

## ABBREVIATIONS

**ACCS**

Adult Community  
Clinical Supports

**ACO**

Accountable Care  
Organization

**BH CP**

Behavioral Health  
Community Partners

**DMH**

Department of Mental  
Health

**FFS**

Fee-for-service

**HRSN**

Health-Related Social  
Needs

**LTSS**

Long-Term Services  
and Supports

**MCO**

Managed Care  
Organization

**NF**

Nursing Facility

**PCC**

Primary Care Clinician

# MassHealth Behavioral Health and Long-Term Services and Supports Community Partners Program

## *What are community partners?*

Behavioral Health (BH) and Long-Term Services and Supports (LTSS) Community Partners (CPs) are community-based entities that provide care coordination to Accountable Care Organization (ACO) and Managed Care Organization (MCO) members, Department of Mental Health (DMH) clients, and Nursing Facility (NF) clients with complex needs. BH CPs provide supports to certain MassHealth members with significant behavioral health needs, including serious mental illness and substance use disorder. LTSS CPs provide supports to certain members with complex LTSS needs (for example, children and adults with physical and developmental disabilities and brain injuries).

MassHealth members enrolled in an ACO or MCO may be eligible to participate in the CP Program. CPs are not available to members enrolled in the Primary Care Clinician (PCC) Plan or in MassHealth's fee-for-service (FFS) program unless the member is affiliated with the Department of Mental Health's Adult Community Clinical Supports (ACCS) program. When members have other state agency or provider supports, CPs supplement and coordinate with those supports but do not duplicate the functions those supports provide.

## *Supports Provided by Community Partners*

CPs perform enhanced care coordination activities, including but not limited to the following.

- Conducting in-person or virtual outreach to the CP enrollee to initiate contact and confirm CP Program participation
- Conducting a Comprehensive Assessment covering immediate care needs and current services, health conditions, medications, communication abilities, functional status and needs, and a Health-Related Social Needs (HRSN) screening
- Developing a Person-Centered Treatment Plan (Care Plan) reflecting the preferences, goals, and needs of the member
- Forming and coordinating a Care Team for the member to facilitate communication among providers, assist the CP enrollee in accessing services, and conduct ongoing care planning
- Coordinating and managing care across services including medical, behavioral health, long-term services and supports, and other state agency services, as appropriate
- Connecting enrollees to social services and community resources

# FACT SHEET

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### ACCS

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Clinical Supports

### ACO

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Organization

### CP

Community Partners

### DMH

Department of Mental  
Health

### HRSN

Health-Related Social  
Needs

### LTSS

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## Information about Enrollment in a CP

- ACOs and MCOs identify eligible members for the CP Program based on several different criteria, including but not limited to diagnosis, service history, and HRSN needs. These members are enrolled with a CP in their area.
- ACCS and Post-ACCS Clients who are eligible for the CP Program are identified and referred to the CP Program by the Department of Mental Health (DMH).
- MassHealth sends a letter to each CP enrollee. CP staff will also contact enrolled members to explain the CP Program. Letters will be mailed on an ongoing basis to newly assigned members.
- Members may request a different CP in their area or may decline to participate in the CP Program at any time. Their decision will not impact their MassHealth benefits in any way.

## What CPs Mean for Providers

- MassHealth providers should continue to deliver services in accordance with all applicable regulations, program or service specifications, agency guidance, and contracts with ACOs, MCOs, and the MassHealth behavioral health vendor.
- Community Partners coordinate with providers and supplement, but don't duplicate, functions performed by other providers. CPs are a resource and support for coordinating with the CP enrollee's providers and ACO/MCO. For example, CPs support integration by making sure that ACOs/MCOs, PCPs, and other providers share the appropriate information and coordinate services, including additional social services, through a single Care Plan.
- Providers who believe a member they serve might benefit from the CP Program should contact the member's ACO/MCO to discuss participation in the CP Program. A resource for locating ACO and MCO contact information can be found at [mass.gov/info-details/masshealth-health-plans](https://mass.gov/info-details/masshealth-health-plans).

## Who to Contact for More Information

ACO and MCO members should contact their health plan for more information about the CP Program. If they are not enrolled in an ACO or MCO but meet the other eligibility requirements, they can contact their ACCS provider. If they receive services from a provider who is also a Community Partner, they can ask that provider to help them enroll in the CP Program. Nursing facility residents can reach out to their nursing facility for more information about the CP Program.

For more information about the CP Program, please contact [CPInfo@mass.gov](mailto:CPInfo@mass.gov).