connect referral	SLX Screening Tool
Service Entry Point	-SPED system (Ch.688, IEP, 504 Plan) -VR area office, PCM, ADRC OC (ILC/ASAP), providers, hospitals, SNFs	-SNFs (does ARPA funding have to be tied to SNF only?) -ADRC OC (ILC/ASAP), providers -CTLP coordinators, waiver case coordinators, -LTSS and peer mentors/support workers, etc.
Scope of Services	Ongoing vendored out case coordination assisting with: **1. PCA Surrogacy,** 2. Personal Health Care, 3. Financial Management, 4. Household Management, 5. Finding/Maintaining Accessible/Affordable Housing, 6. Access to social, educational, vocational, and recreational opportunities, 7. AT, VM, HM 8. Advocacy, 9. Access to transportation, 9. Remote Supports (if applicable)	Ongoing vendored out case coordination assisting with: While in SNF: Discharge & safety planning including lining up all needed supports for transition and service coordination, housing stabilization. Upon transition back into the community: **1. Behavioral Health Services**, 2. Personal Health Care, 3. Financial Management, 4. Household Management, 5. Finding/Maintaining Accessible/Affordable Housing, 6. Access to social, educational, vocational, and recreational opportunities, 7. AT, VM, HM 8. Advocacy, 9. Access to transportation, 10. Remote Supports (if applicable), **11. Peer supports**
Providers	SL Providers + Independent Case Managers (*new as of 11/2022)	Options Counselors + SL Providers + Independent Case Managers +

Supported Living Expansion

Goal: Provide supported living services to folks with co-occurring/behavioral health conditions currently in nursing facilities to be able to maintain in the community.

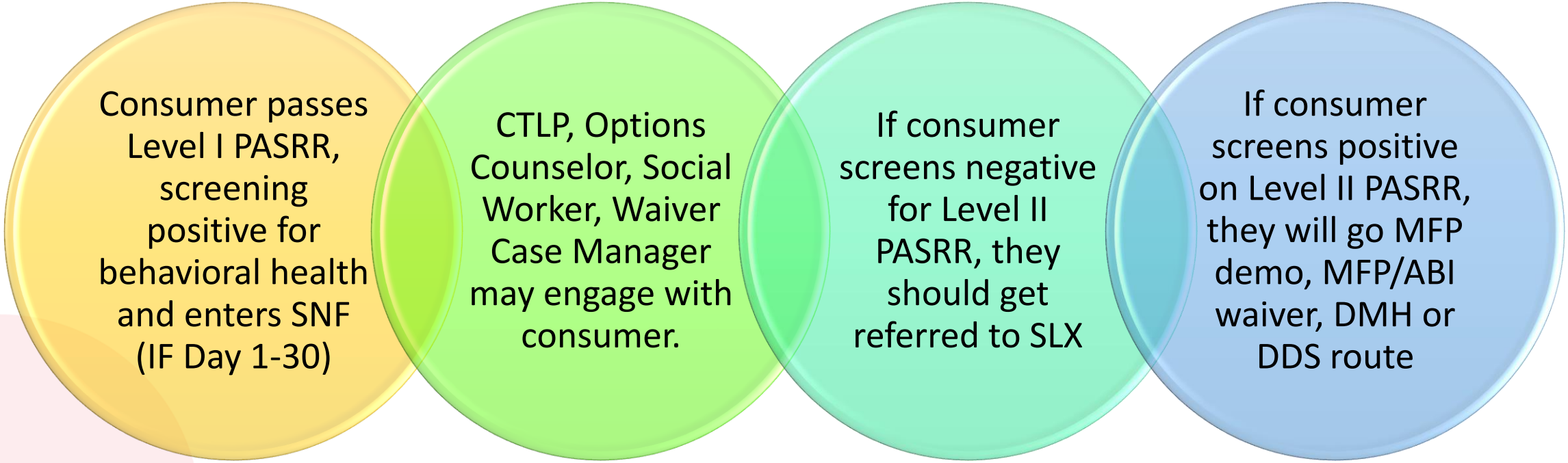
Overview:

- Individuals are ineligible for DMH, DDS or MRC waiver services and currently in a nursing facility between 1-30 days, not screening positive for Level II PASRR.
- Individuals need to be their own guardian and presumed to live safely in the community with the supports we can provide and have spent 1-30 days in a SNF.
- Supports range from assisting with behavioral health services, behavioral health supports, PCA surrogacy (if needed), home making, adaptive equipment, obtaining/maintaining housing, benefits, assisting with financial & household management, access to social, recreational, vocational and educational opportunities, transportation and advocacy, peer supports, remote supports
- Project duration: 07/2023-04/2025
- Referral information: individuals/support staff will submit a referral via the SLX Screening Tool

Supported Living Expansion Pilot

- Target area:
  - Suffolk County
  - Norfolk County
  - Middlesex County
  - Bristol County
- Target SL Providers (lead):
  - Bay Cove
  - Empower
  - UCP Boston
- Pilot ILC/RLC Partners:
  - NERLC/NILP
  - BCIL/MWCIL
  - SCIL
- Team Comp. (Pre-engagement):
  - CTLP/OC Representative
  - MRC Program Coordinator/Clinician (as needed)
  - SL Provider in Catchment area & Peer Support via ILC/RLC

Referral Mapping



Point of Entry

Presumptive Eligibility

- Given the profile of the targeted individual for the expansion, it is imperative to have fewer and warmer handoffs. Qualtrics screening tool will be submitted.
- Upon referral submission by CTLP/OC, the referral will go to SL directly and be reviewed and distributed to SLX vendor and Peer Support vendor within 2 business days based on presumptive eligibility.
- Vendors are asked to respond to referrals and reach out to referral source for warm handoff to SLX participant within 2 business days.
- Pre-engagement would ensure more information collection. SLX provider will submit the MRC Connect application and submit the assessment.

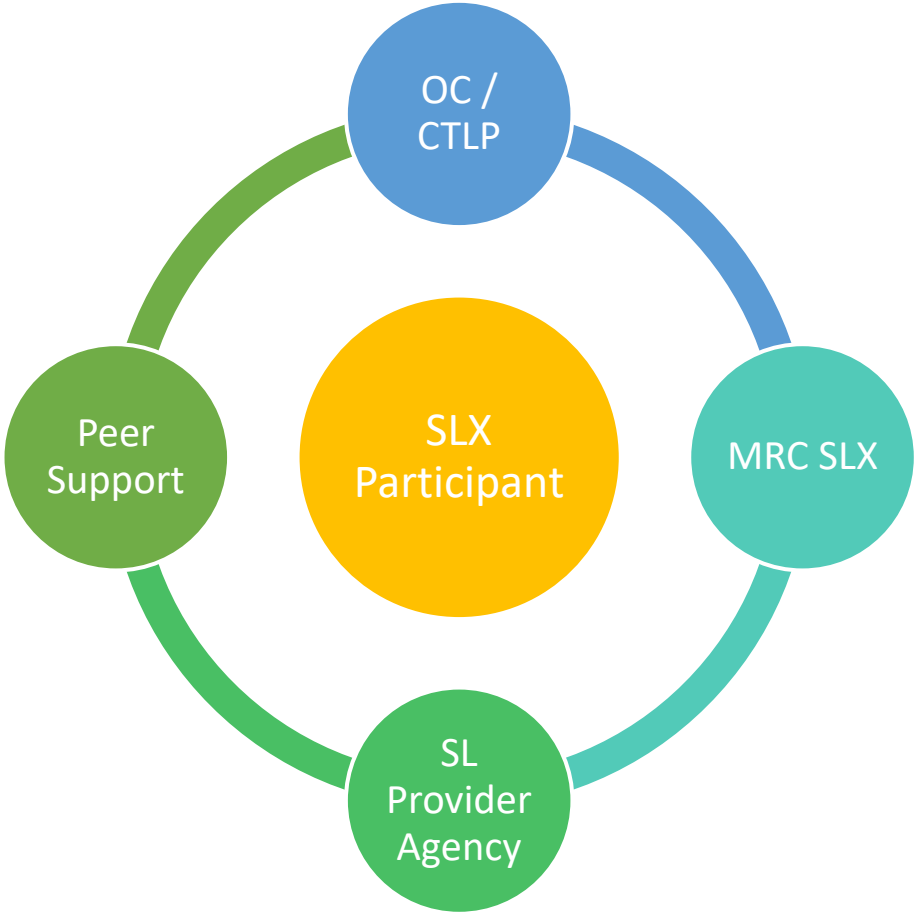
Pre-Engagement

1. Initial engagement with consumer by SLX referral source. CTLP/OC identify main need areas upon intake with potential SLX consumer and conduct basic screening via Qualtrics link which includes ROI.

2. Submission and receival of SLX referral will substantiate presumptive eligibility through assessment and service planning stage.

3. MRC will connect the integrated team in the region (i.e. SL provider (lead), Peer Support (ILC/RLC), contracted clinician (if needed) to engage with the consumer within two business days.

Integrated Team Roles



Hannah's journey

- Hannah is a 22 yr old female who lives with roommates in Greater Boston. Hannah has completed the first two years of her undergraduate degree and has had a number of short-term part-time and full-time jobs in customer service.
- During adolescence, Hannah started experiencing symptoms of bi-polar disorder and started self-medicating. Her family has not been supportive of her life choices and have removed themselves from her life.
- While she also on and off engaged in therapeutic supports, she has found it difficult to find a therapist she felt any type of bond with and felt that they were listening to her.
- Hannah has decompensated at times in her life and has attempted checking herself into psych units without any luck due to shortage of beds or medical staff assuming she was fine and did not need this level of intervention.
- Hannah has applied for and been denied DMH services in the past. She has also attempted applying for SSI and SSDI but has been denied.
- After her most recent break-up, she attempted suicide and swallowed her entire month's prescription bottle of sleep medication.
- Her roommate found her unconscious and called 911. The EMTs brought her to Mass General where she was able to get stabilized after being in critical care for a few days and on suicide watch. Hannah suffered an acquired brain injury, due her brain being deprived of oxygen for 5+ minutes until the EMTs got to her.
- Hannah spent a week at Mass General and was transferred to a skilled nursing facility for additional care as she was extremely weak and had to relearn a number of motor skills.
- While in the hospital, Hannah also found out her roommate was moving out and she either had to move out herself or get her landlord to agree to keep her living there and find another roommate to split the rent with as she did not have any income. In addition, the landlord was concerned about the status of the apartment as Hannah had been unable to maintain a level of cleanliness when she was not doing well.

Hannah's journey

- While gaining strength and movement at the SNF, she overheard some of her peers talking about an advocate they were working with to get back out into the community.
- Hannah felt overwhelmed with how to go about her living situation and supports needed once she left the SNF.
- Hannah connected with the Community Transition Liaison who submitted the SLX Qualtrics Screening Tool with her.
- MRC's SLX program received the referral information and send the referral under presumptive eligibility to both, the SLX provider agency and the peer support agency. Both were asked to engage within 48 hours.
- Provider X followed up with the referral source for the warm handoff along with the peer support entity.
- The Provider X and Hannah met with other by Hannah identified team members and discussed her needs regarding housing stabilization, peer supports, behavioral health supports, safety planning and any other services she may benefit from.
- Based on this, Provider X also submitted a supported living service plan and started coordinating with all additional services.
- With Hannah, Provider X reached out to her landlord, to discuss any possibilities of Hannah maintaining her living situation with additional services and another roommate at least until a more suitable and affordable option was found. Since the landlord was very concerned about Hannah's ability to maintain a clean apartment, Provider X initiated discussions with MRC to also provide HCAP services for basic housekeeping, etc. Provider X also helped Hannah in posting for a roommate and advertised the apartment through her local ILC network as well. Her goal was to find someone who could sympathize with her situation and would not jeopardize her sobriety.
- Provider X also focused on connecting Hannah with peer supports and out-patient services in addition to submitting a referral for an AT evaluation to add additional tools, reminder options, etc. to assist Hannah in getting through her day to day.
- Once all initial supports were identified and Hannah also completed a safety plan, a discharge meeting was held with all identified support parties present and everyone agreed to initiate transition.

Assistive Technology

MassMATCH

MA's initiative to enhance the independence of people living with disabilities.

- AT Regional Centers
- Short-term/long-term device loans
- AT Loan Program
- GetATStuff

*RE*Quipment/AT DME

Reutilization program

- Assistive Technology IL
- Provides low- and high-tech solutions to increase independence in life through low- and high-tech solutions. Provides devices, training, and other supports.
- Financial eligibility requirements.

Home & Vehicle Modifications

Goal: Provide access to adaptive vehicle and home modification services for consumers.

Overview:

- MRC will be able to fund vehicle modifications, driver evaluations as well as driver training for consumers.
- MRC will be able to fund home modifications for consumers including wheelchair ramps, widening of doors, installing stair lifts, etc.
- Project duration: 07/2022-04/2025

Home Care Program

The Home Care Assistance Program (HCAP) is a statewide program administered by the Commission for eligible individuals whose disabilities result in a need for homemaking and coordination of services in order to live independently in the community.

The Home Care Assistance Program provides needed homemaking and coordination of services to eligible individuals, age 18 through 59 with disabilities other than legal blindness.

Eligibility for the Home Care Program is based on the following criteria:

- Age
- has a medically documented physical or mental disability that results in the individual's inability to perform essential homemaking tasks
- the provision of homemaking services is necessary for the individual to live independently in the community
- the individual and any other adults in the home where the individual resides, are unable to perform the homemaking tasks, as determined in the Homemaking Services Eligibility Assessment, due to disability or the relationship between the individual and other adults in the home; and
- the individual meets the financial criteria pursuant to 107 CMR 11.11.

Independent Living Centers (ILCs)

The Mass Rehab Commission contracts with ten **Independent Living Centers (ILCs)** across the state, serving people of all ages regardless of the type of their disability.

At least 51% of the board and staff of ILCs are persons with disabilities.

ILCs provide:

- Information & Referral
- Skills Training
- Advocacy (Individual & Systems)
- Peer Counseling
- Transition services

Learn more - www.masilc.org

Independent Living Centers (ILCs) & ARPA

ILC consumers can become eligible for the following ARPA-funded projects:

- ARPA Wheelchair Ramp – Up to $13,000
- ARPA Home Modification – Up to $50,000
- ARPA Vehicle Modification – Up to $50,000
- ARPA Assistive Technology – Requests under $1500 should go through Part B

Eligibility

- Adults 17+ with a **physical or medical disability** at risk of institutionalization (without the requested service/item).
- People receiving services through ILCs and have a plan and goal (no ILP waiver).
- People who are unable to receive funds through another entity (will not qualify for this if tied to DDS or DMH or waiver)

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- ***Nefta Russell:*** Vehicle Mod/Home Mod ARPA Coordinator - Nefta.Russell@mass.gov
- ***Blessed Ovie:*** ARPA Coordinator – Blessed.Ovie@mass.gov

Resources

- Massachusetts Rehabilitation Commission (MRC)
- MRC Connect
- Benefits Counseling: Project Impact
- MassMATCH
- Assistive Technology Regional Centers
- Assistive Technology Loan Program
- REQuipment
- Assistive Technology Exchange
- Independent Living Centers
- Transition to Adulthood (TAP) Programs

Q&A

Thank you

What's Next?

Upcoming Meetings & Trainings

September CTLP Office Hours

Tuesday, September 12, 2023

10:00am – 11:00am

September CTLP Training

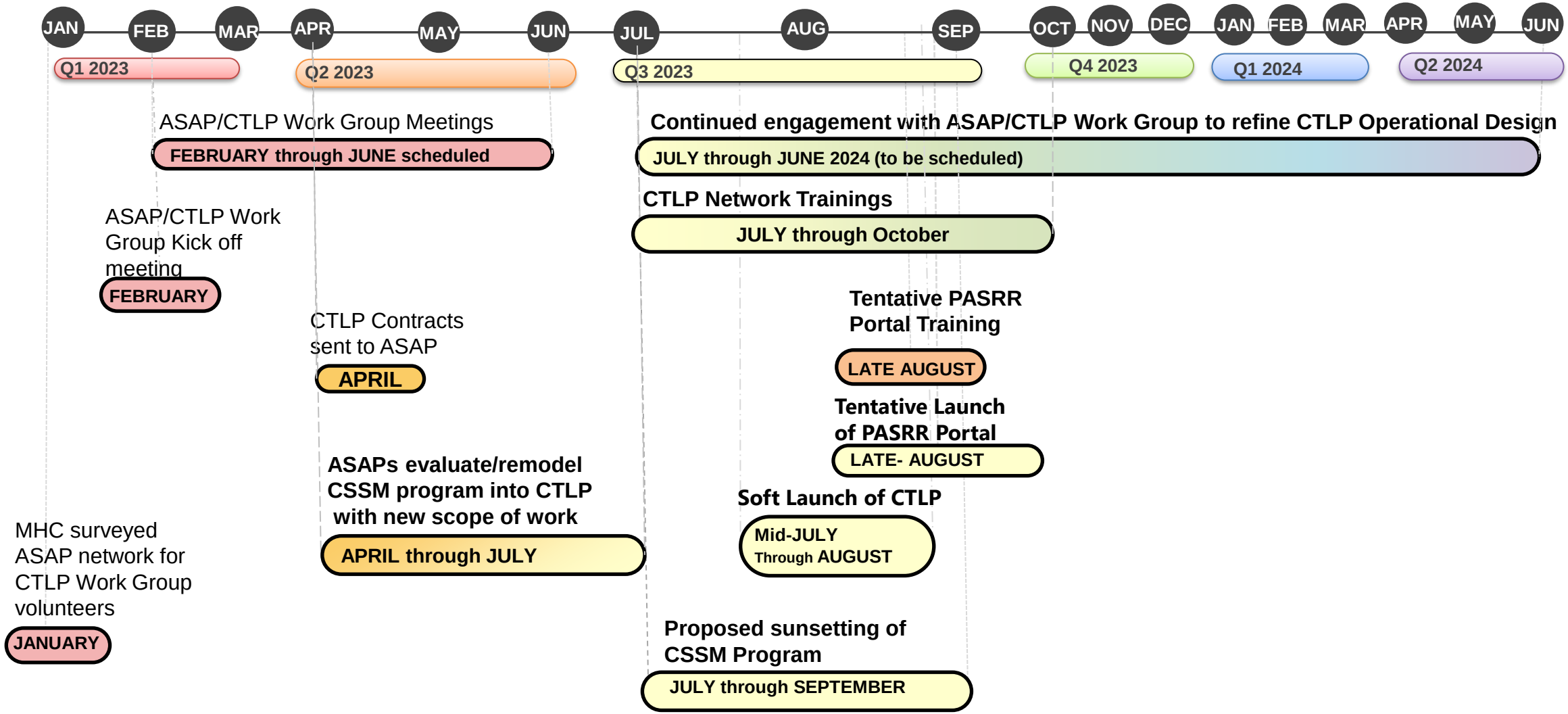
Tuesday, September 26, 2023

1:00pm – 3:00pm

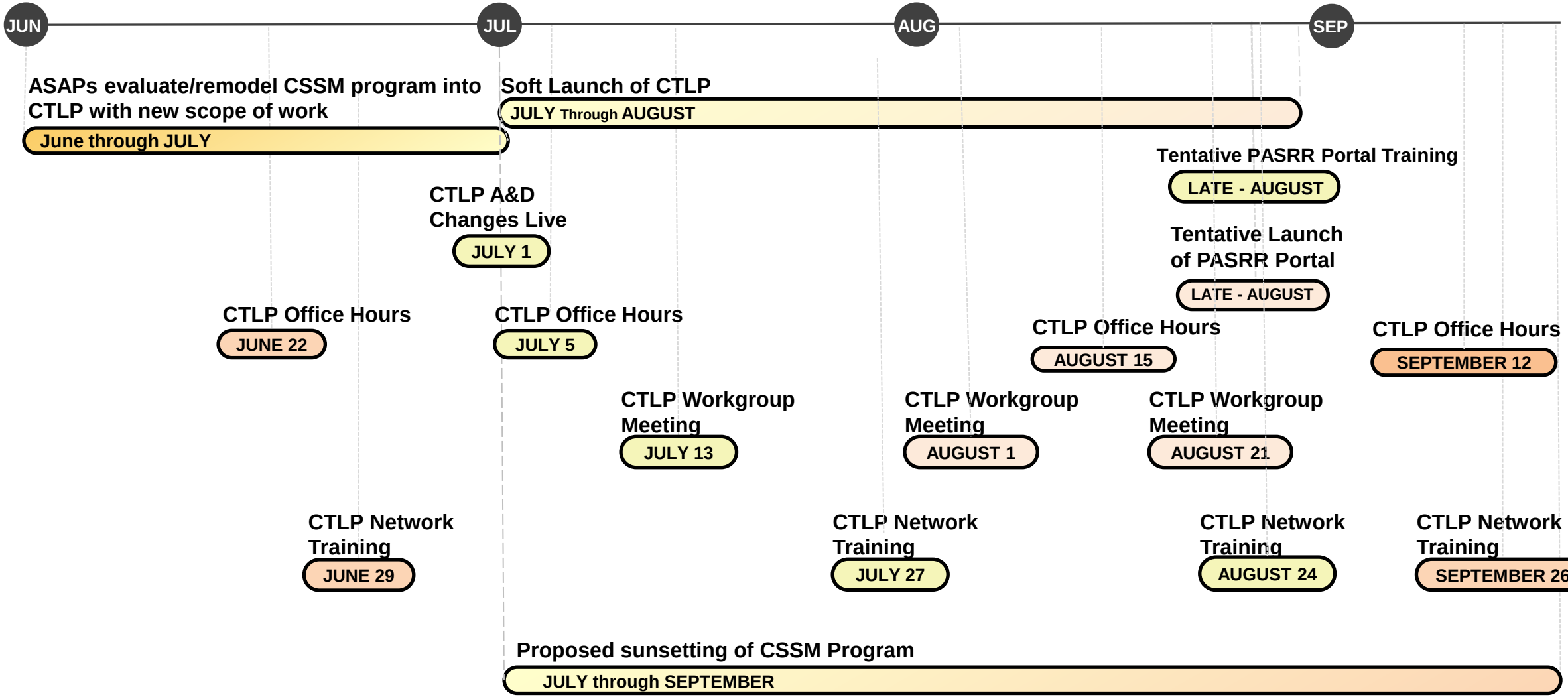
- *Guest Speakers: DDS & State Ombudsman Program*

Appendix

CTLP Operational Implementation Timeline CY2023 into CY2024



CTLP Operational Implementation Timeline: CTLP Soft Launch Window (updated)

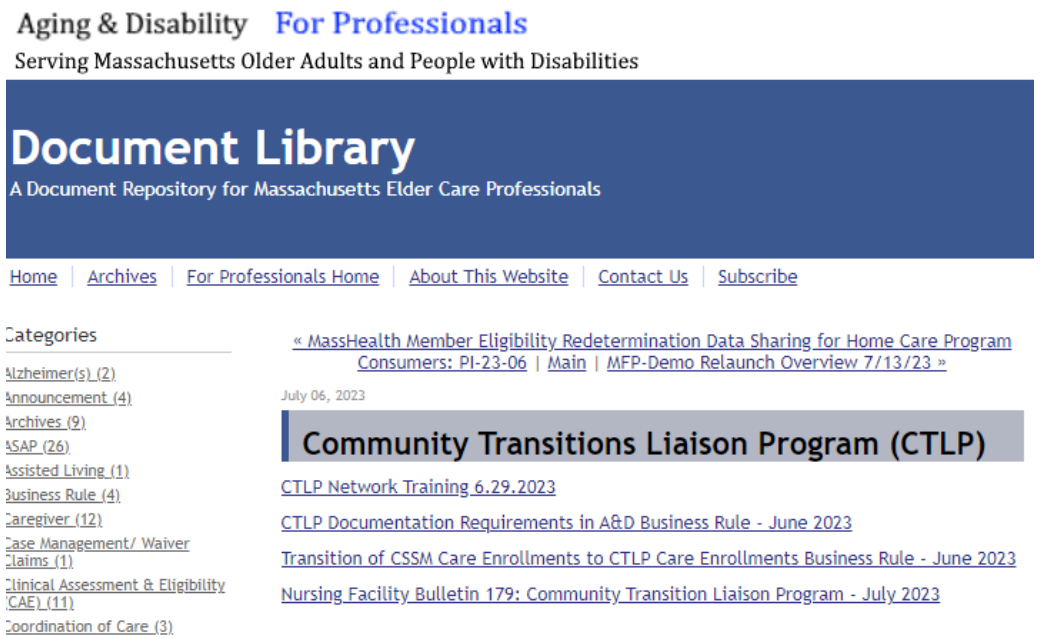


Resources

800AgeInfo – Document Library

https://documentlibrary.800ageinfo.com/2023/06/ctlp.html

- Available documents
  - CTLP Network Training 6.29.2023
  - CTLP Documentation Requirements in A&D Business Rule – June 2023
  - Transition of CSSM Care Enrollments to CTLP Care Enrollments Business Rule – June 2023
  - Nursing Facility Bulletin 179: Community Transition Liaison Program – July 2023



Resources

800AgeInfo – Document Library

https://documentlibrary.800ageinfo.com/2023/05/cssm-to-ctlp-transition.html

- Available documents
  - CSSM to CTLP ASAP Network Meeting Slide Deck
  - CTLP ASAP Minimum Skill Set Qualifications
- Password Protected Documents
  - Password = EOEA_homecare

Resources

800AgeInfo – Document Library

https://documentlibrary.800ageinfo.com/2020/09/cssm-business-rule-september-2020.html

Available documents

- CSSM Enrollments and Terminations Report User Guide
- CSSM Business Rule Sept 2020

CTLP Talking Points

Talking points provided to Nursing Facility Industry 6/15/2023 by MassHealth

Community Transition Liaison Program (CTLP), expansion of current Comprehensive Screening and Service Model (CSSM) Program

- What is the Community Transitions Liaison Program? Who is eligible?
  - The CCSM Program is managed by the Aging Services Access Points (ASAPs) and has been in existence since 2005. This program will be rebranded as the Community Transitions Liaison Program (CTLP) with enhanced funding and focus on supporting all nursing facility residents who are 22 and older, regardless of diagnosis or insurance type, who are interested in transitioning to the community.
  - Each nursing facility will have an assigned CTLP team of two people that will operate out of the regional Aging Services Access Point (ASAP) and will coordinate with other state agencies as needed to best support an individual interested in transitioning into the community.

- How will the CTLP teams get involved? Will they be on the premises?
  - Assigned CTLP teams will work with NF staff, NF Ombudsman, NF residents, family and informal supports as well as others.
  - CTLP teams will have a weekly on-site presence at the nursing facility.
  - CTLP teams will provide marketing materials (e.g., flyer, brochures) with program details and team contact information.
  - CTLP teams will be involved with and provide support in discharge planning meetings.
- What can I expect from the CTLP teams assigned to the residents in my facility?
  - CTLP teams will meet with residents to discuss their needs and provide options for a safe plan to return to community living, assist with applications for housing and public benefits including collecting all necessary documentation, and coordinate with state and community agencies to identify resources and make referrals.
  - To accomplish this CTLP teams may need the following from facilities:
    - Continued access to residents;
    - Access to a conference room or a copy machine;
    - Support to help share information about the CTLP program;
    - Referrals to the CTLP program.

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