**Slide 2: Agenda**

Today’s training is an introduction to MassHealth’s Community Partners (CP) Program.

The training will cover the following topics:

* What are CPs?
* What are the objectives of the CP program?
* Who do the CPs serve; and
* How do members access CP supports?

We will review the two types of CPs: Behavioral Health Community Partners (BH CPs), and Long Term Services and Supports Community Partners (LTSS CPs). We will look at how they help members navigate and coordinate care, how Accountable Care Organizations (ACOs), Managed Care Organizations (MCOs) and CPs work together, discuss the implications of the CP program for providers, and will end with a list of CP organizations and the service areas they cover.

**Slide 3: What are CPs**

CPs are community-based organizations who have been contracted by MassHealth to provide enhanced care coordination for MassHealth members with complex needs who are enrolled in ACOs and MCOs. The CPs are organizations that have a history of providing services to members with significant behavioral health (BH) needs and supporting members with complex long term services and supports (LTSS) needs. CPs are available to ACO and MCO members, and certain Department of Mental Health affiliated members, who are identified by MassHealth’s algorithm, or who otherwise meet ACO or MCO referral standards. CPs are not available to members enrolled in the Primary Care Clinician (PCC) Plan or the MassHealth fee-for-service (FFS) program , unless the member is affiliated with DMH’s Adult Community Clinical Supports (ACCS) Program, or has a DMH affiliation and was formerly a member of the Community Based Flexible Supports (CBFS) program.

**There are 2 types of Community Partners:**

The first type - Behavioral Health Community Partners, or BH CPs, provide care management and coordination across the healthcare continuum for members with significant BH needs. BH CPs coordinate a members’ physical health and behavioral health care as well as their LTSS and social services. There are 18 BH CPs that provide these supports across the Commonwealth. Collectively, BH CPs may support up to approximately 35,000 members at any one time.

The second type of CP is the Long Term Services and Supports Community Partner, or LTSS CP. These CPs provide LTSS subject matter expertise to ACOs and MCOs and provide LTSS care coordination for MassHealth members with complex LTSS needs. There are 9 LTSS CPs that provide these supports across the Commonwealth, and LTSS CPs may support approximately 20,000 – 24,000 members at any one time.

ACOs and MCOs must formally partner with CPs in all the areas the ACO or MCO serve.

**Slide 4: What are the objectives of the CP Program**

The primary objective of the CP Program is to provide enhanced care coordination supports for individuals with Serious Mental Illness (SMI) and/or addiction treatment needs and individuals with complex long term service and supports needs.

Other objectives include:

* Improving member experience and quality of care,
* Leveraging expertise and capabilities of the existing community based organizations and investing in the development of infrastructure such as technology and information systems that are sustainable over time,
* Delivering integrated care through improved collaboration between ACOs/MCO, CPs, providers and community organizations and through improved coordination across BH, physical healthcare and LTSS as well as addressing the social determinants of health; and
* Supporting the values of Community First, recovery and independent living principles and promoting culturally competent care.

**Slide 5: So who do the CPs serve**

**MassHealth members may be eligible for BH CP services if they:**

* Are MassHealth managed care members ages 21-64 who are enrolled in an ACO or MCO
* If they Have complex BH needs, such as SMI (e.g., schizophrenia) and/or addiction treatment needs
* And Are identified by MassHealth

**In addition, MassHealth members who are in DMH’s ACCS program (and certain former CBFS members) are eligible for BH CP services, unless they are enrolled in One Care or SCO.** And theseMembers will continue to receive supports from a BH CP even after they are no longer in need of ACCS services and have transitioned to other services.

* *DMH ACCS clients who have MassHealth and Medicare and* ***who enroll in a One Care or SCO plan receive similar enhanced care coordination and supports through One Care or SCO instead of a BH CP***

**MassHealth members may be eligible for LTSS CP supports if they:**

* Are MassHealth managed care members ages 3-64 and are enrolled in an ACO or MCO
* If they Have complex LTSS needs; and
* Are identified by MassHealth\*
* Members who are identified as eligible for both BH CP and LTSS CP services will receive all CP services from the BH CP

**\***Comprehensive care coordination is provided by some MassHealth programs, such as Home and Community Based Services (HCBS) Waivers, Community Case Management (CCM), and the Children’s Behavioral Health Initiative (CBHI). Members in these programs will not be pre-identified by MassHealth to receive LTSS CP Supports. However, members in these programs could be referred for LTSS CP Supports if there is a need for additional coordination and integration.

**Slide 6: So how do members enroll in a CP**

**There are two ways by which a member can be enrolled in a CP**:

* The first way is when MassHealth identifies members with high behavioral health needs or complex LTSS needs using a claims and service based analysis. Once these members are identified, the ACOs or MCOs assign them to CPs. MassHealth identifies members through analytics on a quarterly basis.
  + For the ramp-up of this program – i.e. through December 2018 - MassHealth is assigning identified members directly to CPs.
* The second way a member can access CP supports is when the ACO or MCO determines that a member may benefit from a BH CP or LTSS CP. Beginning in January 2019, CP Program referral recommendations may be made to the member’s ACO or MCO by the enrolled member, family of the member, a CP or a provider. ACOs and MCOs will review these referral recommendations and, if the ACO or MCO determines that the member should be enrolled in a CP, the ACO or MCO will assign the member to a CP.

**Once a member is identified and assigned for CP supports:**

* Eligible members will be assigned to a CP in the member’s area
* Each assigned member will receive a letter from MassHealth in the mail and will be contacted by CP staff who will explain the program
* Members have the right to request a different CP in their area or may decline to participate in the CP program at any time

**Slide 7: BH CPs**

Let’s talk about BH CPs

**Slide 8: BH CPs**

Approximately 35,000 MassHealth members with the most complex behavioral health needs will have access to BH CP supports. The BH CPs provide comprehensive care coordination for members, covering the continuum, coordinating across physical health, behavioral health, LTSS and social services.

The 18 BH CPs are community based organizations with extensive experience providing services and supports to the target population

**The BH CP will:**

* Conduct active outreach and engage eligible members in their health care
* Assess the member’s physical and behavioral needs, LTSS needs and social services needs and work with the member to develop and maintain a care plan to address those needs
* Coordinate care (together with the member’s ACO or MCO), helping the member connect to their health care providers (including primary care providers (PCPs), BH providers, LTSS providers, and other specialists) and helping members to navigate the health care system
* The BH CP Connect members to and coordinate with social services and other state agencies and their programs, such as DMH’s ACCS program
* Support the member when they transition between care settings
* Provide health and wellness coaching and
* Support Medication reconciliation

BH CPs do not perform service authorization activities for MassHealth, ACOs or MCOs or duplicate functions performed by providers. We will talk about this in greater detail on slide 18.

A couple of other important notes to mention:–

* Any providers of services that require prior authorization should continue to submit authorization requests to ACOs, MCOs and MassHealth, as applicable. This process has not changed.
* Also, the member’s person centered treatment plan developed by the BH CP must be approved and signed by the member and also by the member’s PCP or PCP designee.

**Slide 9: BH CPs help integrate care across the continuum for MassHealth members and their family members**

This slide illustrates the way BH CPs coordinate services that the member may need across the continuum, as we discussed in the previous slide.

CPs will take an active role in helping members navigate and coordinate with the various entities and services on this slide. Including services provided by the member’s MassHealth Plan, other state agencies such as DMH, social services and LTSS.

**Slide 10: BH CPs conduct comprehensive assessments and develop person-centered treatment plans that drive member care**

Once a member is enrolled in a BH CP, either through identification by MassHealth or by an ACO or MCO, the BH CP conducts a comprehensive assessment using an approved tool.

MassHealth requires BH CPs to utilize the interRAI Community Health Assessment (or CHA) as part of the comprehensive assessment. BH CPs also include additional supplemental questions that are approved by EOHHS in the assessment.

In preparation for completing the comprehensive assessment, BH CPs may reach out to providers and ACOs/MCOs to gather available information about the member. This information can inform the comprehensive assessment and will be confirmed with the member. By using available information, BH CPs can reduce member burden that can be caused by completing multiple assessments with providers.

The BH CP completes a person-centered treatment plan with the member that is based on assessment results and reflects the preferences, goals and needs of the member. The person-centered treatment plan must be approved and signed by the member and the member’s PCP or PCP Designee. The person-centered treatment plan is a key tool used by the BH CP in performing care coordination and care management.

The BH CP forms a care team for the member, facilitates communication across providers, assists the member in accessing services, and implements the person-centered treatment plan with the member. As we discussed previously, services may need authorization from MassHealth, the Accountable Care Partnership Plan or MCO.

**Slide 11: BH CPs may engage members at the point of care**

BH CPs perform outreach and engagement upon member enrollment. A BH CP may be able to begin working with the member by conducting an assessment and completing a person-centered treatment plan with the member. There will be circumstances when the BH CP first engages a member during an acute episode at the point of care or during a care transition. In these cases, the member’s BH CP will work with the member’s current providers to meet the member’s immediate needs, including care transitions. When the member is able, the BH CP completes the comprehensive assessment and person-centered treatment plan with the member which also must be approved and signed by the member and the member’s PCP or PCP Designee.

**Slide 12: LTSS CPs**

Let’s move on to LTSS CP’s, the second type of CP.

**Slide 13: LTSS CPs**

Between 20,000 and 24,000 MassHealth members will have access to LTSS care coordination through LTSS CPs. These are MassHealth members with physical disabilities, intellectual and developmental disabilities, brain injury, children ages 3 and up with LTSS needs, and older adults up to age 64 who are managed care eligible.

The 9 LTSS CPs are community based organizations with extensive experience providing services and supports to these populations. As subject matter experts for ACOs and MCOs, LTSS CPs work closely with the ACOs and MCOs as part of the member’s care team.

The ACO or MCO conducts a comprehensive assessment which includes physical health, behavioral health, functional and social needs of the member. The LTSS CP works with the member and the ACO or MCO care team to collaboratively develop and implement a person-centered care plan to meet the member’s LTSS need and that best meets the member’s individual goals.

**The LTSS CP’s work also includes:**

* Conducting active outreach and engaging eligible members in their care
* working with the member to develop and maintain a LTSS care plan to address needs identified in the member’s comprehensive assessment
* Coordinating care (together with the member’s ACO or MCO), and supporting the member to navigate the complex health and LTSS systems
* LTSS CPs also Connect members to and coordinate with social services and other state agencies and their programs such as Department of Developmental Services (DDS) and the Massachusetts Rehabilitation Commission (MRC)
* Support the member when they transition between care settings
* Provide health and wellness coaching to the member

LTSS CPs do not perform service authorization activities for MassHealth, ACOs or MCOs or duplicate functions performed by providers. We will talk about this in greater detail shortly.

A couple of other points to note from the provider perspective –

* As with the BH CPs - Providers of services that require prior authorization should continue to submit authorization requests to ACOs, MCOs and MassHealth, as applicable.
* Also, the member’s LTSS care plan, developed by the LTSS CP, must be approved and signed by the member and also by the member’s PCP or PCP designee

**Slide 14: LTSS CPs help ACOs and MCOs to integrate LTSS and social services with physical and BH care**

This slide illustrates the connections the LTSS CPs will make in carrying out their functions as we discussed in the previous slide.

CPs will take an active role in helping members navigate and coordinate with the various entities and services in the green boxes on this slide. Including other state agencies such as DDS, social services and LTSS providers

**Slide 15: LTSS CPs integrate LTSS into a member’s care plan**

As discussed previously, a member’s care is driven by a comprehensive assessment and care plan. Once a member is enrolled in an LTSS CP, either through identification by MassHealth or by an ACO or MCO, the ACO or MCO conducts a comprehensive assessment using an approved tool. The ACO or MCO may incorporate additional information received from providers in preparation for completing the comprehensive assessment, and that information should be confirmed with the member upon assessment. Provider involvement in sharing data can reduce member burden and assessment burnout.

The LTSS CP completes an LTSS care plan with the member that is based on assessment results and reflects the preferences, goals and needs of the member. The LTSS care plan must be approved and signed by the member and the member’s PCP or PCP Designee and is incorporated into the member’s overall ACO/MCO care plan. The LTSS CP participates on the member’s ACO/MCO care team as an LTSS expert and advocate for the member’s needs, facilitates communication across LTSS providers and other coordinators at state agencies, assists the member in accessing LTSS; and implements and monitors the LTSS care plan with the member. Services within the LTSS care plan may need authorization from MassHealth, the Accountable Care Partnership Plan or MCO.

**Slide 16: LTSS CPs may engage members at the point of care**

LTSS CPs perform outreach upon member enrollment. An LTSS CP may be able to begin working with the member immediately to develop an LTSS care plan based on the ACO/MCO comprehensive assessment. Alternatively, an LTSS CP may first engage the member during an acute episode at the point of care or during a care transition. In these cases, the LTSS CP will work with the member’s current providers to meet the member’s immediate LTSS and social services needs. When the member is able, the LTSS CP completes the LTSS care plan with the member and continues to implement and monitor the care plan. As indicated previously, the LTSS care plan must be approved and signed by the member and the member’s PCP or PCP Designee.

**Slide 17: How ACOs/MCOs and CPs work together to provide integrated care**

ACOs, MCOs and CPs are required to have executed agreements and to develop documented processes that outline each party’s responsibilities regarding the integrated, collaborative care coordination each is required to provide to members.

ACOs and CPs are being held financially accountable for meeting specific quality measures and have funding at risk if they do not meet those measures.

Quality measures across ACOs and CPs are aligned and include:

* Providing **preventive care**
* Managing **chronic diseases** such as diabetes and heart failure
* **Screening for behavioral health conditions** and initiating appropriate treatment for mental health, addictions, and co-occurring disorders
* Ensuring appropriate **follow-up care** after a hospitalization
* Maintaining **members living in the community** rather than in facilities
* Results of **member experience surveys**

For more information about the CP Program, Providers can contact their ACO or MCO, or visit the [CP homepage](https://www.mass.gov/guides/masshealth-community-partners-cp-program).

Questions about the CP Program can be emailed to [CPinfo@MassMail.State.MA.US](mailto:CPinfo@MassMail.State.MA.US).

**Slide 18: What does the CP Program mean for providers**

CPs are a resource for providers, as well as for members. As a provider, you may be providing services to a member who is supported by a CP. A CP may contact you to inform ongoing care planning, to connect the care you provide with other services the member is receiving, to support improvements in member engagement, and to support integration with the member’s health plan and all of the services the member is receiving. CP may also reach out to you for support in locating a member – such as a request to share contact information or if you are the member’s PCP, the CP may ask you to review and sign the member’s care plan.

Effective healthcare integration relies on the collaborations and partnerships on a member’s care team.

CPs provide care coordination - they do not perform service authorization activities for MassHealth, ACOs or MCOs. CP supports are designed to align with other MassHealth programs and services. CPs will coordinate with providers and will supplement not duplicate services provided. Providers are expected to perform their typical functions in accordance with the relevant regulation, agency guidance, contract with EOHHS and contract with ACOs or MCOs as applicable.

MassHealth expects providers to coordinate care, and as a component of this, engage with CPs for care planning purposes.

Beginning around January 2019, Providers will be able to recommend referral of members who they believe would benefit from CP supports by contacting the member’s ACO or MCO.

**Slides 19 - 23**

The following slides list all of the BH and LTSS CPs and the service areas covered by region.

Most service areas have 2 or more (BH and LTSS) CPs that can serve members in that area.

This list can also be found on the [CP homepage](https://www.mass.gov/guides/masshealth-community-partners-cp-program).

**Slide 24: Additional CP Resources for Providers**

More information on the CP Program can be found on the [CP homepage](https://www.mass.gov/guides/masshealth-community-partners-cp-program).

Provider training event schedules and other PCDI information can be viewed and downloaded on the [MassHealth Provider PCDI Resources webpage](https://www.mass.gov/lists/provider-pcdi-resources).

There is also a link that will direct you to the portals where you can enroll in provider PCDI trainings.

Questions about the CP Program can be directed to [CPinfo@MassMail.State.MA.US](mailto:Community.Partners@MassMail.state.ma.us).