Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

Nursing Facility Bulletin

DATE: January 2026

TO: Nursing Facilities Participating in MassHealth

FROM: Mike Levine, Undersecretary for MassHealth

RE: **Community Transition Liaison Program**

Introduction

The Community Transition Liaison Program (CTLP), formerly known as the Comprehensive Screening and Service Model (CSSM) Program, is administered by the Aging Services Access Points (ASAPs). Since its expansion in 2023, the program has focused on supporting all nursing facility (NF) residents aged 22 and older—regardless of payer source — who wish to transition to community living.

Each NF is assigned a CTLP team that operates out of the regional ASAP and coordinates with other state agencies as needed to best support individuals seeking community placement.

This bulletin supersedes Nursing Facility Bulletin 179 (issued July 2023) and provides clarification regarding the respective roles of NFs and CTLP teams in facilitating the transition of eligible residents back to the community.

Role of CTLP Teams in Working with NFs

CTLP teams play a critical role in helping nursing facility residents explore and pursue a safe transition back to community living. To be effective, they rely on close collaboration with nursing facility staff, including regular communication with the facility's social worker. For residents enrolled in CTLP, nursing facilities and CTLP teams must work collaboratively to ensure coordinated and effective discharge planning.

In performing CTLP functions, CTLP teams:

1. Visit assigned nursing facilities on a weekly basis, or as directed by Executive Office of Aging and Independence (AGE) and regularly follow up with all residents enrolled in the CTLP program;
2. Review the resident's comprehensive care plan ("NF Care Plan") — developed by the nursing facility in accordance with 105 CMR 150.008 and 42 CFR 483.21 — to understand which services the resident is currently receiving and which services the resident may need in the community;
3. Assist in identifying residents' needs that must be addressed as part of discharge planning;

4. Assist residents and coordinate with nursing facility staff (for example, the facility social worker) with completing applications for housing and public benefits, including gathering all required documentation; priority should be given to nursing facility residents who are likely to be discharged within the next several weeks, particularly those who have received a 30-day notice of discharge and whose appeal has been denied by the Board of Hearings (BOH);
5. Coordinate with state and community agencies to identify available resources and make appropriate referrals in coordination with the nursing facility. This includes making referrals to the Money Follows the Person Demonstration (MFP Demo) and submitting applications for Home and Community Based Services (HCBS) Waivers — these programs may provide services such as home modifications and other supports — and following up with the relevant state agencies and nursing facilities to ensure that these applications are processed and addressed in a timely manner;
6. As available, participate in, and contribute to, quarterly interdisciplinary team meetings (also known as Quarterly Care Plan Meetings) and any other discharge planning meetings held by the nursing facility for enrolled residents; and
7. Contact the enrollee's chosen supporters including family members particularly those who participate in the resident's care or are likely to reside with the resident after discharge — to keep them informed of the resident's desire to transition back to the community and to understand the family and social circumstances into which the resident may transition.

Role of NFs in Working with CTLP Teams

NF teams must collaborate closely with CTLP teams, including maintaining required regular contact with the CTLP staff. NFs and CTLP teams must coordinate on all aspects of discharge planning, including arranging for housing, community-based services and supports (for example, personal care attendant (PCA) services, MFP Demonstration, and HCBS Waivers), home modifications, and any other resources necessary to ensure a safe and successful transition to the community.

As part of these responsibilities, NFs must:

1. Provide CTLP staff with a census of all current residents, upon request;
2. Ensure that CTLP staff have continued access to all residents;
3. Provide CTLP staff with access to the facility's EMR to see enrolled residents' medical records, including their NF Care Plan, upon request;
4. Assist in sharing information about CTLP with residents, families, and facility staff, and make referrals to the CTLP for individuals who express interest in transitioning to the community;
5. Assist CTLP teams with completing applications for housing and public benefits, including gathering all required documentation. This includes providing CTLP staff with access to meeting space (for example, a conference room) and copying equipment as needed to support these activities;
6. Ensure that CTLP staff are included in, and able to meaningfully contribute to, quarterly interdisciplinary team meetings (also known as Quarterly Care Plan Meetings) and any other discharge planning meetings held by the nursing facility for

enrolled residents. This includes making reasonable accommodations for CTLP staff who wish to participate in these meetings remotely; and

7. Inform CTLP staff of any planned or unplanned discharges from the facility of residents enrolled in CTLP, as well as transfers to hospitals. For planned discharges of residents enrolled in CTLP, the NF must notify CTLP staff when a 30-day notice of discharge is issued, and again when the actual discharge occurs. NFs have 1 business day to inform CTLP staff of enrolled residents' planned/unplanned discharges and transfers to hospitals that are likely to result in discharge from the facility.

NFs are required to comply with the requirements outlined in this bulletin or will otherwise be subject to sanctions. NFs continue to be subject to MassHealth regulations, including 130 CMR 456.000: *Long Term Care Services*; Department of Public Health regulations, including 105 CMR 150: *Standards for long-term care facilities*; and the federal PASRR regulations at 42 CFR 483.100. Pursuant to these regulations, NFs are required to create care plans and perform care coordination and discharge planning for all residents.

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Questions?

If you have questions about the information in this bulletin, please email your inquiry to InstitutionalPrograms@mass.gov, with a copy to CTLP@mass.gov.