COMMONWEALTH OF MASSACHUSETTS

Community Living Initiative Annual Report: Year One

Strengthening Pathways to Integrated Community Living for People with Disabilities

Informed Choice

Inclusion

Opportunity

Community

Colleagues, Friends, and Partners,

I am pleased to share with you the Commonwealth's first annual Community Living Initiative Report.

A coordinated effort across the Healey-Driscoll Administration, the Community Living Initiative expands opportunities for people with disabilities and older adults to live with dignity, independence, and choice within the communities they call home.

This work is grounded in the promise of the Supreme Court's landmark civil rights decision, *Olmstead v. L.C.*, which affirmed the rights of individuals to live in and receive services in the most integrated setting appropriate to their needs. In Massachusetts, that promise is not abstract. We carry forward this commitment every day.

Informed by our values and strengthened through partnerships with advocates, providers, and — most importantly — the individuals and families we serve, the Community Living Initiative reflects the Commonwealth's responsibility to turn our commitments into meaningful action.

State government plays a vital role in building the systems, supports, and housing opportunities that make community living possible. Through coordinated efforts across our state's health, human services, and housing agencies we are working to remove barriers, expand capacity, and ensure that people have real choices about where and how they live.

This report details expanded in-reach efforts to ensure individuals in nursing facilities are aware of and can access community-based options; strengthened behavioral health care coordination for individuals with serious mental illness residing in nursing facilities; and significant investments in affordable and accessible housing. It also highlights considerable progress towards our goal of helping at least 2,400 people with disabilities transition out of nursing facilities into the community over eight years.

Inside this report, you will see their faces and read their stories. Behind the numbers are real stories of independence restored, connections renewed, and lives reshaped. They reflect the dedication of frontline staff, the collaboration of state agencies, and the resilience of the people we serve.

This work is ongoing. The challenges are real, and the need for continued investment and innovation remains. But the progress outlined in this report demonstrates what is possible when we align our efforts around a shared vision of equity, inclusion, and opportunity.

Massachusetts has long been a leader in advancing community-based care. Through the Community Living Initiative, we are building on that legacy and reaffirming our commitment to ensuring that every resident is offered choice and has the opportunity to live with dignity.

Sincerely,

Kiame Mahaniah, MD, MBA
Secretary
Massachusetts Executive Office of Health and Human Services

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Overview of the Massachusetts Community Living Initiative

The Community Living Initiative is the Healey-Driscoll administration's focused effort to expand the state's capacity to support people with disabilities in community-based settings, and as an alternative to receiving services in a nursing facility.[1] The initiative reflects and builds upon the state's long-term commitment to reducing our society's reliance on long-term nursing facility care for persons with disabilities and expanding access and utilization of community-based services as a viable alternative.

Taking a multi-pronged approach, the initiative seeks to address the underlying reasons people with disabilities may enter, and remain in, long-term nursing facility care. This includes

- increasing awareness of community-based options,
- providing transition support to those interested in moving to the community, and
- addressing barriers to transition, such as housing needs—including increased access to subsidized housing and medically necessary home modifications—to make community living a viable alternative.

For persons identified as having serious mental illness through the state's nursing facility pre-admission screening and resident review (PASRR) process, the initiative seeks to improve the coordination and delivery of behavioral health services in nursing facilities to support successful transitions back into the community.

As part of this initiative, the Healey-Driscoll administration has set an ambitious goal: to assist at least 2,400 people with disabilities—who have resided in a nursing facility for 60-days or longer—to move from nursing facilities into community settings over the next eight years. While the number of transitions is an important benchmark, the broader goal is to build a stronger, more inclusive long-term care system that empowers people with disabilities to live in the places they choose.

The data in this report for the first year of the Community Living Initiative shows encouraging progress. Numbers alone, however, do not tell the whole story. Alongside the numbers, this report includes personal stories from Massachusetts residents who have successfully moved out of nursing facilities and back into the community under this initiative. Their stories reveal the true impact of this effort—highlighting the real people at the heart of this work. By combining facts with these firsthand experiences, the report provides a more complete understanding of how this initiative is improving the lives of Massachusetts residents across the state.

[1] The Community Living Initiative grew out of a class action settlement, Marsters v. Healey.

Year One Progress

The following pages highlight progress made during the first year of this initiative, focusing on four key areas:

1) **In-Reach into Nursing Facilities:** Efforts to identify and engage with people in nursing facilities about community living options
2) **Behavioral Health Care Coordination:** Efforts to improve coordination of behavioral health care for persons with Serious Mental Illness[2] (SMI) in nursing facilities
3) **Residential Services and Accessible Community-Based Housing Expansion:** Efforts to expand residential services and accessible community-based housing options as an alternative to nursing facility care
4) **Nursing Facility to Community Transitions:** Progress made towards the state's goal of helping at least 2,400 people with disabilities transition from nursing facilities to the community over eight years

1. In-Reach into Nursing Facilities

Effective in-reach is the foundation of the Community Living Initiative. Because many nursing facility residents may not know about the support outside of a nursing facility, in-reach requires staff who can engage with residents, build trust, and start conversations about returning to the community. In-reach ensures that nursing facility residents have real opportunities to learn about community living options and that they can make choices that reflect their preferences, values, and goals. Two core elements make this work successful: supporting informed choice and ensuring that staff performing in-reach are trained in culturally responsive communication.

The **first** core element—**informed choice**—guides how in-reach to nursing facility residents under the Community Living Initiative is performed, including

- how information about community options is shared, and
- how the resident's decision-making is supported throughout the process.

Grounding the in-reach process in informed choice ensures staff understand each nursing facility resident's needs, concerns, and strengths as well as their potential barriers to transition. Grounding the process in informed choice also ensures that staff know how to connect residents to community-based housing, services, and peer supports in ways that respect their autonomy and lived experience.

[2]SMI as defined under federal PASRR regulations at 42 CFR 483.102 (b)(1).

The **second** core element is **strong staff training based on** the national Culturally and Linguistically Appropriate Services (CLAS) framework. Integrating CLAS principles—such as cultural competence, health literacy, and responsive communication—into training ensures that case managers and transition staff performing in-reach under the Community Living Initiative provide a respectful, inclusive, and person-centered approach. The training helps staff engage effectively with nursing facility residents of all backgrounds and strengthens the quality of in-reach and transition planning.

Together, informed choice and training in the Culturally and Linguistically Appropriate Services (CLAS) framework create the foundation for meaningful, effective in-reach. The two primary in-reach vehicles under the Community Living Initiative are the **Community Transition Liaison Program (CTLP)** and the **Money Follows the Person Demonstration** (the 'MFP Demo').

The Community Transition Liaison Program

The Community Transition Liaison Program (CTLP), run by the Executive Office of Aging and Independence (AGE), helps people living in nursing facilities explore options for returning to community living. CTLP is available to all nursing facility residents age 22 and older, regardless of diagnosis or insurance status.

Through CTLP, two person teams, made up of a community transition liaison and a case assistant, are based at all 24 Aging Services Access Points (ASAPs) across the state and overseen by AGE. Each CTLP team makes regular on-site visits to their assigned nursing facilities to meet with residents to inform them about and discuss available community options, and offer hands-on support throughout the transition process for residents interested in moving back to the community.

In Year One, 45 two-person CTLP teams made **17,177** in-person visits to nursing facilities across Massachusetts, reaching residents in all **327** Medicaid-participating nursing facilities. As a result, **3,152** nursing facility residents enrolled in the program to obtain assistance moving back into the community, and **728** transitions were completed by CTLP.

Table 1: *Community Transition Liaison Program (CTLP) Chart: Number Enrolled State Fiscal Year 2025 and Number of CTLP Assisted Transitions*

State Fiscal Year	CTLP Enrollment	All CTLP Assisted Transitions
2025	3,152	728[3]

[3] Includes transition support provided to individuals who resided in a nursing facility for less than 60 days.

Colleen’s Journey Home

A Community Transition Liaison Program Success Story

After suffering a stroke, Colleen’s life, and her husband’s, changed overnight. What began as a short-term nursing facility stay stretched into more than two years, separating her from her home and the life she shared with her husband. When Colleen met with the Community Transition Liaison Program (CTLP), she shared a clear goal: to return to the community and live with her husband again.

CTLP worked alongside Colleen to explore her options and help address the barriers preventing her return home. Her former apartment was not accessible, and installing a ramp was not possible, so the team helped her search for housing that would meet her needs. After months of effort, Colleen and her husband were offered an accessible, subsidized apartment in a nearby town. CTLP helped coordinate the move and put home health, therapy, and nursing supports in place so she could live safely at home.

Colleen has since moved into her new home, reuniting with her husband after more than two years apart. In the weeks that followed her move, the CTLP team checked in as Colleen and her husband settled in. Grateful for the support, the couple shared a thank-you email and a “selfie” photo celebrating their first night together under one roof. Today, Colleen and her husband are together again in the community, taking part in local activities and continuing to rebuild their daily lives side by side.

The Money Follows the Person Demonstration

In addition to CTLP, the state performs in-reach into nursing facilities through the Money Follows the Person Demonstration (the 'MFP Demo'). The MFP Demo helps MassHealth eligible individuals move out of nursing facilities and back into the community. It is designed for people who have lived in a nursing facility for at least 60 days and are interested in returning to community living.

As part of the MFP Demo, state agency staff from MassAbility and the Department of Developmental Services conduct in-reach into nursing facilities to speak with residents about their options for community living and to offer support with the transition process for individuals interested in moving back into the community. Nursing facility residents who enroll in the MFP Demo receive case management and access to additional supports funded through the Demonstration. These additional supports may include help finding housing, start-up funds to furnish their new home, as well as medically necessary home modifications to make their new living space safe and accessible.

The MFP Demo works alongside CTLP, offering another way for nursing facility residents to learn about and access community living options. Depending on their situation and preferences, individuals may choose to participate in one or both programs.[4]

In the first year of the Community Living Initiative, state agency staff from MassAbility and the Department of Developmental Services conducted **1,328** in-person nursing facility visits through the MFP Demo across the state's **327** Medicaid participating nursing facilities, and which is in addition to the in-reach visits conducted through CTLP. Through the combined CTLP and MFP Demo in-reach efforts, **1,247** nursing facility residents enrolled in the MFP Demo program and **438** transitions were completed.

***Table 2**: Money Follows the Person (MFP) Demonstration Chart: Number Enrolled State Fiscal Year 2025 and Number of Transitions*

State Fiscal Year	MFP Demo Enrollment	MFP Demo Participants (transitioned to the community)
2025	1,247	438

[4] Individuals enrolled in both CTLP and the MFP Demo receive case management and transition support from a single state entity to prevent duplication of case management and transition support services.

Richard's Journey Home

An MFP Demo Success Story

For more than two years, 74-year-old Richard lived in a nursing facility, receiving care for Chronic Obstructive Pulmonary Disease (COPD). Although he wanted to return to the community, he lacked both housing and the transition support needed to navigate that move. That changed when, through In-Reach provided through the MFP Demo, he enrolled in the MassHealth Moving Forward Plan—Community Living (MFP-CL) Waiver program. With the guidance from his MFP-CL case manager, Richard navigated housing applications and in February 2025, secured state-subsidized housing in Cambridge, Massachusetts.

Richard's MFP-CL waiver team coordinated his transition by managing logistics and helping him set up his new home. Once settled, he began receiving home health aide services, skilled nursing, and transportation services.

In his new apartment, Richard has found both stability and joy. He now spends time with his daughter and grandchildren, takes short walks in his neighborhood with oxygen support, and continues to build strength and confidence.

Quarterly visits and phone calls with his MFP-CL case manager now tell a different story—one marked by renewed energy and optimism. Richard says he feels "like a new person" and describes a positive outlook on life that is very different from how he once felt. "I don't know what I'd do without the waiver program," he shared. "I'd probably still be in a nursing facility, feeling like that's where I'd spend the rest of my days." Richard's experience illustrates how person-centered transitions can restore dignity, connection, and quality of life, even in the face of chronic illness.

2. Behavioral Health Care Coordination

A core component of the Community Living Initiative is its focus on improved coordination of behavioral health services for persons with serious mental illness (SMI) in nursing facilities, which brings together three key programs:

- the Commonwealth's pre-admission screening and resident review (PASRR) program,
- the Behavioral Health Community Partners program, and
- the Department of Mental Health (DMH) Transition Case Management program.

Together, these programs help identify nursing facility residents with serious mental illness (SMI)[5] prior to admission, coordinate the behavioral health services they need while in the nursing facility, and support safe, successful transitions back to the community. This coordinated model ensures that individuals with PASRR-identified SMI receive consistent, person-centered care from admission through discharge planning.

Pre-Admission Screening and Resident Review

For persons with serious mental illness (SMI)[6] , or suspected of having SMI, the Commonwealth operates a pre-admission screening and resident review (PASRR) program according to federal requirements. Through PASRR, the Commonwealth is able to ensure that persons seeking admission to a nursing facility are screened for SMI and that persons suspected of having SMI receive a comprehensive evaluation prior to their admission. The comprehensive evaluation includes an assessment, recommendation, and determination as to whether the person's total care needs can be met in a nursing facility or whether community-based services would be more appropriate.

Under the Community Living Initiative PASRR plays a critical role by identifying individuals with serious mental illness and determining whether nursing facility admission is appropriate, and if so, the behavioral health services and supports they may require while in the nursing facility. In Year One, **108,702** PASRR Level I screenings were completed to determine if a person was suspected of having SMI, and **7,245** PASRR Level II evaluations were conducted to confirm whether a person had SMI. Of these, **389** were determined to have SMI and with care needs appropriate for admission to a nursing facility.

[5] SMI as defined under federal PASRR regulations at 42 CFR 483.102 (b)(1).
[6] Ibid.

Table 3: *PASRR Screenings for SMI, State Fiscal Year 2025*

PASRR Screenings Completed	Metrics
Number of PASRR level I screens completed July 2024-June 2025 *The PASRR Level I screen assesses whether a person may have SMI. If the screening indicates the assessed person may have SMI a PASRR Level II evaluation is performed.*	108,702
Number of PASRR level II evaluations completed July 2024-June 2025 *The PASRR level II evaluation determines whether a person has SMI.*	7,245
Number of nursing facility residents with PASRR-identified SMI	389

Behavioral Health Community Partners in Nursing Facilities

Behavioral Health Community Partners are central to supporting nursing facility residents identified through the pre-admission screening and resident review program as having serious mental illness (SMI). Through this program, the Executive Office of Health and Human Services (EOHHS) partners with Behavioral Health Community Partner organizations—specialists in behavioral health care—to coordinate the services recommended through PASRR while the person is admitted to the nursing facility. The goal is to strengthen care coordination and improve access to behavioral health services for nursing facility residents with SMI. Their work includes helping nursing facility residents stay engaged in treatment and coordinating communication among all providers involved in the nursing facility resident's care. In Year One, **894 nursing facility residents** with PASRR-identified serious mental illness received Behavioral Health Community Partners' support.

Department of Mental Health Transition Case Management

For nursing facility residents with PASRR-identified SMI who are anticipated to transition to the community within 90 days, the Department of Mental Health (DMH) provides a specialized Transition Case Management program. DMH transition case managers are trained to ensure that behavioral health supports are in place before discharge and that each nursing facility resident has a clinically appropriate, person-centered transition plan. Their work includes coordinating outpatient behavioral health care, setting up services with community providers, ensuring continuity of medications and treatment plans, and addressing housing, safety, and crisis planning needs specific to each individual.

Through the combined efforts of the pre-admission screening and resident review program, Behavioral Health Community Partner care coordination, and DMH transition case management, the Commonwealth is working to strengthen cross-agency behavioral health coordination. By integrating these efforts, Massachusetts helps ensure that behavioral health challenges do not prevent nursing facility residents from returning to community living—and that individuals with SMI can transition safely, confidently, and with the supports they need to thrive in the community.

In Year One, DMH successfully supported the transition of **127** nursing facility residents to the community through its nursing facility transition case management efforts. For individuals returning to a DMH supported housing environment or to their own apartments with DMH supports, DMH facilitated multidisciplinary team meetings to ensure that needed behavioral and home care services were coordinated at the time of discharge. For individuals transitioning to the community through other state agency programs, such as the Moving Forward Plan Residential Supports waiver, DMH transition case management staff collaborated with partner agencies to support safe and timely transitions to community-based settings.

Table 4: *Behavioral Health Community Partners and Department of Mental Health (DMH) Nursing Facility Transition Team: Year One Data*

Behavioral Health Community Partners Care Coordination Enrollment and DMH Nursing Facility Transition Team Supported Transitions: Year One	Metrics
Number of persons with PASRR-identified SMI enrolled with Behavioral Health Community Partners care coordination	894
Number of persons with PASRR-identified SMI who transitioned from a nursing facility to the community with transition support provided by the DMH Nursing Facility Transition Team	127[7]

[7] Includes transition support provided to individuals who resided in a nursing facility for less than 60 days.

Brian’s Journey Home

A DMH Transition Case Management Success Story

At 62, Brian’s life took a sharp turn when he suffered a significant mental health crisis, leading to hospitalization and then placement in a nursing facility in late 2023. What began as a short stay for physical and occupational therapy stretched into more than 20 months. Needing hands-on support with activities of daily living and managing mental health challenges, substance use, and multiple hospitalizations, Brian faced significant barriers to discharge—but also showed unwavering determination to rebuild his life in the community. With support from the Department of Mental Health (DMH), he connected with a DMH transition case manager who would become a key partner in helping him pursue his goal of living on his own again.

Brian’s transition centered on person-focused care, elevating his voice and choices throughout the process. With support from his DMH case manager, he applied for and accepted into the MassHealth Moving Forward Plan - Community Living (MFP-CL) waiver. Brian’s MFP-CL waiver team helped him secure accessible housing in the community, arranged for home health aides, visiting nurse services, substance use treatment, and psychiatric and primary care follow-up. Every detail—from medication management to mobility support—was tailored to help Brian thrive in a less restrictive, community environment.

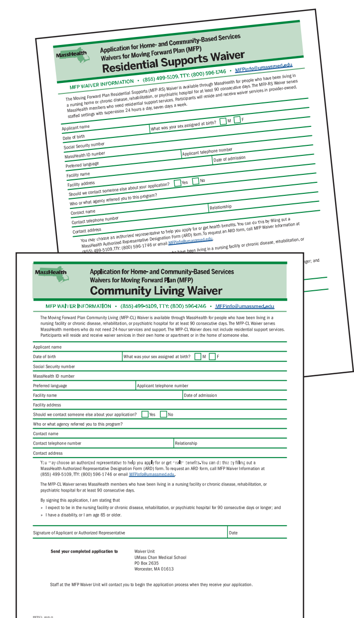
Brian has since moved into his own accessible apartment in Charlestown. With daily home health support, ongoing clinical oversight, and engagement in outpatient treatment, he has remained stable, connected, and increasingly confident in his independence. He has built friendships within his building and regained a sense of belonging that had been missing for years.

3. Residential Services and Accessible Community-Based Housing Expansion

For many nursing facility residents, the ability to return to the community depends on the availability of safe, affordable housing along with the long-term services and support needed to maintain independence. Recognizing this, as part of the **Community Living Initiative** the Commonwealth has committed to expanding residential services and community-based housing options to people leaving nursing facilities, ensuring that individuals have real, meaningful choices about where and how they live. This effort includes expanding capacity in MassHealth's two Home and Community-Based Services (HCBS) waivers that are specifically designed to support individuals transitioning from facility-based care to the community. It also focuses on strengthening and broadening the full continuum of community living options for people with disabilities—from fully staffed residential settings to independent housing with targeted in-home supports—while investing in rental subsidies and home modifications that help ensure housing is both accessible and affordable.

Moving Forward Plan Waivers

The MassHealth **Moving Forward Plan–Residential Supports (MFP-RS) waiver,** operated by the Department of Developmental Services (DDS), serves individuals who require 24/7 supervision and support in provider-operated settings. The MassHealth **Moving Forward Plan–Community Living (MFP-CL) waiver,** operated by MassAbility, supports individuals who are able to live independently in their own homes or apartments with targeted services.



MassHealth

Application for Home- and Community-Based Services
Waivers for Moving Forward Plan (MFP)
Residential Supports Waiver

MFP WAIVER INFORMATION • (855) 499-5109, TTY: (800) 596-1746 • MFPinfo@umassmed.edu

The Moving Forward Plan Residential Supports (MFP-RS) Waiver is available through MassHealth for people who have been living in a nursing home or chronic disease, rehabilitation, or psychiatric hospital for at least 90 consecutive days. The MFP-RS Waiver serves MassHealth members who need residential support services. Participants will reside and receive waiver services in provider-owned, staffed settings with supervision 24 hours a day, seven days a week.

Applicant name
Date of birth | What was your sex assigned at birth? ☐ M ☐ F
Social Security number
MassHealth ID number | Applicant telephone number
Preferred language | Date of admission
Facility name
Facility address
Should we contact someone else about your application? ☐ Yes ☐ No
Who or what agency referred you to this program?
Contact name | Relationship
Contact telephone number
Contact address

You may choose an authorized representative to help you apply for or get health benefits. You can do this by filling out a MassHealth Authorized Representative Designation Form (ARD) form. To request an ARD form, call MFP Waiver Information at (855) 499-5109, TTY: (800) 596-1746 or email MFPinfo@umassmed.edu.

MassHealth

Application for Home- and Community-Based Services
Waivers for Moving Forward Plan (MFP)
Community Living Waiver

MFP WAIVER INFORMATION • (855) 499-5109, TTY: (800) 596-1746 • MFPinfo@umassmed.edu

The Moving Forward Plan Community Living (MFP-CL) Waiver is available through MassHealth for people who have been living in a nursing facility or chronic disease, rehabilitation, or psychiatric hospital for at least 90 consecutive days. The MFP-CL Waiver serves MassHealth members who do not need 24-hour services and support. The MFP-CL Waiver does not include residential support services. Participants will reside and receive waiver services in their own home or apartment or in the home of someone else.

Applicant name
Date of birth | What was your sex assigned at birth? ☐ M ☐ F
Social Security number
MassHealth ID number
Preferred language | Applicant telephone number
Facility name | Date of admission
Facility address
Should we contact someone else about your application? ☐ Yes ☐ No
Who or what agency referred you to this program?
Contact name
Contact telephone number | Relationship
Contact address

You may choose an authorized representative to help you apply for or get health benefits. You can do this by filling out a MassHealth Authorized Representative Designation Form (ARD) form. To request an ARD form, call MFP Waiver Information at (855) 499-5109, TTY: (800) 596-1746 or email MFPinfo@umassmed.edu.

The MFP-CL Waiver serves MassHealth members who have been living in a nursing facility or chronic disease, rehabilitation, or psychiatric hospital for at least 90 consecutive days.

By signing this application, I am stating that

- I expect to be in the nursing facility or chronic disease, rehabilitation, or psychiatric hospital for 90 consecutive days or longer; and
- I have a disability, or I am age 65 or older.

Signature of Applicant or Authorized Representative | Date

Send your completed application to Waiver Unit
UMass Chan Medical School
PO Box 2635
Worcester, MA 01613

Staff at the MFP Waiver Unit will contact you to begin the application process when they receive your application.

MFP-CL_2025-11

As part of the Community Living Initiative, the Commonwealth has committed to expanding both waivers to increase community-based options. This includes expanding the MFP-RS waiver by adding capacity to serve 50 additional people each year over eight years for a total increase in capacity to serve 400 additional people. This additional capacity will help nursing facility residents with significant care needs transition to provider-operated settings—such as group homes and Shared Living—that offer round-the-clock supervision and support.

For individuals who can live independently with supportive services, the Commonwealth has committed to expanding capacity in the MFP-CL waiver over eight years to serve an additional 595 persons. This additional capacity will allow more people to receive in-home supports, personal care, assistive technology, and other services available under the MFP-CL waiver that help people live safely in their own home within the community.

Year One Progress

In the first year of the Community Living Initiative, MassHealth increased capacity across the two waivers by **125 slots**, strengthening pathways for individuals to move from facility-based settings to community living.

Table 5: *MFP Waiver Expansion Community Living Initiative Year One*

Moving Forward Plan Waivers Capacity Expansion: Year One	Slots Added
Moving Forward Plan – Residential Supports Waiver	50
Moving Forward Plan – Community Living Waiver	75
Total Additional Capacity Added: Year One	125

Department of Mental Health Supported Housing Continuum

The Massachusetts Department of Mental Health (DMH) maintains a comprehensive continuum of provider-staffed residential settings designed to support individuals with mental illness in the least restrictive setting appropriate to their clinical needs. As part of the Community Living Initiative, DMH has committed to expanding this continuum of provider operated settings to better support individuals seeking to transition from a nursing facility to a community setting.

DMH's supported housing continuum is designed to align service intensity with clinical needs, and includes the following types of settings:

- **Enhanced Medical Group Living Environments (Enhanced Medical GLEs)** serve individuals with significant psychiatric conditions accompanied by complex medical needs.
- **Intensive Group Living Environments (Intensive GLEs)** provide highly structured supports and staffing for individuals who benefit from substantial oversight but have more stabilized medical needs.
- **Group Living Environments (GLEs)** offer shared housing with consistent staff support, fostering autonomy while reinforcing daily living skills, treatment engagement, and community participation.
- **Supported Independent Environments (SIEs)** represent the least restrictive provider-staffed setting, combining independent housing with scheduled, individualized outreach that promotes housing stability, self-determination, and sustained recovery.

Increasing capacity across the continuum strengthens opportunity for movement across settings, allowing individuals to transition to Enhanced Medical GLEs (rather than to a nursing facility) if clinical needs intensify, or to less restrictive options such as Supported Independent Environments (SIEs) as stability and skills grow. This person-centered approach ensures the right level of support at the right time while promoting recovery, independence, and long-term community living.

In Fiscal Year 2025, DMH expanded capacity in its supported housing continuum by adding **10 Group Living Environments, 3 Intensive GLEs, and 6 Supported Independent Environments,** creating **186 new beds** and increasing community-based options for individuals across varying levels of need.

Table 6: *Year One: Increase in Department of Mental Health Supported Housing Capacity*

Reporting Period June 17, 2024-June 30, 2025	**Intensive Group Living Environment**	**Group Living Environments**	**Supported Independent Environments**
New Sites	3	10	6
New Beds	24	54	108

Rental Subsidies for Accessible, Affordable Housing

Accessible housing that is affordable is foundational to successful community living. The Community Living Initiative supports this objective by expanding rental subsidies for individuals with disabilities through programs administered by both the Department of Mental Health (DMH) and the Executive Office of Housing and Livable Communities (EOHLC). Through the Community Living Initiative, DMH has committed to expanding its rental subsidy program to support an additional **320 individuals** over the course of the initiative. These subsidies bridge the gap between what a person can afford and market rents and are paired with DMH-funded services and clinical supports to promote housing stability, independence, and recovery.

Through EOHLC, the Commonwealth has also committed to creating **800 new subsidized housing opportunities** for older adults and people with disabilities transitioning from nursing facilities over the next eight years. Developed through a combination of mobile and project-based vouchers as well as targeted capital investments, these units reflect the recognition that affordable accessible housing is critical to expanding community living options and sustaining successful transitions to the community.

Year One Progress

In the first year of the Community Living Initiative, DMH added **192 rental subsidies**, while EOHLC added **259 rental subsidies,** significantly expanding access to affordable housing for people with disabilities.

Table 7: *Year One: Increase in Department of Mental Health and Executive Office of Housing and Livable Communities Rental Subsidies for Accessible Affordable Housing*

Reporting Period	DMH Rental Subsidies	EOHLC Rental Subsidy
June 17, 2024-June 17, 2025	192	259

Medically Necessary Home Modifications

Another way the Commonwealth is advancing accessible, affordable housing for individuals with disabilities is through programs that fund medically necessary home modifications. Removing physical barriers in the home helps address a major challenge that can prevent individuals from leaving nursing facilities and returning to community living.

Through the Moving Forward Plan–Community Living (MFP-CL) waiver and the Money Follows the Person Demonstration, the Commonwealth provides up to **$50,000 per participant** for modifications such as ramps, widened doorways, and accessible bathrooms. These investments enhance the safety and accessibility of home environments, enabling individuals with mobility or functional limitations to return to homes that support independence and provide a practical pathway to live in the setting of their choice while strengthening long-term community living.

In the first year of the Community Living Initiative, MassAbility completed 100 home modification projects. Of these 100 projects, 80 were considered major home modifications (costing more than $5,000) and the average cost of home modification projects was $21,254.

Table 8: *Home Modifications by MassAbility FY2025*

State Fiscal Year	Major Home Modifications (>$5,000)	Minor Home Modifications (<$5,000)	Total	Average Home Modification Cost
2025	80	20	100	$21,254

Colleen's Journey Home

A MassAbility Home Modification Success Story

After nearly a year in a nursing facility recovering from a stroke, 65-year-old Colleen returned home on May 30, 2025. Throughout her recovery, she remained unwavering in her determination to reunite with her family under one roof. The journey home, however, was not easy. Her stroke resulted in complex care needs that demanded significant modifications to her living space. Compounding these challenges, her apartment complex initially denied requests to alter the fixed structures. Through the Community Living Initiative, and with support from MassAbility's Home Modification program, a path forward emerged.

Staff at MassAbility's Home Modification Program identified adaptive equipment that could make independent living possible without structural changes to her apartment. A custom shower transfer system and lift devices were installed. Along with these modifications, home health services, skilled nursing, therapy, and individual supports were woven into Colleen's care plan, and her daughter Jessica took on the role of direct care worker through the MFP-CL Waiver Self-Directed Program—enabling her daughter to be one of her care supports.

Today, Colleen is thriving in the community, living with her family under one roof and making steady progress in her recovery. A published author of five books, she remains passionate about writing and is determined to strengthen her word-finding skills with the support of speech therapy and her family. Colleen's story reflects not only her personal resilience but also the impact of the Community Living Initiative and MassAbility's Home Modification Program in making community living, and a meaningful return home, possible.

4. Nursing Facility to Community Transitions

All of the efforts described above—including in-reach and engagement, behavioral health care coordination for persons with PASRR-identified SMI, and the expansion of residential services and supports—are aimed at one ultimate goal: helping people with disabilities move out of nursing facilities and return to community living.

In the first year of the Community Living Initiative, Massachusetts made meaningful progress toward its long-term goal of helping at least 2,400 nursing facility residents with disabilities—who had resided in a nursing facility for 60 days or longer—transition to the community over eight years. Thanks to strengthened in-reach, improved behavioral health coordination, expanded residential capacity, and targeted housing and home modification supports, more residents were able to consider community living as a real option—and many achieved it. In Year One, **391 individuals** who had resided in a nursing facility for more than 60-days successfully transitioned from nursing facilities back to the community with support provided under the Community Living Initiative.

Transitions occurred across all regions of the Commonwealth, supported by AGE's Aging Services Access Points (ASAPs), MassAbility, the Department of Mental Health (DMH), the Department of Developmental Services (DDS), and many other partners. Individuals moved into a wide range of settings—independent apartments, supportive housing, group living environments, Shared Living homes, and homes with family—depending on their clinical needs, functional abilities, and personal preferences. This variety reflects the initiative's commitment to informed choice and person-centered planning.

Those who transitioned to community living represented diverse ages, disabilities, linguistic, and cultural backgrounds. Many had significant medical, behavioral health, or mobility needs, underscoring the value of enhanced care coordination and accessibility supports. Home modifications, rental assistance, dedicated transition case management, and Behavioral Health Community Partners coordination were essential in creating safe and sustainable pathways back to the community.

The chart on the next page highlights Massachusetts Year One progress, illustrating not only the number of transitions but also the types of community settings individuals chose. Together, these metrics show how the initiative is expanding opportunities for nursing facility residents to live safely, independently, and with dignity in the community.

Table 9: *Year One Community Living Initiative Transitions by Community Setting*

Year One 'Countable' Community Living Initiative Transitions by Community Setting[9]	Metrics
Own Home or Apartment	139
Own Home or Apartment with Housing Subsidy	109
Own Home or Apartment with Home Modification	28
Provider Operated Setting (e.g. Group Home, Shared Living, Group Living Environment)	97
Assisted Living Facility	15
PACE Housing Site	3
Total	391

[8] For a transition to be 'countable' towards the Community Living Initiative's goal of assisting at least 2,400 individuals to transition from a nursing facility to the community, the individual must have resided in a nursing facility for more than 60 days.

IndiaCali's Journey Home

A Moving Forward Plan Waivers Success Story

For many years, IndiaCali lived independently in the community with support from MassHealth Personal Care Attendant (PCA) services. As her mobility declined, she required more support and medical oversight, leading to her admission to a skilled nursing facility in December 2017 for treatment of severe bed sores, renal failure, and nocturnal hypoxia.

What was intended to be a short stay ultimately extended into seven years.

Determined to return to the community, IndiaCali remained focused on her goal of living in the community again. Through the Community Living Initiative, she pursued that goal with support from her transition team, which assisted her in enrolling in the Money Follows the Person–Residential Supports (MFP-RS) Waiver Program. Through the program, IndiaCali was able to move to a four-person group home with staffing support for her health needs.

Since transitioning to her MFP-RS waiver group home, IndiaCali has made significant progress.

With physical and occupational therapy twice a week, she continues to build strength and confidence. Initially fearful of falling, she worked closely with her physical therapy assistant to manage anxiety through strategies such as deep breathing and music. As a result, IndiaCali can now transfer independently without a mechanical lift. She enjoys spending time with family, shopping, and doing crafts with her housemates, and recently celebrated the holidays in her own home for the first time in years.

Conclusion: A Look into Year Two

Building on the momentum of the Community Living Initiative's first year, in Year two the Commonwealth will continue to identify and support individuals interested in transitioning from nursing facilities to community living. Year two priorities center on strengthening in-reach and engagement by refining referral pathways, as well as improving data sharing across agencies.

The Commonwealth will also pilot new strategies to increase enrollment and participation in DMH Clubhouse services for nursing facility residents with serious mental illness (SMI). DMH Clubhouses play a critical role in helping these individuals prepare for and succeed in community living. Clubhouses offer a structured, recovery-oriented environment where members can engage in meaningful daily activities, form social connections, and receive support related to employment, education, wellness, and life skills.

The Healey-Driscoll administration celebrates the significant progress achieved in Year One of the Community Living Initiative and remains strongly committed to expanding community living opportunities in the years ahead. As the initiative advances toward its goal of helping 2,400 people with disabilities in nursing homes return to communities of their choice, the administration will continue to invest in strategies that make community living a viable and sustainable alternative to nursing facility care.

Notes

Photos descriptions on front cover

Top left: Graham, and Kerianne both smiling and enjoying their fishing trip on Thursdays mornings by a nearby lake in Westborough.

Top center: Destiny and her brown labrador retriever, Salem, enjoying the warm sunshine.

Top right: Chelsea spending the day at Fenway Park.

Bottom left: Dan using his mobility bike in the community, which he uses to go fishing, run errands locally, or just getting some fresh air.

Bottom center: Kimberly enjoying a relaxing and active day participating in a DCR Kayaking outing at Hopkinton State Park with a staff member, Pierre.

Bottom right: IndiaCali walking in her local community.