**Slide 2: 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 3: 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.

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 4: 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.

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 5: 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**

**Slide 6: 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.