MCO and Provider Guidance Packet

NJ FamilyCare Community-Based Palliative Care

NJ Department of Human Services
Prepared by the NJ Division of Medical Assistance and Health Services (DMAHS)

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NEW JERSEY HUMAN SERVICES

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About This Guide

This guide serves as a resource for providers and MCOs on New Jersey's Community-Based Palliative Care Medicaid benefit.

Within this guide, providers and MCOs will find:

Introduction

- A brief introduction to NJ FamilyCare
- Overview of NJ's Community-Based Palliative Care benefit

Detailed program guidance

- Enrollment with NJ FamilyCare
- Participating in Managed Care Organization (MCO) Networks (i.e., credentialing and contracting)
- Covered populations
- Covered services
- Member journey processes
- MCO care management
- Payment model, billing & claims
- Provider enrollment & credentialing
- Quality strategy, monitoring & reporting

This guide is not intended to replace detailed guidance provided by each MCO, such as information included in MCO provider manuals, which are an essential resource for any provider seeking to participate with a specific MCO.

Introduction

This section provides a brief introduction to NJ's Medicaid Program (NJ FamilyCare) and gives an overview of NJ FamilyCare's Community-Based Palliative Care (CBPC) benefit

Introduction to NJ FamilyCare

NJ FamilyCare is the name of the Medicaid Program in New Jersey, and includes core Medicaid, the Children's Health Insurance Program (CHIP), and Medicaid expansion populations.

Who is eligible for coverage?

New Jersey residents who meet certain criteria are eligible to enroll in NJ FamilyCare, including:

- **Adults (19-64):** With income up to 138% Federal Poverty Level (FPL) ($1,732/month for singles, $2,351/month for couples). In general, immigrants must have five years of Legal Permanent Resident status to qualify, but some immigrants (e.g., asylees) may qualify sooner.
- **Children under 19:** With family income up to 355% of the FPL ($9,230/month for a family of four), regardless of immigration status. Coverage requires annual renewal.
- **Pregnant Individuals:** With income up to 205% FPL ($5,330/month for a family of four), with no entry-date restrictions for lawfully present immigrants.
- **Seniors (65+), Blind, Disabled, Long-Term Care Recipients, and Adults with Medicare**: Eligible based on specific criteria.

As of July 2025, NJ FamilyCare has nearly 2 million enrolled members, providing them access to many of the physical and mental health services they need to thrive.

What services are covered?

NJ FamilyCare is a comprehensive healthcare coverage program that provides a wide range of services, including:

- Doctor visits
- Hospitalization
- Lab tests
- X-rays
- Prescriptions
- Eyeglasses
- Regular check-ups
- Mental health and substance use disorders service

- Dental services
- Preventive screenings
- Autism services
- Community doula services
- Help with personal care needs

How is the program delivered?

Today, NJ FamilyCare is delivered using two different models:

- **Fee-for-service (FFS)**: Traditional model where providers bill the State of NJ directly for services delivered
- **Managed care:** Value-based model, predominant for medical services in NJ, where services are managed by five managed care healthcare plans, also known as managed care organizations (MCOs): Aetna, Fidelis Care, Horizon, UnitedHealthcare, and Wellpoint

Key features and differences between the two models are highlighted in the table below:

Fee for service (FFS)	Managed care
• Managed by NJ State • Providers bill state Medicaid directly for services • Also used for members not enrolled in a MCO and members with presumptive eligibility	• Managed by one of 5 MCOs, under contract with NJ State: Aetna, Fidelis Care, Horizon, UnitedHealthcare, Wellpoint • Providers bill MCOs for services; MCOs receive funding from state to manage total cost of care • Used for most physical health services and some behavioral health services

Why become a NJ FamilyCare provider?

Providers **must be enrolled** with NJ FamilyCare in order to provide services to NJ FamilyCare members.

By becoming a NJ FamilyCare provider, you not only expand your practice and secure financial benefits but also make a meaningful contribution to public health by helping to serve some of the most vulnerable residents in New Jersey. Your participation is crucial in ensuring that all New Jersey residents have access to high-quality health services.

Definitions

Advance Care Planning: A structured process in which patients, families, and care teams explore, clarify, and document preferences regarding future medical care, including goals of care, values, and treatment preferences.

Assessment: An initial medical assessment of the referred/screened member, completed by any licensed, Medicaid enrolled clinician, using the Comprehensive Medical Assessment Tool, to make a recommendation of eligibility for the CBPC benefit to be authorized by the member's managed care plan.

Bundled Payment: A bundled payment for the palliative care benefit is a single, comprehensive reimbursement that covers all interdisciplinary, community-based services provided to a member with a serious illness over a defined period (a month, for this benefit). This model promotes coordinated, person-centered care by aligning payment with the holistic delivery of palliative services, such as medical, psychosocial, and supportive interventions, rather than individual service codes.

Care Coordination Activities: A set of actions carried out by the palliative care IDT to ensure seamless, integrated care across clinical settings, providers, and services. Activities include arranging referrals, sharing care plans, synchronizing medication lists, tracking transitions (e.g., hospital to home), and maintaining communication with primary care, specialists, and MCO Care Managers. These activities are essential to reduce fragmentation and avoid preventable acute utilization.

Chaplain: Trained provider who is part of the interdisciplinary palliative care team, responsible for addressing the spiritual, existential, and emotional needs of the member and their family, regardless of religious affiliation or belief system. Must certify non-proselytization in their work.

Child Life Specialist: Trained healthcare professional who supports children and adolescents affected by serious illness, either as patients themselves or as family members of a patient receiving palliative care.

Community-Based Palliative Care (CBPC): Refers to palliative care services delivered outside of an inpatient hospital setting. CBPC may be provided in a member's home, in outpatient clinics, assisted living facilities, or other community settings. The focus is on managing symptoms, coordinating care, and supporting patients and families facing serious illness, without requiring the member to be homebound or to forgo curative treatment.

Community Health Worker: In CBPC, a professional trained to support individuals and families through outreach, education, care navigation, and linkage to social and clinical services. CHWs help build trust, identify barriers to care (e.g., transportation, housing), and reinforce care plans, particularly among underserved populations. They may also provide culturally responsive health education and caregiver support.

Concurrent Services: Medically necessary, discrete care services provided to a member enrolled in the CBPC program that are distinct and reimbursed separately from the palliative care benefit itself. These services may be the same type as those included in the Per Member Per Month (PMPM) bundled rate structure but are rendered to address acute, chronic, or preventive care needs that fall outside the scope of the member's palliative care diagnosis or care plan.

IDT: The interdisciplinary team; a team of professionals delivering palliative care services that must include, at a minimum, a physician or nurse practitioner, a registered nurse, a qualified mental health practitioner (Licensed Clinical Social Worker, Licensed Professional Counselor or Licensed Marriage and Family Therapist), and a chaplain. The team may also include other appropriate professionals deployed based on the member's needs. The IDT conducts, develops, and updates individualized care plans, coordinates services, and ensures integration with the member's existing care providers.

Lead IDT Clinician: The palliative care practitioner (MD, DO, NP or PA) most directly responsible for rendering patient care, including prescribing. Listed as rendering/ attending provider on claims. Must have a palliative care credential, as defined in guidance.

Palliative Care: Person- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering caused by serious illness. Palliative care addresses physical, intellectual, emotional, social, and spiritual needs and facilitates member autonomy, access to information, and choice. Palliative care is delivered by an interdisciplinary team working together with the member's other healthcare providers to provide an extra layer of support for the member and their care journey. It is appropriate at any age and can be provided along with curative treatment.

Psychosocial Support: Services that address the emotional, mental health, social, and spiritual needs of the patient and their caregivers. This includes counseling, grief support, help with social determinants of health (e.g., food, housing insecurity), and assistance navigating complex life circumstances. In palliative care, psychosocial support is delivered by licensed social workers, chaplains, or other qualified providers and is integral to whole-person care.

Reassessment: A second or further assessment of the enrolled member, using the same Comprehensive Assessment Tool, to redetermine eligibility for the CBPC benefit. Must be completed at least every six months or, if sooner, upon change in member's condition.

Symptom Management: An interdisciplinary process focused on identifying, assessing, and alleviating distressing physical symptoms such as pain, dyspnea, fatigue, nausea, and insomnia. Community-based palliative care emphasizes proactive, evidence-based symptom management using pharmacologic and non-pharmacologic strategies in the home or outpatient setting to maintain function and quality of life.

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Overview of NJ FamilyCare Community-Based Palliative Care

Background & overview

Program Goals

Community-Based Palliative Care (CBPC) is a new benefit within NJ FamilyCare. This initiative was established by the directive of New Jersey Assembly Bill 5225 enacted in 2023, underscoring the state's commitment to expanding access to essential healthcare services and support for residents facing serious illness.

The NJ Division of Medical Assistance and Health Services (DMAHS) launched the benefit via a State Plan Amendment (SPA) on April 1, 2026. As of April 1, motivated providers can start to bill MCOs and members can begin receiving services.

CBPC has been shown to improve quality of life and reduce acute care utilization for Medicaid members with serious illnesses. Under the benefit, Medicaid members receive longitudinal care from an interdisciplinary team to manage symptoms and navigate the healthcare system. Unlike hospice care, this program does not require a terminal prognosis or forgoing curative treatment. Rather, CBPC is designed to work in conjunction with curative treatments, broadening access to crucial support services.

The following sections provide a summary of guidance for each program area, which are further explained in the detailed guidance section.

Covered Populations

Medicaid members can qualify for the benefit if they have serious disease **and** show evidence of reduced quality of life, including:

- Are in functional decline (e.g., significant difficulty with 1+ activity of daily living) **OR**
- Two (2) or more emergency department visits in the past six (6) months **OR**
- One (1) acute hospitalization in the past year

MCOs can also approve members via individual determinations of medical necessity based on the member's condition and the standardized **Comprehensive Medical Assessment Tool**—a DMAHS-designed form that captures diagnosis and severity, recent utilization or decline, key needs, and care goals—even if the above criteria are not met.

The CBPC benefit is available to all NJ FamilyCare members who meet the above

criteria, including adult and pediatric members, MCO and FFS members, duals and non-duals, and any plan type (e.g., Core Medicaid, MLTSS, FIDE-SNP).

Further details on eligibility can be found in the Covered Populations section.

Covered Services

The CBPC benefit covers a comprehensive set of services delivered by an interdisciplinary team (IDT) to enhance the quality of life for eligible members. CBPC services can be delivered in any non-inpatient hospital setting.

Covered services may include, but are not limited to:

- Comprehensive care planning and coordination
- Advance care planning discussions
- Symptom assessment and management
- Medication review: adjustments, titration, and prescribing/deprescribing
- Home-based or clinic-based visits by licensed IDT practitioners
- Psychosocial counseling and caregiver support
- Spiritual and emotional care
- Referral coordination to Medicaid-covered services
- Access to a 24/7 telephone line

Further details regarding services can be found in the detailed Covered Services section.

Member Journey

There are five key stages in the member journey through CBPC:

1. Referral/Screen
2. Assessment & Authorization
3. Care Planning & Maintenance
4. Reassessment
5. Discharge

Referral/Screen

The referral and screening stage is designed to quickly identify potentially eligible members and direct them to a more comprehensive assessment if indicated. It is intended to lower barriers and increase potential access to the benefit, while optimizing provider resources for assessment.

To broaden access, DMAHS developed a brief, standardized **Program Eligibility Screening Tool** as an optional method to identify members who may be eligible for the benefit. This tool can be used in lieu of a referral and can be completed by anyone, not just a healthcare provider. The Program Eligibility Screening Tool is non-reimbursable.

Like other benefits and services, a member may be directly referred for assessment for CBPC by their healthcare provider or MCO if they believe that the benefit could improve the member's quality of life and reduce their acute care use.

Assessment & Authorization

The assessment & authorization stage serves to evaluate whether a member meets clinical and disease severity criteria for CBPC. To ensure member access, prior authorization is not allowed as a prerequisite to receive assessment (or reassessment).

After a member is referred for assessment, whether directly or using the Program Eligibility Screening Tool, a clinician or provider entity conducts a reimbursable eligibility assessment using the standardized **Comprehensive Medical Assessment Tool.** It documents member illness severity, examines their degree of acute care use, measures their functional decline (using measures like Palliative Performance Scale or the Karnofsky scale), identifies physical, psychosocial, spiritual, and social needs, and captures goals for care.

At the end of the assessment, based on findings in the tool, the assessor makes a recommendation of eligibility for the benefit. If the member does not meet the exact criteria included on the tool, the assessor may make an individual recommendation of eligibility with an accompanying justification.

Upon completion, the clinician must submit the assessment to the member's MCO within 5 business days, and the MCO must review and store the assessment. Providers must also store the assessment and the referral source (if applicable) in the member's electronic health record (EHR).

MCOs are permitted but not required to exercise prior authorization on the CBPC bundle. If the MCO requires prior authorization of the bundle, the MCO makes the authorization decision based on only the Comprehensive Medical Assessment Tool.

Because of the relative effort required to perform the Comprehensive Medical Assessment, it is a reimbursable activity.

The assessment (and re-assessment) may be completed by any qualified, Medicaid-enrolled MD, DO, PA, APN, or LCSW provider (participation in CBPC or CBPC IDT is

not a requirement).

Care Planning & Maintenance

Once authorized by their health plan, the member moves to the care planning & maintenance stage of the benefit. The purpose of the member care plan is to use insights from the member's Comprehensive Medical Assessment and build a comprehensive palliative care strategy.

Care planning utilizes the **Care Plan** tool**,** a standardized, patient-centered document used to capture and organize the individualized goals, preferences and care coordination strategy for the member.

Multiple practitioners participate in the creation of the member's care plan, and the Lead IDT Clinician meets with the member to create the plan. The Lead IDT Clinician's first interaction with the member must be conducted in person; if the care planning meeting is that first interaction, it must be in person.

Upon finalization of the care plan, the Lead IDT Clinician, the MCO Care Manager (CM), the Member, and Caregiver (if applicable) must sign off.

Care planning helps identify which IDT practitioners will be involved in the member's care. Care planning also facilitates care coordination and referrals, pain management, medication management, and advance care planning for the member.

Every month during the six-month authorization window, the IDT must meet at least once internally (including the MCO CM) and at least once with the member. The meetings serve to discuss member care and update the care plan as needed.

A new Care Plan must be drafted upon reauthorization, and if a significant change triggers a reassessment, a new Care Plan should also be drafted. Upon finalization (e.g., initial authorization, reauthorization), the Care Plan should be submitted to the member's MCO within 5 business days and MCO should review and store.

Reassessment

Reassessment serves two purposes: informing care plan updates if the member's condition changes and reauthorization (i.e., determining continued eligibility, once every six months).

If a member's condition changes significantly within the six-month authorization window (e.g., their condition progresses or they suffer a fall), that member should be reassessed using the **Comprehensive Medical Assessment Tool** to document the member's current condition. Reassessment is a reimbursable activity. Reassessments due to change in condition should be submitted to the MCO for reimbursement, accompanied by an updated care plan addressing the member's change in condition within 5 business days of the member's reassessment. A member may only be reassessed a maximum of once per month.

To remain in the benefit, members must be reassessed every six months and be authorized to continue care. For reauthorization, providers complete the same **Comprehensive Medical Assessment Tool** and may bill for reassessment**.** If, based on the reassessment findings, the MCO reauthorizes care, that reauthorization is valid for six additional months of care from the end date of the existing authorization period. Only reassessments conducted in the final 30 days of an authorization period, and submitted with a prior authorization request, will be considered by MCOs to be a request to extend authorization period. For reassessments received prior to the last thirty days of an existing authorization period, MCOs may process the claim and maintain the existing six-month authorization period.

If reassessment determines the member is no longer eligible, the member will be discharged from the benefit. The provider should submit (re)assessments to the MCO, regardless of the eligibility determination and complete the Discharge Tool (see below).

Discharge

When a member leaves the benefit (e.g., in case of exit to hospice or discharge after determined ineligible), the provider must submit the **Discharge Tool** to the member's health plan and store the Tool in the member's EHR. The IDT should review the member's concurrent services and request to extend those that are still needed.

If the member is switching providers or MCOs, the same process applies. For switching, the IDT must transmit all relevant medical information, including assessments and care plans, to the member's new provider or MCO.

Further details on assessment and authorization processes and standard tools can be found in the detailed Member Journey section.

MCO Care Management

Under the CBPC benefit, MCOs play an integral role in the effective administration and operation of community-based palliative care services. Each member enrolled in CBPC is assigned an MCO Care Manager (CM) who collaborates closely with the interdisciplinary team to coordinate care and facilitate access to broader Medicaid services. Any MCO CM can serve palliative care members (if appropriately trained), and members should retain their existing MCO CM if already assigned, as possible.

Responsibilities of the MCO CM include but are not limited to:

- Facilitating access to Medicaid-covered concurrent services, such as Personal Care Assistance (PCA)
- Coordinating complementary Medicaid services identified as beneficial by the IDT
- Participating actively in monthly IDT meetings to refine member care plans

For FFS members, the provider IDT is expected to fulfill the role of the MCO CM.

Training and Responsibilities

MCO Care Managers are required to undergo specialized training, delivered by the MCO and approved by DMAHS, to ensure consistent and knowledgeable support for CBPC members.

Training should include (1) fundamentals of community-based palliative care, (2) IDT collaboration and documentation standards, (3) cultural responsiveness and spiritual care, (4) addressing the unique clinical, social, and emotional needs specific to palliative care, and (5) effective care coordination practices to optimize outcomes.

Additional information regarding the MCO CM role and responsibilities is available in the MCO Care Management section.

Payment Model, Billing, and Claims

The CBPC benefit has three payment types, tied to stages of the member journey:

1. An initial assessment payment;
2. Ongoing monthly payments via a Per Member Per Month (PMPM) bundled rate; and
3. Periodic reassessment payments

Providers bill MCOs or FFS Medicaid directly based on the member's enrollment status, with required documentation and expectations for payment clearly defined. MCOs must reimburse providers at or above the FFS floor.

Key components of the payment structure include:

Initial Assessment: Reimbursable upon completion of the Comprehensive Medical Assessment Tool, with no prior authorization permitted. Providers may be paid for a maximum of one initial assessment per member per quarter. Any qualified, Medicaid-enrolled MD, DO, PA, APN, or LCSW provider may complete the assessment. The current FFS rate floor for the initial assessment is $100.

Per Member Per Month Bundle: Monthly reimbursement, authorized for six months, covering all interdisciplinary services as outlined in the care plan. Providers must document at least one IDT-member interaction and at least one IDT meeting each month that includes the MCO Care Manager. The current FFS rate floor for the PMPM bundle is $686. MCOs and providers are permitted to negotiate rates and / or alternate payment methodologies for the bundle, but reimbursement rate cannot be lower that the FFS rate. MCOs are permitted but not required to exercise prior authorization on the CBPC bundle. If the MCO requires prior authorization of the bundle, the MCO makes the authorization decision based on only the Comprehensive Medical Assessment Tool.

Reassessment: Conducted at least every six months or upon significant changes in the member's condition. Providers may be paid at a maximum of one reassessment per member per month. Any qualified, Medicaid-enrolled MD, DO, PA, APN, or LCSW may

complete the reassessment. The current FFS rate floor for reassessment is $85.

Claims must comply with the standard billing practices outlined in the **Payment Model, Billing & Claims** section. Providers are required to maintain thorough documentation, including care plans, assessments, and interactions in Electronic Health Records (EHR).

Depending on the member's overall condition, concurrent services separate from those included in the bundle may be appropriate (e.g., a home health aide for a broken hip). DMAHS does not mandate incremental prior authorization for concurrent services for CBPC members. Providers billing a-la-carte for services in the PMPM bundle remain subject to existing prior authorization requirements, and MCOs may require additional prior authorization at their discretion.

Provider Enrollment & Credentialing

Provider Qualifications

Acceptable provider entity types include: hospice, home health agency, physician group, or independent clinic. Note: operationalization for FQHCs will not begin in Year 1 of benefit implementation.

Provider entities delivering CBPC services must be able to deploy a full team of qualified IDT practitioners to ensure high-quality, comprehensive, and coordinated care.

At minimum, a CBPC provider entity must employ a lead IDT clinician and employ or directly contract all other required IDT roles. Based on member need, a CBPC provider entity may deploy optional practitioners. Optional NPs and PAs may be employed or directly contracted, while other optional practitioners may be employed, contracted, or subcontracted, as long as they are appropriately credentialed and licensed in New Jersey.

Additionally, provider entities must demonstrate sufficient proficiency in palliative care by following one of two paths:

- **Entity-level:** Hold entity-level certification from a nationally recognized body specializing in palliative care (The Joint Commission, Community Health Accreditation Partner, Accreditation Commission for Health Care) **OR**

- **Practitioner-level:** Submit proof of each required IDT practitioner's individual certification in palliative care OR completed 12 Continuing Education Units (CEUs) in palliative care

Additionally, provider entities must offer a 24/7 telephone line to triage member issues.

For full details of provider requirements, please reference the Provider Enrollment and Credentialing detailed section and the CBPC Credentialing Add-

on for further details, including training requirements dependent on entity and individual certifications

Required Practitioners – Entity-Level

All provider entities must employ or directly contract a Medical Director:

Practitioner	Deployment Options	Required Licensure	Required Certification *(always required regardless of entity certification)*	Palliative Care Proficiency *(required only if no entity- level certification)*	Notes
Medical Director	Directly employed or contracted	MD or DO	None beyond licensure	If no entity-level certification, clinician must: 1. Hold Certification (HPM) **OR** 2. Complete 12 CEUs of training on topics within palliative care list	Must be Medicaid-enrolled **OR** if applying for Medicaid ID, must hold Medicaid ID prior to MCO credentialing

Required Practitioners – IDT-Level

All provider entities must employ the Lead IDT Clinician and either employ or directly contract the following required practitioners. Each IDT must contain these practitioners at a minimum:

Practitioner	Deployment Options	Required Licensure	Required Certification *(always required regardless of entity certification)*	Palliative Care Proficiency *(required only if no entity-level certification)*	Notes
Lead IDT Clinician	Directly employed	MD, DO, PA, or NP DEA/CDS also required	***If MD/DO:*** Board Certification in Hospice and Palliative Medicine (HPM) **OR**	If no entity-level certification, clinician must: 1. If holds HPM,	If an MD or DO, Lead IDT Clinician can also fulfill role of

			Certified Hospice Medical Director (CHMD) ***If NP:*** Advanced Certified in Hospice and Palliative Nurse (ACHPN) ***If PA:*** CAQ in Palliative Medicine & Hospice Care	ACHPN, or CAQ certification → then no additional training required **OR** 2. If holds CHMD → then complete 12 CEUs of training on topics within palliative care list	Medical Director Must be Medicaid-enrolled **OR** if applying for Medicaid ID, must hold Medicaid ID prior to MCO credentialing
Registered Nurse	Directly employed or contracted	RN	None beyond licensure	If no entity-level certification, practitioner must: 1. Hold Certification (ACHPN, CHPN) **OR** 2. Complete 12 CEUs of training on topics within palliative care list	
Licensed Mental Health Professional	Directly employed or contracted	LCSW, LPC, or LMFT	None beyond licensure	If no entity-level certification, practitioner must: 1. Hold Certification (APHSW-C) **OR** 2. Complete 12 CEUs of training on topics within	Must be Medicaid-enrolled **OR** if applying for Medicaid ID, must hold Medicaid ID prior to MCO credentialing

				palliative care list	

Practitioner	Deployment Options	Required Licensure	Required Certification *(always required regardless of entity certification)*	Palliative Care Proficiency *(required only if no entity-level certification)*
Chaplain	Directly employed or contracted	N/A	None beyond licensure	If no entity-level certification: 1. Chaplain must hold healthcare chaplaincy certification from an approved body **OR** 2. Chaplain must complete Level II Clinical Pastoral Education (CPE) from a program accredited by Association for Clinical Pastoral Education (ACPE) **OR** 3. Entity must be a Medicare-certified hospice **AND** Chaplain must complete 12 CEUs of training on topics within palliative care list
Child Life Specialist *required only for pediatric members; optional otherwise	Directly employed or contracted	N/A	Certified Child Life Specialist (CCLS) credential	If no entity-level certification, practitioner must: 1. Complete 12 CEUs of training on topics within palliative care list

Optional IDT Practitioners

The entity may include optional practitioners based on the individual needs of members. Unless explicitly noted, these practitioners may be employed, contracted, subcontracted, or not included in a provider entity's IDT. If included, these providers must all be appropriately credentialed and licensed in New Jersey:

- Nurse Practitioner (NP) (non-rendering) – *may not be subcontracted*
- Physician Assistant (PA) (non-rendering) – *may not be subcontracted*
- Pharmacist
- Home Health Aide (HHA)
- Certified Nursing Aide (CNA)
- Licensed Practical Nurse (LPN)
- Community Health Worker (CHW) – *must complete Colette Lamothe-Galette training and demonstrate 6 or more months experience in community clinics, federally qualified health centers, and/or the Medicaid program*

Provider Enrollment

To deliver CBPC services under NJ FamilyCare, provider entities must enroll in the NJ Medicaid Management Information System (NJMMIS). Provider entities are required to submit a complete Fee-For-Service Provider Enrollment Application package for their provider type, including the new CBPC-specific section (Form FD-439 for "Provider Enrollment: Palliative Care Add-On Form") to add the CBPC specialty code (999). Entity enrollment is contingent upon employing (or, if allowable for the role type, contracting) all required entity-level and IDT roles. Additional entity-level requirements will also be evaluated in enrollment. At enrollment, entities must hold entity-level palliative care certification or demonstrate each required practitioner's palliative care proficiency via individual certification or training. Providers will submit attestations detailing subcontracting arrangements and 24/7 telephone line capability. Gainwell will verify this information as part of enrollment.

All lead IDT practitioners as well as any practitioner with referring, ordering, prescribing, and/or attending authority (i.e., practitioners with existing enrollment pathways in NJMMIS) must be Medicaid-enrolled, including optional practitioners not listed on claims. All enrolled practitioners, including all lead IDT clinicians, must have their NPIs linked with the provider entity NPI upon enrollment.

Note that upon re-validation of enrollment within three years, all provider entities are required to hold entity-level certification in palliative care.

Provider Credentialing

In addition to Medicaid FFS enrollment, providers are encouraged to complete credentialing and contracting with Managed Care Organizations (MCOs) to deliver care to members in MCOs. Providers are encouraged to apply and participate with all five MCOs to support full member access. Providers must first enroll with NJ Medicaid FFS as CBPC providers before being able to complete MCO contracting and credentialing.

MCOs will use their individual credentialing forms and the DMAHS-standardized FD-439 Palliative Care Add-On Form. The FD-439 Add-On form is the same form for both FFS Enrollment and Credentialing, but must be re-submitted to each MCO for credentialing

along with any other information required.

In-network providers already participating as one of the four accepted provider types need only complete the CBPC add-on form and provide required palliative care documentation to the MCO. After credentialing, providers must execute contracts (new or addendum) with each MCO outlining payment, authorization, and care coordination.

In this process, MCOs will verify staff licensure, Medicaid enrollment status, and credentials for lead IDT clinicians. MCOs will also confirm that the entity employs or, if allowable for the role type, contracts all required IDT roles. They will confirm the entity offers a 24/7 member telephone line and either holds palliative care certification or has demonstrated each required practitioners' appropriate palliative care proficiency through individual certification or training.

Further details on enrollment and credentialing can be found in the Provider Enrollment & Credentialing section.

Quality Strategy & Monitoring/Reporting

DMAHS has established a quality strategy to ensure that the CBPC benefit effectively delivers person-centered care. DMAHS evaluates program performance regularly by tracking metrics related to member access, quality, and compliance with benefit standards.

Key quality metrics include member enrollment, provider enrollment/credentialing, authorization approval rates, assessment and PMPM volume, claim approval rates, and MCO Care Management metrics, among others. DMAHS will primarily use internally maintained claims data for program monitoring, minimizing the administrative burden on MCOs and providers while ensuring continuous program improvement.

Further details on quality metrics can be found in the Quality Strategy, Monitoring, & Reporting section.

Detailed Guidance

This section provides detailed guidance for providers and MCOs across each area of the Community-Based Palliative Care program

Covered Populations

Community-Based Palliative Care is designed to support New Jersey Medicaid members living with serious illnesses and significant quality of life impairments.

Members of all ages (adult and pediatric), enrollment statuses (FFS and MCO), plan types (Core Medicaid, MLTSS, FIDE-SNP, etc.), dual Medicaid-Medicare eligibility status (duals and non-duals), and conditions may qualify for the benefit.

Unlike hospice, CBPC **does not** require forgoing curative treatment. Rather, CBPC seeks to aid those members in navigating the healthcare system and support them in dealing with their individual illnesses.

To qualify for the benefit, members must meet **both** of the following criteria established by DMAHS:

1. Diagnosis with a serious illness

   Eligible conditions include (but are not limited to):

   Adult:

   - Cancer (Stage III or IV)
   - Congestive Heart Failure
   - COPD
   - ESRD or chronic kidney disease
   - Cirrhosis or liver disease
   - Degenerative neural condition (i.e. Parkinson's, severe neurodegenerative disorders)
   - Alzheimer's and dementias
   - Diabetes
   - Stroke
   - AIDS

   Pediatric (for conditions marked with an *, children do not need evidence of disease severity to qualify for the benefit):

   - Cardiac Disease
   - Pulmonary Disease
   - Neurological Disorder
   - Cancer
   - Renal Disease

- End-stage Liver Disease
- Genetic Disorders*
- Metabolic/Inclusion Disease
- Gastrointestinal Disease or Conditions*
- Orthopedic Disorders*
- Neonatal*
- Infectious Disease

2. Quality of life impairment (member must qualify under one of the three subcategories to meet quality of life impairment criteria):

   A. Documented functional decline **OR**
      - KPS <= 70
      - ECOG: grade of 3 or higher
      - PPS <= 70
      - MELD > 19
      - FAST => 5
      - MLTSS Enrollment

   B. Acute care utilization **OR**
      - Two (2) or more emergency department visits in the past six (6) months
      - One (1) acute hospitalization in the past 12 months

   C. Other functional decline/indication of disease severity not captured above
      - While the enumerated eligibility criteria establish the minimum threshold for member eligibility, MCOs and practitioners may apply clinical judgement to approve additional members based on individual determination of medical necessity.

Covered Services

Overview

The CBPC benefit offers a standardized package of interdisciplinary services designed to support individuals with serious illnesses in the community setting. These services are delivered by a qualified interdisciplinary team (IDT) and are based on an individualized care plan tailored to the member's needs, values, and goals of care.

CBPC services are intended to complement the member's existing medical care and do **not** require the member to forgo curative treatment for their serious disease. Instead, the focus is on symptom relief, care coordination, and emotional and spiritual support that align with the member's goals and priorities.

Covered Services within the PMPM bundle

Once the member is authorized for CBPC and a care plan is in place, the following types of services may be provided in the PMPM bundle, based on the member's individual needs and preferences:

- Comprehensive care planning and coordination
- Advance care planning discussions
- Symptom assessment and management
- Medication review: adjustments, titration, and prescribing/deprescribing
- Home-based or clinic-based visits by licensed IDT practitioners
- Psychosocial counseling and caregiver support
- Spiritual and emotional care
- Referral coordination to Medicaid-covered services
- Access to a 24/7 telephone line

CBPC services involve a member's primary care physician, curative treatment team, and an interdisciplinary palliative care team working closely together to coordinate care. These services can be delivered to members while residing in any non-hospital setting, such as at home, a Skilled Nursing Facility (SNF), or an Assisted Living Facility (ALF).

The services delivered must be clinically appropriate and well-documented in the member's electronic health record (EHR). EHR documentation should include clinical rationale and practitioner interactions.

While the intensity of services may vary by member, all services must be aligned with the member's care plan and be reassessed regularly.

Example Service Codes

The table below contains a list of service codes that fall under covered services within the PMPM bundle:

Code	Description
98008 - 98015	Telephone assessment and management service provided by a physician
98966 - 98968	Telephone assessment and management service provided by a qualified nonphysician
99202 - 99205, 99211 - 99215	OP visit for evaluation and management
99242 - 99245	Outpatient consult
99341 - 99342, 99344 - 99345, 99347 - 99350	Home or domiciliary visit for evaluation and management
99358 - 99359	Prolonged services (non-face-to-face)
99366 - 99368	Team conference / care planning
99421 - 99423	Online digital E/M
99424 - 99427	Principal Care Management
99437, 99439	Chronic care management
99446 - 99449, 99451-99452	Interprofessional consult
99487, 99489	Chronic care management (complex)
99490-99491	Chronic care management services
99492 - 99494	Collaborative care management
99495 - 99496	Transitional care management services
99497 - 99498	Advance care planning
G0019, G0022	Community Health Integration
G0023 - G0024, G0140, G0146	Principal Illness Navigation
G0155	Clinical Social Worker (CSW) services
G0156	Home Health Aide (HHA) services

G0175	Interdisciplinary Team Conference
G0506	Chronic Care Management Add-on
G0556 - G0558	Advanced Primary Care Management
H0031	Mental health assessment
H0034	Home health nursing
H2010	Comprehensive medication services
S9122	Personal care / aide / respite
S9123 - S9124	Home health nursing
T1001 - T1004	Home health nursing
T1019	Personal care / aide / respite
T1021	Home health nursing

Some members may receive different combinations of services within the bundle based on their individual needs. The intensity of service delivery scales with the degree of member need.

All services will be delivered by the IDT.

Note providers are required to document interactions in the EHR and have available upon MCO audit but not otherwise submit encounter data to MCOs. Interactions with the member and revisions to the care plan will be reviewed at the monthly IDT meeting.

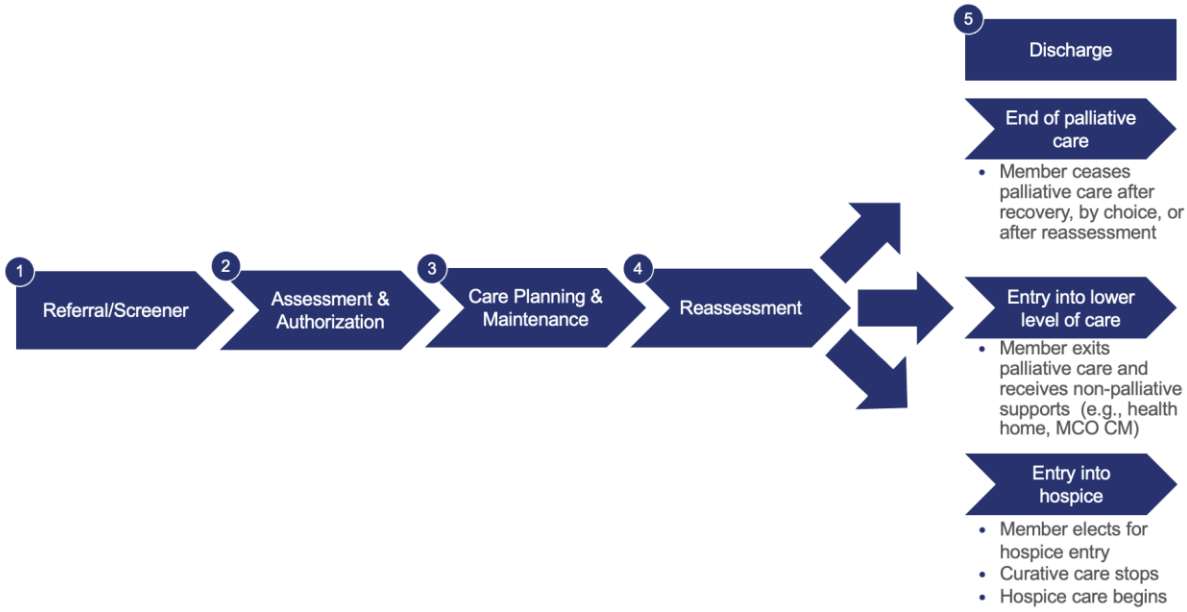
Member Journey Processes

Overview

This section provides a detailed view of the five core stages in a member's progression through the CBPC benefit: Referral, Assessment & Authorization, Care Planning & Maintenance, Reassessment, and Discharge.

The journey is designed to promote timely access to care aligned with the member's evolving health needs and care preferences. This structured journey ensures that eligible members receive appropriate support throughout their time in the benefit, while also enabling a seamless transition out of the program when clinically indicated.

The tools that support this journey—including the Program Eligibility Screening Tool, the Comprehensive Medical Assessment Tool, and the Member Care Plan Tool—are separate documents described throughout this section, along with expectations for documentation, clinical decision-making, and coordination among providers and MCOs. All tools should be stored in the member's electronic health record (EHR).



Referral/Screen

The first stage of the member journey is referral or screening. This is intended to be a low-barrier entry point to the benefit for potentially eligible members. Members may be directly referred to assessment by their healthcare provider or MCO, or they may use the Program Eligibility Screening Tool as a method to reach assessment.

To broaden access, DMAHS developed a brief, standardized **Program Eligibility**

Screening Tool as a method to identify members who may be eligible for the benefit. It is an optional tool that may be sent alongside a referral. It must be maintained by the provider entity in case of audit.

The Tool can be completed independently by a member or by anyone in the community, including clinicians and non-clinicians. It asks simple questions relating to a member's illness and disease severity. It consists of the following sections:

- **Referral Information**: Gathers key referral details including the referral date, referring person's contact information, and expected discharge date if applicable.
- **Member Information**: Gathers comprehensive information including the member's Medicaid details, preferred language, caregiver information, and consent status.
- **Primary Care Physician Information**: Ensures primary care providers are informed and involved in the coordination process.
- **Eligibility Screening Form:**
    - **Diagnosis Criteria**: Members must have at least one serious illness, such as cancer (Stage III or IV), Congestive Heart Failure, Alzheimer's/ dementias, Chronic Kidney Disease, COPD, or other similar serious conditions.
    - **Quality-of-Life Impairment:** Members must experience quality-of-life impacts, including recent/frequent ER visits, hospitalizations, difficulty with daily living activities (e.g., bathing, dressing), or similar impairments.

If, after completing the Tool, potential eligibility for the benefit is indicated, the member should proceed to assessment. If the member has administered their own screen or otherwise had the screen administered by a non-referring provider, member should contact their MCO (or, for FFS members, DMAHS) to locate an in-network provider for assessment. If a member contacts a provider entity unilaterally without prior MCO engagement, they are encouraged to present their screen before assessment begins. Providers should store the Screening Tool in the member's EHR and submit to the MCO's Provider Portal (specific MCO Provider Portals listed below).

Similarly to other benefits, if a member's healthcare provider determines that the member may be eligible for CBPC, that provider can directly refer the member for an assessment. MCOs may also proactively identify potentially eligible members and refer them to an assessment.

Assessment & Authorization

Whether directly referred or identified as potentially eligible using the Program Eligibility Screening Tool, members proceed to the Assessment & Authorization stage. This stage includes a comprehensive medical assessment, using the **Comprehensive Medical Assessment Tool** to identify and document a holistic view of the member's health. The

assessment must be completed in person and may be completed by any qualified, Medicaid-enrolled MD, DO, PA, APN, or LCSW (does not need to be participating in a CBPC IDT). In the case that a member is referred for an assessment, providers should document the referral source.

To ensure timely access to assessment, MCOs cannot request prior authorization for providers to bill for assessment. At the completion of the assessment, the provider makes a recommendation of eligibility for the benefit based on the holistic view of the member's condition.

The Comprehensive Medical Assessment Tool is a standardized form designed by DMAHS intended to support eligibility determinations and health plan authorization of care for the CBPC benefit. The assessment may be completed by a single provider, billed under a clinician's NPI as the rendering/attending provider, and must be completed in person.

The Tool comprises several essential sections, including:

- **Member and Assessor Information:** Gathers standard demographics for the member, caregiver, primary care, and assessing provider.
- **Qualifying Clinical Condition**: Confirms the member's serious illness diagnosis (e.g., advanced cancer, CHF, COPD, CKD, Alzheimer's).
- **Indication of Disease Severity:** Evaluates hospital and ER utilization frequency and functional decline using validated tools such as:
  - Karnofsky Performance Status (KPS) ≤70
  - Eastern Cooperative Oncology Group (ECOG) grade ≥3
  - Palliative Performance Scale (PPS) ≤70
  - Functional Assessment Staging Tool (FAST) stage ≥5
  - Model for End-Stage Liver Disease (MELD) score >19
  - **Other Severity Indicators**: Includes dependency on durable medical equipment (e.g., oxygen, ventilators, wheelchairs), clinical biomarkers indicating advanced disease stages, and evidence of comorbid conditions.
- **Comprehensive Assessments:**
  - Physical Symptoms: Evaluated using either Edmonton Symptom Assessment Scale (ESAS), Functional Assessment Staging Tool (FAST), Palliative Performance Scale (PPS), or Karnofsky Performance Status (KPS)
  - Psychosocial Status: Screens for depression with PHQ-2 and PHQ-9; assesses caregiver burden using the Zarit Burden Interview (ZBI)
  - Spiritual Needs: Uses the FICA Spiritual Assessment Tool to document faith, spirituality's importance, community engagement, and preferences for spiritual care
  - **Goals for Care**: Documents advance directives, Physician Orders for Life-

Sustaining Treatment (POLST) forms, and health proxy identification, confirming member preferences for treatment and care priorities.

- **Clinical Summary & Eligibility Determination**: Summarizes key findings from the assessment and indicates provider's determination of member eligibility.

The completed Comprehensive Medical Assessment Tool enables the member's health plan to authorize care (i.e., the PMPM bundle of services) based on documented serious illness, indications of disease severity or provider and MCO judgement based on the member's condition. A provider may only be paid for one **initial** assessment per member per quarter.

MCOs are permitted but not required to exercise prior authorization of the CBPC bundle. For MCOs exercising prior authorization, the submission of the completed Comprehensive Medical Assessment Tool serves as the prior authorization request. For MCOs not exercising prior authorization, this submission is used for eligibility documentation and payment.

Providers must store the Comprehensive Medical Assessment Tool in the member's EHR and submit the Tool to the MCO within 5 business days. The MCO must store the Tool, regardless of whether the MCO exercises prior authorization of the CBPC bundle.

MCO-specific policies for tool submission and prior authorization of the **CBPC bundle** are as follows:

MCO	Prior authorization required for PMPM?	Tool submission method(s)
Aetna	Yes	**NJ Medicaid**: Authorization Requested • Portal: http://www.availity.com/providers • Phone: 1-855-232-3596 • Fax: 1-844-797-7601 No Authorization Requested (Reassessment or Discharge Tool) • Care Management ICM and MLTSS o ABHNJPalliativeCare@aetna.com **NJ FIDE:** Authorization Requested • Portal: http://www.availity.com/providers • Phone: 1-844-362-0934 • Fax: 1-833-322-0034 No Authorization Requested (Reassessment or Discharge Tool)

		• Care Management FIDE ICM MLTSS ○ NJ_FIDE_SNP_CM@Aetna.com
Fidelis Care	Yes	• Portal: Fidelis Care Provider Portal • Phone: 1-855-642-6185 *(customer service)* • Fax: 1-855-573-2346 *(preferred)*
Horizon	Yes	• Portal: Availity Essentials™ • Phones: Medicaid: 800-682-9094 MLTSS: 844-444-4410 FIDE-SNP: 888-621-5894

United Healthcare	Yes	• Phone: 888-362-3368
		
		Providers have 3 methods to submit claims: Paper, EDI, or UHC Provider Portal.
		
		Paper claims can be mailed by any provider to:
		• UnitedHealthcare Community Plan
		P.O. Box 5250
		Kingston, NY 12402-5250
		
		Electronic Data Interchange (EDI)
		• The 835 Payer ID for UnitedHealthcare Community Plan of New Jersey is 86047
		
		UHC Provider Portal
		• Providers who currently access the UHC Portal Sign In | One Healthcare ID should use their current login to submit claims
		• Providers who are new to UHC and require portal access can go to:
		  ○ Main Webpage identifying process and: Provider portal registration | UHCprovider.com
		  ○ Create your own One Healthcare ID to register your secure access Registration | One Healthcare ID
		  ○ Log in to complete tasks and manage your account Sign In | One Healthcare ID
		  ○ Connect organization TIN(s) and select your portal tools for access

Wellpoint	Yes	• Portal: Wellpoint Provider Portal
		• Core Medicaid department: 800-452-7101
		• UM fax: 877-244-1720
		  ○ Suzanne Veit, Manager
		  ○ Email: suzanne.veit@wellpoint.com

		○ Direct phone: 732-623-5861 • Long-term services and supports (LTSS) department: 800-452-7101 • UM fax: 888-240-4716 ○ Keisha Woodson, Manager ○ Email: keisha.woodson@wellpoint.com ○ Direct phone: 732-882-4606 • FIDE department phone: 866-805-4589 • UM fax: 844-429-9632 ○ Patrick Alston, Manager ○ Email: patrick.alston@wellpoint.com ○ Direct phone: 757-268-6106

MCOs are required to make prior authorization decisions within the following timeframes, measured from the time of MCO receipt of the Comprehensive Medical Assessment Tool, with urgency indicated on the Tool by the assessing provider:

- **Non-urgent authorization requests**: Within seven (7) calendar days

- **Urgent authorization requests**: Within 24 hours. If the MCO requires additional information from the submitting provider, the MCO must request this within 24 hours of initial receipt, and upon receipt of the updated Tool submission, make a decision within 24 hours and no later than 72 hours from receipt of the original submission.

MCOs may apply medical necessity reviews to prior authorization requests for the CBPC PMPM bundle. MCOs may use the following reference guides to support medical necessity reviews:

- Clinical Practice Guidelines for Quality Palliative Care (National Coalition for Hospice and Palliative Care)
- Standards of Practice for Pediatric Palliative Care (National Hospice and Palliative Care Organization)

For Year 1, MCOs will report denial decisions, based on medical necessity review, on a case-by-case basis to DMAHS within 5 business days of denial.

Authorizations should be unique to a member and servicing CBPC provider authorized to bill for the member. This ensures the member's provider of choice is documented and authorized to bill. MCOs may support the member with provider selection while they are reviewing the authorization request or immediately after providing authorization. For example, if the member has selected a CBPC provider when reviewing the authorization request, the MCO may authorize the member and selected provider at the same time. If the MCO authorizes the member first, they may support the member with provider selection immediately after. Once the member has selected a CBPC provider, the provider should be authorized to bill for the member. This process may vary based on MCO UM policies.

When a member is identified as eligible or potentially eligible for CBPC (i.e., via referral, screener, Comprehensive Assessment, or other MCO identification), MCOs should give members a reasonable number of in-network CBPC provider entities in geographic proximity (at least 3 recommended), ask whether they have a particular provider in mind and give a set number of days to make a decision. In the event a member does not choose a CBPC provider, they may be assigned one by the MCO.

After authorization to receive the benefit, the member enters the Care Planning & Maintenance stage of the benefit. Authorization is valid for a period of six (6) months.

In the case of a member switching MCOs or switching from FFS to an MCO, the member's new MCO is expected to honor the existing palliative care authorization for at least 60 days. After this period, the MCO may order a reassessment to determine a member's continued eligibility.

For FFS, DMAHS will replace the responsibilities of the MCO noted above. DMAHS will exercise prior authorization of the CBPC bundle for FFS members. The Comprehensive Medical Assessment Tool will be used to determine authorization for the PMPM bundle. To request prior authorization, email MAHS.CBPC@dhs.nj.gov. DMAHS will respond with a PA-15 request form that includes a unique PA number. Providers should submit the completed PA-15 form and the assessment to MAHS.CBPC@dhs.nj.gov as scanned attachments. DMAHS will notify the provider once an approval has been issued.

Care Planning & Maintenance

This stage is characterized by advance care planning, care coordination and management of the member's condition by an interdisciplinary team (IDT) of practitioners.

At the beginning of the care planning stage, the member is assigned an IDT who will be responsible for participating in the member's care planning and delivering all other services within the CBPC bundle. To develop the member's care plan, the IDT uses the **Care Planning Tool** developed by DMAHS.

The Care Planning Tool is a standardized, patient-centered document used to capture and organize the individualized goals, preferences, care coordination strategy and IDT practitioners for the member receiving the benefit.

Multiple practitioners participate in the administration of the Care Planning Tool to create the member's care plan, and the Lead IDT Clinician must meet with the member to create the plan. The Lead IDT Clinician's first interaction with the member must be conducted in person; if the care planning meeting is that first interaction, it must be in person. If the Lead IDT clinician was the conductor of the patient's initial assessment, which should be conducted in-person, then the assessment counts as the first in-person interaction. The Tool requires signoff from the Lead IDT Clinician, MCO Care Manager,

Member, and Caregiver (if applicable) when the plan is finalized (e.g., initial authorization, reauthorization). Providers should submit material care-plan changes to MCOs within 5 business days. The Care Plan should be stored in the member's EHR and reviewed by the IDT and MCO CM at monthly IDT meetings.

The IDT uses the Care Planning Tool to translate findings from the member's medical assessment into an actionable, personalized palliative care strategy. It specifies details necessary for care plan implementation and ongoing coordination, including:

- **Member Information**: Confirms member Medicaid details, primary spoken language, and other demographic information.
- **Qualifying Clinical Condition & Functional Decline**: Outlines primary diagnoses, functional decline measurements, and primary and specialty providers.
- **Medications**: Details current medications, medication changes, deprescribing considerations, and allergies.
- **Care Coordination & Support Services**: Outlines necessary referrals to complementary services (e.g., home health, hospice, HCBS, behavioral health), identifies durable medical equipment needs (e.g., hospital bed, wheelchair) and other needs (e.g., community resources, caregiver support), and confirms the need for expedited approvals for medications and equipment.
- **Interdisciplinary Team (IDT) Involvement**: Lists required core staff (Lead IDT Clinician, RN, LCSW/LPC/LMFT, Chaplain, and CCLS for children) and optional staff (e.g., non-rendering NP/PA, LPN, CNA/HHA, Pharmacist, Community Health Worker), including their roles and contact information.
- **Advance Care Planning (ACP) & Goals Review**: Summarizes patient and caregiver goals, records code status and health power of attorney, documents ACP discussions and presence of advance directive/POLST, and identifies transition planning needs, follow-up steps, and key priorities for the next visit.
- **Palliative Care Plan of Care**: Provides a comprehensive plan across symptom domains (e.g., pain, dyspnea, GI, psychological) and addresses social factors and resource needs. Documents interventions, referrals, resources provided, and upcoming IDT meeting and patient follow-up dates.

Reassessment

There are two use cases for reassessment: reauthorization (i.e., determining continued eligibility) and informing care plan updates if the member's condition changes.

At the end of all six-month authorization windows the member must be reassessed for continued eligibility. Reassessment uses the same Comprehensive Medical Assessment Tool as the initial eligibility assessment. Providers should note any changes in the member's condition across all assessment categories. The completed

Tool must be stored in the member's EHR and submitted to the member's MCO for reauthorization within 5 business days via the MCO-specific policies for tool submission. Reauthorization is valid for an additional six months of care from the end date of the existing authorization period. If reauthorized, the provider must update the member's care plan, and the IDT should continue to address the member's condition.

If a member's condition changes significantly within the six-month authorization window (e.g., their condition progresses or they suffer a fall), that member should be reassessed.

Providers may only be reimbursed for one reassessment per member per month. MCOs retain the right to audit documentation to verify the change in condition and to recoup payment as appropriate. For reassessments received during an existing six-month authorization period, MCOs may process the claim and maintain the existing six-month authorization period. Only reassessments conducted in the final 30 days of an authorization period, and submitted with a prior authorization request, will be considered by MCOs to be a request to extend authorization period.

Given that reassessment uses the same Tool as initial assessment, the MCO may make individual determinations to extend member authorizations. Please note that the reassessment criteria differ from the initial assessment in terms of inpatient utilization. A member may be eligible for reauthorization if they have serious disease and show evidence of reduced quality of life, including:

- Are in functional decline (e.g., significant difficulty with 1+ activity of daily living) OR
- Two (2) or more emergency department visits in the past six (6) months OR
- One (1) acute hospitalization **in the past six (6) months**

If the reassessment results in an indication that the member is no longer eligible, and the MCO does not reauthorize care, the member moves into discharge from the benefit.

For FFS, DMAHS will replace the responsibilities of the MCO noted above. To request prior authorization, email MAHS.CBPC@dhs.nj.gov. DMAHS will respond with a PA-15 request form that includes a unique PA number. Providers should submit the completed PA-15 form and the reassessment to MAHS.CBPC@dhs.nj.gov as scanned attachments. DMAHS will notify the provider once an approval has been issued.

Discharge

Discharge from CBPC follows a standard process, regardless of the member's exit timing or destination.

In the case of member exit from the benefit, the provider must submit a completed **Member Discharge Form** to the MCO. The Member Discharge Form is a standardized

form developed by DMAHS and completed by the IDT that aids in the member's transition out of the benefit. The IDT should review the member's concurrent services and request to extend those that are needed beyond their exit from the benefit.

In the case of a member being discharged from the benefit after being reassessed as ineligible, the provider must also store the completed reassessment form in the member's EHR and submit the form to the MCO via the MCO-specific policies for tool submission.

In the case of a member switching providers or MCO, the member's current provider must transmit all relevant medical information, including assessments and care plans, to the member's new provider or MCO.

If the member switches to a new MCO and their existing provider is out of network, the MCO must honor their existing authorization for a period of 60 days to ensure care continuity.

Tool Summary

The requirements for tool completion, submission, and storage are outlined below:

Tool	Required?	Completed by	Submitted to	Stored by
Screener	No, optional to send alongside a referral	• Provider **OR** • MCO **OR** • Anyone in the community (member, caregiver, etc.)	• Provider to perform Comprehensive Assessment **OR** • MCO (via MCO-specific policy for tool submission) to coordinate provider to perform Comprehensive Assessment	Provider: Store in member EHR in case of audit MCO: Store when received
Comprehensive Medical Assessment	Yes, required for member entry to benefit	• Qualified, Medicaid-enrolled	• FFS: Scan and email with request for PA	Provider: Store in member

	and for reauthorization every 6 months / upon member change in condition	clinician (MD, DO, APN, PA, or LCSW) • Must be completed in person	to MAHS.CBPC@dhs.nj.gov • MCO: via MCO-specific policy for tool submission	EHR MCO: Must store, regardless of whether member enters benefit
Care Planning Tool	Yes, required when member enters benefit and updated every 6 months / upon member change in condition	• CBPC IDT – Lead IDT Clinician must complete with the member (must be in person if it is Lead Clinician's first interaction with member)	• N/A, maintained in member's EHR • Shared with MCO CM for signoff upon finalization • Reviewed at the monthly IDT meeting	Provider: Store in member EHR
Member Discharge Tool	Yes, required when member exits benefit or changes providers / MCOs	• CBPC IDT	• FFS: Scan and email to MAHS.CBPC@dhs.nj.gov • MCO: via MCO-specific policy for tool submission • In case of provider switching, new provider (along with assessments and care plan)	At discretion

MCO Care Management

Overview

Care management within the CBPC benefit involves collaborative engagement between the MCO Care Manager (CM) and the IDT. MCO Care Managers play a pivotal role by supporting member care coordination and facilitating access to the broader Medicaid service offerings that members may require.

Roles and Responsibilities

Upon entry into the benefit, each member will be assigned an MCO Care Manager if they do not already have one. If members already have an MCO CM, it is expected that they retain the same MCO CM, as possible.

Any MCO CM may serve as a care manager for a member in the benefit, and it is permissible that MCO CMs can support both members in palliative care, along with members in other programs. This will enable members to retain continuity in care management when they join the benefit.

MCO Care Managers support the IDT in coordinating services, which may include:

- Facilitating access to concurrent Medicaid-covered services such as Personal Care Assistance (PCA) for activities of daily living (ADLs).
- Assisting with securing or accelerating access to medically necessary Medicaid-covered services that complement the member's palliative care plan (e.g., home oxygen, controlled substances).
- Collaborating with the IDT by participating in monthly meetings to review, evaluate, and refine care plans.

Because care coordination is a core function of the IDT supported through the PMPM, the MCO and provider may decide that the IDT will take the lead on care coordination activities (e.g., day-to-day care management, member touchpoints, and plan navigation) to streamline efforts and avoid duplication.

Once a member is enrolled in CBPC, the MCO CM is responsible for initiating contact with the provider entity, establishing ongoing communication with the provider IDT, and coordinating the member's care in collaboration with the IDT.

The MCO CM's active participation at least monthly at internal IDT meetings will verify the care plan is updated appropriately and the required interactions are taking place. Additionally, MCO CMs are expected to oversee and ensure IDT completeness (e.g., replacement of any required IDT practitioners who exit the provider entity).

The format of the IDT meeting is at MCO/provider discretion. Provider IDTs will be expected to take the lead in scheduling MCO-specific meetings and streamlining with MCO Care Managers where possible.

Communication at and between meetings should be bidirectional, with the MCO CM actively participating to refine the plan and coordinate complementary Medicaid services.

Care Plan and Concurrent Services Management

The Care Plan requires signatures from the provider, the MCO Care Manager, member, and caregiver (if applicable). The order and format of signatures are not prescribed (e.g., digital or documentation of verbal signoff acceptable). Signatures are captured when the plan is finalized (e.g., initial authorization, reauthorization). Material care-plan changes should be communicated between providers and MCOs within 5 business days and reviewed at the next IDT meeting.

The IDT and the MCO CM collaborate to ensure integration with concurrent Medicaid services provided outside the core palliative care benefit. It is the responsibility of the IDT to assess members' broader needs and coordinate closely with the MCO CM to connect members to these complementary services.

MCO Care Manager Caseload

In Year 1, DMAHS will not set MCO Care Manager staffing requirements (i.e., no prescribed monthly hours, caseload caps, or weighting standards). To inform potential updates in future years, DMAHS will collect data on CMs serving CBPC members – additional information is provided in "Quality Strategy, Monitoring, & Reporting" section.

MCO Care Manager Training

Any existing MCO Care Manager may support members in the CBPC benefit if they complete specialized palliative care training. The training will be delivered by the MCO. Training content will be approved by DMAHS and must cover:

- Fundamentals of community-based palliative care
- IDT collaboration and documentation standards – *Please see the "Member Journey Processes" and "Payment Model, Billing & Claims" sections for additional information on documentation, requirements for payment, and more*
- Cultural responsiveness and spiritual care
- Addressing the clinical, social, and emotional needs specific to palliative care
- Effective care coordination practices to optimize outcomes

MCOs must maintain training plans and logs and confirm that Care Managers are assigned CBPC members only after training is completed.

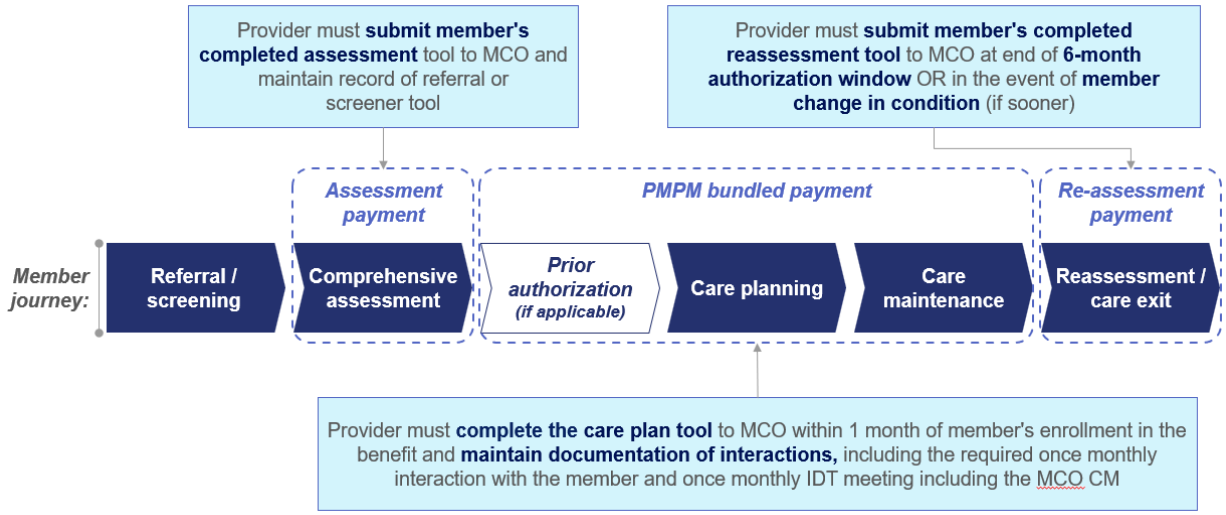
Care Management for FFS members

For FFS members, the Lead IDT Clinician is expected to replace the role of the MCO Care Manager. This includes managing all care coordination and care plan oversight activities that the MCO CM would conduct, as well as ensuring quality of care and appropriate touchpoints delivered within each month.

Payment Model, Billing & Claims

Overview

The CBPC benefit uses a payment structure that is aligned to the member journey through the benefit. Providers bill in three phases: initial assessment, ongoing Per Member Per Month (PMPM) bundled services, and periodic reassessments. This section details payment structure, expectations for payment, billing requirements, claims timeliness and concurrent services details for the benefit.



Payment Structure

Initial assessment: The minimum initial assessment reimbursement rate will be the Fee-For-Service (FFS) rate established in the fee schedule. As of April 1, 2026, that value is $100. Prior authorization is not permitted for the initial assessment. Providers may only submit for reimbursement for one initial assessment per member per quarter.

Providers must submit the completed Comprehensive Medical Assessment Tool to the MCO (or to DMAHS for FFS members) and retain the member's referral or Program Eligibility Screening Tool in case of audit.

Assessment reimbursement is not conditional on a member being assessed eligible. MCOs must reimburse providers for the full amount of the assessment even if the assessment is terminated early in the event that a member is determined ineligible in sections E or F of the assessment tool.

PMPM bundle: The minimum PMPM reimbursement rate will be the FFS rate established in the fee schedule. As of April 1, 2026, that value is $686. Providers must bill bundled PMPM payments using CMS-1500 or CMS-1450 forms, under the provider

entity's NPI (Type II NPI), with the IDT lead clinician documented as the rendering/attending provider (Type I NPI). PMPM authorizations are valid for a minimum duration of six months, with full reimbursement allowed for partial months (e.g., when member enters or exits the benefit mid-month) if all documentation and care requirements are fulfilled.

Providers must clearly document all care planning and maintenance activities, including IDT-member interactions and monthly IDT meetings, in the Electronic Health Record (EHR) system.

Providers are expected to only submit claims for months in which they have delivered all required touchpoints for the member. MCOs retain the right to audit providers and recoup payment if providers are unable to produce the appropriate documentation verifying the completion of required activities for the PMPM bundle. The MCO CM's attendance at least monthly at internal IDT meetings will also verify that required activities are completed and inform quarterly quality reporting.

Reassessment: The minimum reassessment reimbursement rate will be the FFS rate established in the fee schedule. As of April 1, 2026, that value is $85. Members must be reassessed at least every six months for benefit reauthorization. If the member's condition changes significantly, they should be reassessed. Providers may reassess members a maximum of once per month.

The same requirements apply to the reassessment as the assessment: Providers must submit the completed Comprehensive Medical Assessment Tool to the MCO (or to DMAHS for FFS members), and reimbursement is not conditional on a member being assessed eligible.

Service	Rate Code	FFS Rate Floor	Required activities	Notes
Initial Assessment	S0280	$100	Submission of Comprehensive Medical Assessment Tool to MCO	• Prior authorization of assessment not permitted
PMPM Bundle	S0311	$686	Documentation of care coordination activities and EHR recordkeeping; record retention in case of MCO audit	• MCOs permitted to exercise prior authorization • Comprehensive Medical Assessment services as the prior authorization request • Covers services delivered per the

				member's care plan • Authorized for a 6-month window
Reassessment	S0281	$85	Submission to MCO at end of six-month authorization window or upon significant change in member condition	• Prior authorization of reassessment not permitted

Required Activities

Proper delivery of the CBPC benefit is contingent upon completion of specific activities, including documentation, care coordination, and interaction requirements. MCOs and provider entities must ensure these activities are completed and appropriately documented.

Please note: the Lead IDT Clinician must meet **in person (not via telehealth) with the member for at least their first interaction with the member**. If the Lead IDT Clinician conducted the initial assessment, this may count as the first in-person interaction. After the first in-person interaction, **subsequent visits may be conducted via telehealth (video and/or audio), if agreed upon by the member and care team**. Providers must ensure telehealth is accessible to the member if telehealth use is agreed upon.

Required activity	Details	Documentation	Frequency
Care plan	The IDT must work together to create the member's care plan using the standard tool.	EHR chart note and fields in care plan document maintained by provider entity	**At least every 6 months or upon change to member condition**; must be done within 1 month of member enrollment and re-assessment
	As a part of this care planning process, the Lead IDT Clinician must meet with the member and sign off on the care plan.		
	Care plan shared with MCO CM for signoff		

IDT-member interaction	Practitioner(s) from the IDT must meet with the member and may do so **in person or via telehealth**, if telehealth is deemed acceptable by both the member and provider. CBPC providers should ensure telehealth is accessible for all members planning to use this method.	EHR chart note	**Monthly** – required for PMPM claim to be accepted
IDT Meeting	IDT must meet internally with the MCO CM to discuss care planning; **meetings may be conducted virtually**.	EHR chart note; updates sent to other providers and MCO	**Monthly** – required for PMPM claim to be accepted

Providers must develop individualized care plans using the standardized Care Planning Tool created by DMAHS. Care plans must be completed and documented within one month of the member's enrollment into the benefit.

Providers must share the care plan with the MCO Care Manager for signature upon finalization (e.g., at initial authorization, at reauthorization) and ensure the care plan is available upon audit but otherwise do not need to submit the care plan to MCOs. Providers are recommended, but not required, to share finalized care plans with other involved healthcare providers (e.g., curative care provider, member's primary care physician) to ensure coordinated, comprehensive care delivery.

All care plan tasks must be documented clearly within provider EHRs, ensuring fields in the care plan tool are complete, timely, and accurately reflect the member's individualized care. EVV will not be mandated at program launch; DMAHS will revisit this decision after Year 1.

The IDT must conduct at least one interaction with each member each month to ensure care is personalized, responsive, and comprehensive. Additionally, all interactions between IDT practitioners and the member, including evaluations and assessments by social workers or other team professionals, must be documented fully in provider EHR chart notes.

Not every member will have every required practitioner of the IDT deployed for their care, and some members will have additional optional practitioners. Providers will deploy IDT practitioners based on the member's preferences and care plan, which may evolve based on member goals for care or change in status.

IDT is required to meet with the MCO Care Manager (CM) at least once a month to

discuss changes to IDT staffing, CBPC member enrollment, and revised care plans. This requirement to meet with the MCO CM is waived for members enrolled in FFS Medicaid (as they necessarily do not have an MCO CM).

All IDT meetings must be thoroughly documented within the provider's EHR system, and relevant updates must be promptly shared with all entities/individuals involved in the member's ongoing care across the care continuum.

Billing Requirements

Assessment and reassessment:

Providers can submit claims for assessment using either of the following CMS claim forms: CMS 1500 or CMS 1450 (UB-04).

Claims submitted on either form must include the diagnosis code Z51.5 (Palliative Care Encounter). However, this should not be the member's primary diagnosis code, which should be their qualifying serious disease.

Additionally, if billing on the CMS-1450 form, the provider is required to include revenue code 0693 (pre-hospice or palliative care services) in addition to the relevant HCPCS code (S0280 for assessment and S0281 for reassessment).

PMPM bundle:

The CBPC PMPM bundle is billed retrospectively each month (i.e., may not be billed sooner than the first day of the following month). Providers can submit using either of the following CMS claim forms:

- CMS 1500
- CMS 1450 (UB-04)

If billing on CMS 1500, claims must include:

- Rendering NPI (Type I NPI) of Lead IDT Clinician (Field 24J)
- Billing NPI (Type II NPI) of provider entity (Field 32a)

If billing on CMS 1450 (UB-04), claims must include:

- Billing NPI (Type I NPI) of Lead IDT Clinician (Field 56)
- Operating provider entity NPI (Type II NPI) (Field 77)

Additionally, if billing on the CMS-1450 form, the provider is required to include revenue code 0690 (pre-hospice or palliative care services) in addition to the S0311 HCPCS code.

Claims Timeliness

When submitting to MCOs, providers are expected to abide by MCO claim standards. "Clean claims" are typically defined by:

- The claim is for a service or supply covered by the health benefits plan or dental plan;
- The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person;
- The person to whom the service or supply was provided was covered by the carrier's health benefits or dental plan on the date of service;
- The carrier does not reasonably believe that the claim has been submitted fraudulently; and
- The claim does not require special treatment.

DMAHS requires that MCOs process clean claims within:

- 15 days for 90% of electronically submitted clean claims
- 30 days for 90% of manually submitted clean claims
- 45 days for 99.5% of all claims

Providers are expected to submit claims within 180 days of service, following State timeliness standards.

For additional detail on MCO specific billing requirements and processing timelines, please refer to each MCO.

Concurrent Services

If the member requires services included in the PMPM bundle (e.g., home health services) but rendered to address acute, chronic, or preventive care needs that fall outside the scope of the member's palliative care diagnosis or care plan, providers may bill those services a-la-carte.

Prior authorization for these concurrent services will follow existing requirements, and enrollment in CBPC does not create incremental prior authorization obligations. MCOs, however, may apply additional prior authorization at their discretion. Prior authorization should serve as the primary check to ensure appropriate billing for concurrent services. If authorized, providers should bill those concurrent services without the palliative care diagnosis code (Z51.5).

Concurrent services should be documented in the member's care plan and reviewed at the IDT meeting. If a member is already receiving concurrent services prior to entering

palliative care, those services should be documented in the care plan but otherwise not disrupted. If those services require renewal while the member is enrolled in palliative care, the standard prior authorization process continues to apply.

Examples of services accessed by members with serious disease are included below:

Program	Permissible as concurrent service	Rationale
Home health / MLTSS	Yes	Many members will require support with activities of daily living (ADLs) beyond what is available through the benefit
Care management	Yes	MCOs may deem that members may require additional specialized care management support (e.g., for behavioral health). In the scenario where a member has multiple care coordinators, the IDT is expected to play a 'coordinator of coordinators' role to ensure that all activities are aligned
EPSDT	Yes	EPSDT services go beyond the scope of palliative care (e.g., Dental)
Hospice (adults and pediatric)	No – member must exit palliative care to enter hospice	Core hospice services (e.g., pain management, coordination with curative treatment for pediatric members) are duplicative with palliative care. Simultaneous hospice-palliative care enrollment would likely not improve member quality of life and would represent a program integrity risk

Please note the above table is illustrative, not exhaustive; other services may be permissible as concurrent services dependent on member needs and preferences.

NEW JERSEY HUMAN SERVICES

Provider Enrollment & Credentialing

Overview

To participate in the CBPC benefit, provider entities must complete an enrollment and credentialing process. This process is designed to ensure that all participating organizations and practitioners meet high standards of quality, staffing, and service capacity. This section outlines the multi-step requirements, including:

- Qualifications for CBPC provider entities and practitioners
- Medicaid enrollment of the provider entity in the state's NJMMIS system under the CBPC specialty designation
- Enrollment of individual IDT practitioners for roles requiring enrollment, as defined in guidance
- Credentialing with individual MCOs to become in-network providers eligible for reimbursement under managed care

Provider Qualifications

To deliver CBPC services under NJ FamilyCare, provider entities must demonstrate the capacity to deliver comprehensive, team-based care through a qualified IDT. The CBPC benefit is designed to serve members with complex and serious illness needs. As such, provider entities must ensure that their clinical teams meet specific standards to support high-quality, coordinated, and person-centered care.

Entity-Level Requirements

Provider entities be one of four provider types: hospice, home health agency, physician group, and independent clinic. Providers may not hold a license as a hospital or SNF. Note operationalization for FQHCs will not begin in Year 1 of benefit implementation.

All provider entities must either hold certification from a nationally recognized body specializing in palliative care or, for initial enrollment, submit proof of each required IDT practitioner's proficiency in palliative care via individual certification or completed Continuing Education Units.

Entity certification can be through one of the following:

- The Joint Commission (TJC)
- Accreditation Commission for Health Care (ACHC)
- Community Health Accreditation Partner (CHAP)

Each of the approved accrediting bodies conducts a rigorous review of the provider's operations, clinical practices, and organizational policies to ensure alignment with evidence-based standards in palliative care:

The Joint Commission (TJC): Community-Based Palliative Care Certification

- Assesses a provider's ability to deliver integrated, person-centered palliative services. Certification standards evaluate interdisciplinary team functioning, symptom management, advanced care planning, and communication protocols.

Accreditation Commission for Health Care (ACHC): Palliative Care Accreditation or Distinction

- Provides Palliative Care accreditation for home-based and facility-based services. ACHC standards address eligibility and admission processes, individualized plan of care development, staff qualifications, medication management, and patient/caregiver education.

Community Health Accreditation Partner (CHAP): Palliative Care Certification

- Offers certification specifically tailored to palliative care programs, assessing compliance with clinical and administrative standards related to symptom control, coordination of care, caregiver support, and performance improvement.

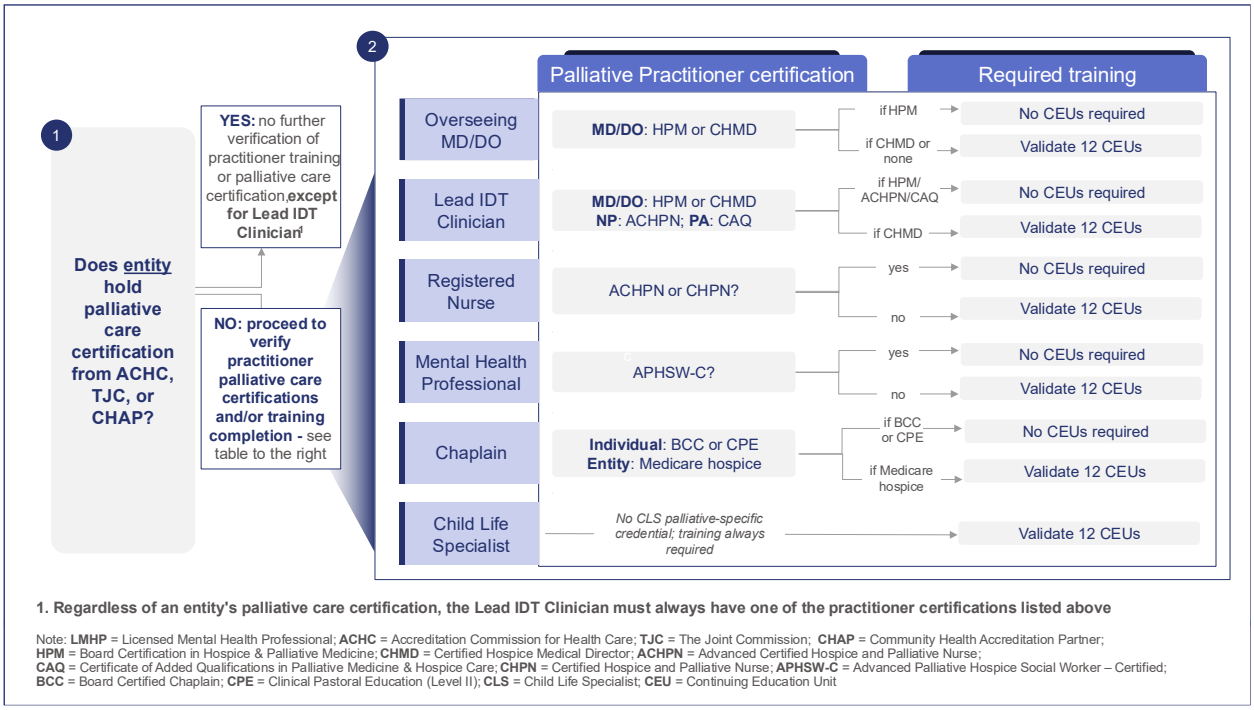
Certification ensures that provider entities are equipped to deliver complex palliative services with the appropriate clinical rigor, infrastructure, and quality assurance processes in place. These certifications:

- Standardize the delivery of care across diverse settings and providers.
- Promote member safety and care quality by enforcing clinical best practices.
- Enhance accountability through ongoing performance review and corrective action processes.
- Build trust with MCOs and referring providers, ensuring confidence that CBPC entities meet state and national standards.

DMAHS expects that provider entities should pursue these certifications if delivering the CBPC benefit. However, providers that have not yet earned one of these entity certifications will need to demonstrate for each required practitioner:

- Individual certification in hospice & palliative medicine *(see logic flow below)* **OR**
- Completion of 12 Continuing Education Units of palliative care-specific training, among a DMAHS-provided list of approved topics. A course must have been completed in the last 12 months and must cover topic(s) from this list to count towards the 12 CEU requirement; not all topics must be covered for a practitioner's training to be considered sufficient:
    - Pain & symptom management
    - Opioid safety

- Psychosocial support
- Spiritual care
- Cultural humility
- Serious illness communication
- Grief & bereavement
- Ethics & legal issues
- Advance care planning
- Crisis intervention
- Interdisciplinary teamwork
- Documentation standards
- Infection control
- Staff wellness



Upon revalidation, all provider entities must hold certification from a nationally recognized body specializing in palliative care.

Outside of the certification / palliative care training, provider entities must also have the organizational capacity to:

- Employ a Lead IDT clinician.
- Employ or directly contract a Medical Director and all required IDT roles.

- Ensure that all required and optional practitioners hold active, valid New Jersey licenses and relevant specialty certifications (where applicable, as specified in guidance).
- Coordinate timely, comprehensive care planning and delivery through a fully staffed IDT.
- Maintain adequate clinical supervision and oversight at the organizational level.

Required Staff

To qualify as a CBPC provider, entities must ensure that their IDT includes the following roles with the corresponding qualifications and credentials.

Note that if the provider entity does *not* hold a palliative care certificate from TJC, ACHC, or CHAP, then MCOs must validate that required team members either hold an individual certification in palliative care, or have completed 12 CEUs of training among the topics listed above in the last 12 months before application. Please note not all topics must be covered for a practitioner's training to be considered sufficient. Please see flow chart above and credentialing add-on form for details.

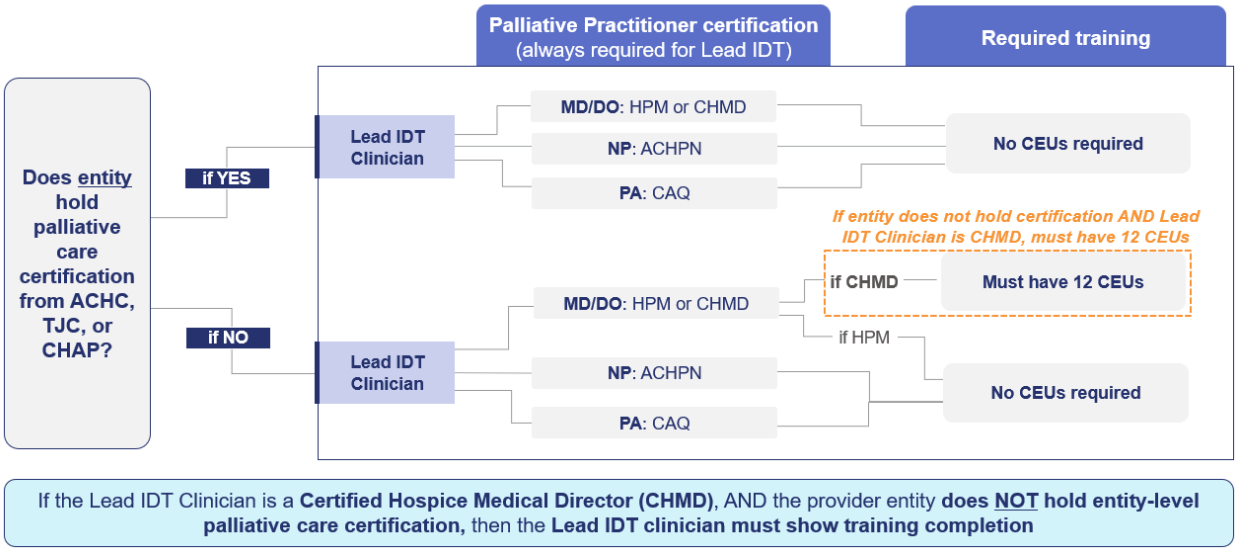
Medical Director

- Qualifications: Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO)
- Employment Status: Must be employed or directly contracted by the provider entity.
- Role: Provides clinical oversight for the IDT, supervises practitioners, and leads clinical governance as the responsible physician for the program. This individual may also fulfill the responsibilities of the Lead IDT Clinician.
- Note: This role may be fulfilled by the Lead IDT Clinician, if the Lead IDT Clinician is an MD or DO

Lead IDT Clinician

- Qualifications: MD, DO, Nurse Practitioner (NP), or Physician Assistant (PA)
- Employment Status: Must be directly employed by the provider entity.
- Certification:
  - MD/DO: Board Certification in Hospice and Palliative Medicine or Certified Hospice Medical Director (CHMD)
  - NP: Advanced Certification in Hospice and Palliative Nurse (ACHPN)
  - PA: Certificate of Added Qualifications (CAQ) in Palliative Medicine and Hospice Care
- Role: Serves as the primary clinical lead for the IDT and is responsible for overseeing care delivery and ensuring clinical appropriateness.

- Lead IDT Clinician must **ALWAYS** have palliative practitioner certification; training is required only if **NO** entity certification **AND** Lead IDT is a CHMD.



Note: **ACHC** = Accreditation Commission for Health Care; **TJC** = The Joint Commission; **CHAP** = Community Health Accreditation Partner; **HPM** = Board Certification in Hospice & Palliative Medicine; **CHMD** = Certified Hospice Medical Director; **ACHPN** = Advanced Certified Hospice and Palliative Nurse; **CAQ** = Certificate of Added Qualifications in Palliative Medicine & Hospice Care

Registered Nurse

- Qualifications: Registered Nurse (RN)
- Employment Status: Must be employed or directly contracted by the provider entity.
- Role: Coordinates nursing care and monitors symptom management and care plan implementation.

Licensed Mental Health Professional

- Acceptable Licenses:
  - Licensed Clinical Social Worker (LCSW)
  - Licensed Professional Counselor (LPC)
  - Licensed Marriage and Family Therapist (LMFT)
- Employment Status: Must be employed or directly contracted by the provider entity.
- Role: Provides mental health screening, emotional support, counseling, and care coordination related to psychosocial needs.

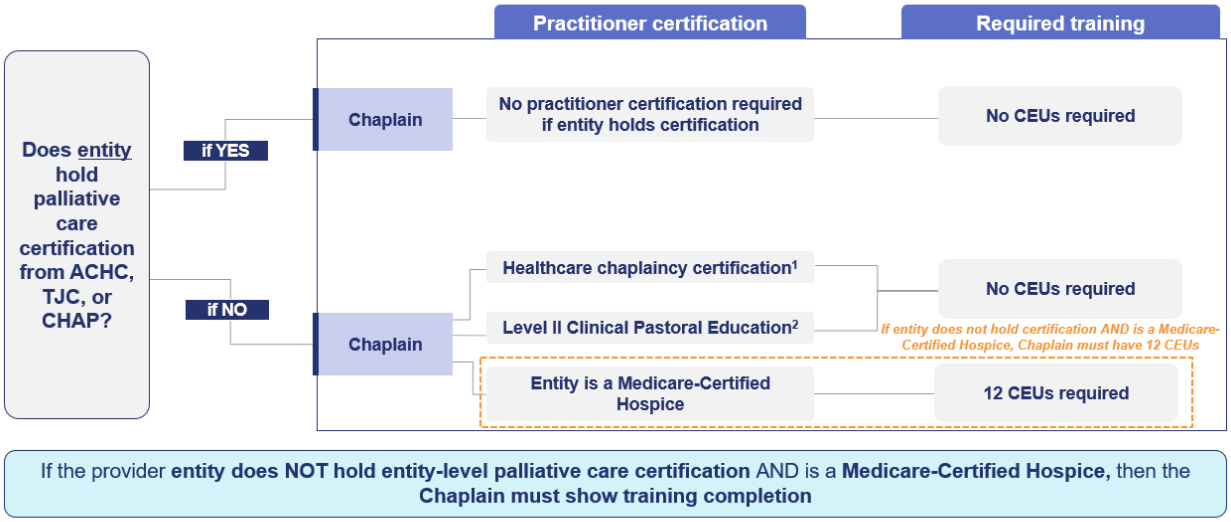
Chaplain

- Qualifications: Chaplains can be individually credentialed as a health care chaplain through either holding a qualification for an appropriate certifying body and/or through completion of clinical pastoral education. The chaplain can

alternatively be considered qualified if the provider entity holds appropriate certification (as these certifying bodies confirm entity ability to provide appropriate chaplaincy services).

  - Acceptable healthcare chaplaincy certifying bodies (*and acceptable certifications)* include:
    - Association of Certified Christian Chaplains (ACCC): *Board Certified Chaplain* or *Board Endorsed Clinical Chaplain*
    - Association of Professional Chaplains (APC): *Board Certified Chaplain*
    - National Association of Catholic Chaplains (NACC): *Board Certified Chaplain*
    - National Association of Veterans Affairs Chaplains (NAVAC): *Board Certified Chaplain* or *Certified Clinical Chaplain*
    - Neshama Association of Jewish Chaplains (NAJC): *Board Certified Member*
    - Spiritual Care Association (SCA): *Board Certified Chaplain* or *Advanced Practice Board Certified Chaplain*
    - Canadian Association of Spiritual Care: *Certified Spiritual Care Practitioner*
  - Level II Clinical Pastoral Education (CPE) through a program accredited by the Association for Clinical Pastoral Education (ACPE)
  - Entity certifications that assess ability to deliver appropriate chaplaincy services (and qualify chaplain in lieu of individual certification or CPE) are:
    - The Joint Commission (TJC): Community-Based Palliative Care Certification
    - Accreditation Commission for Health Care (ACHC): Palliative Care Accreditation or Distinction
    - Community Health Accreditation Partner (CHAP): Palliative Care Certification
    - Medicare hospice certification

- Employment Status: Must be employed or directly contracted by the provider entity.
- Role: Offers spiritual care and emotional guidance aligned with the member's beliefs and preferences.
- If entity is not palliative care certified, (1) Chaplain must hold healthcare chaplaincy certification, OR (2) Chaplain must complete Clinical Pastoral Education, OR (3) entity must be a Medicare-certified hospice AND the Chaplain must also complete 12 CEUs of training.



Note: **ACHC** = Accreditation Commission for Health Care; **TJC** = The Joint Commission; **CHAP** = Community Health Accreditation Partner
1. See NJ CBPC Program Guidance for acceptable healthcare chaplaincy certifying bodies
2. Must be through a program accredited by the Association for Clinical Pastoral Education (ACPE)

Child Life Specialist (required for Pediatric Members)

- Qualifications: To serve as a Child Life Specialist, an IDT practitioner must either:
- Hold a Certified Child Life Specialist (CCLS) credential from the Child Life Certification Commission

- Employment Status: Must be employed or directly contracted by the provider entity.
  - Role: Supports pediatric members and families by addressing developmental, emotional, and psychological needs. Note that only IDTs serving pediatric members are required to include a Child Life Specialist.

Optional Staff

Providers may, but are not required to, deploy optional practitioners based on the specific needs of individual members.

All optional team members must be appropriately licensed (where applicable) and credentialed. Most optional practitioners may be employed, contracted or subcontracted (i.e., deployed by another entity that is subcontracted by the primary provider entity). Note that the NP and PA cannot be subcontracted and must also be Medicaid enrolled as described in the following section. See the CBPC Credentialing Add-on for more information on the requirements associated with each of these optional roles.

These roles enhance flexibility and service breadth but do not substitute for any required IDT member. Optional roles include:

- Nurse Practitioner (non-rendering role) – *may not be subcontracted*

- Physician Assistant (non-rendering role) – *may not be subcontracted*
- Pharmacist
- Home Health Aide (HHA)
- Certified Nursing Aide (CNA)
- Licensed Practical Nurse (LPN)
- Community Health Worker (CHW) – *must complete Colette Lamothe-Galette training, a free training that takes 8+ weeks to complete*

Medicaid Enrollment

All provider entities must enroll in the NJ Medicaid Management Information System (NJMMIS) under a designated Community-Based Palliative Care specialty code (999). The enrollment process has been tailored to reflect the unique needs of CBPC service delivery and will include a distinct palliative care enrollment section. Key enrollment components and guidance are detailed below.

Enrollment Form and Scope: Existing or new hospice providers, home health agencies, physician groups, or independent clinics are required to submit a complete Fee-for-Service Provider Enrollment Application package for their provider type, including the new CBPC-specific section (Form FD-439 for "Provider Enrollment: Palliative Care Add-On Form") to add the CBPC specialty code (999). Practitioners enrolled in the CBPC section will be automatically enrolled as FFS providers.

Eligibility Requirements: To be approved for CBPC participation, entities must demonstrate that they:

- Employ a Lead IDT Clinician.
- Employ or contract with a Medical Director and all required IDT roles.
- Hold entity certification or, for initial enrollment, that all of their practitioners hold individual palliative care certification or have completed 12 CEUs of training in palliative care.
- Offer a 24/7 member telephone line.

Linking of NPI Numbers: The entity's type II NPI must be linked to the type I NPIs of any clinician (e.g., MD, DO, NP, PA) serving as the lead IDT clinician or fulfilling a required entity-level role (e.g., Medical Director). All other clinicians are expected to enroll in Medicaid and link to the entity. This ensures accurate claims processing and eligibility tracking.

Medicaid Enrollment for IDT Practitioners: All lead IDT clinicians and any other referring, ordering, prescribing, or attending (ROPA) practitioners with existing NJMMIS enrollment pathways must be Medicaid enrolled and linked to the provider entity. This includes: MDs, DOs, NPs, PAs, LCSWs, LPCs, and LMFTs.

24/7 Availability: Enrollment will require attestation that the provider offers a 24/7 telephone line that has access to the member's EHR, can triage non-emergent member issues (e.g., health-related social need concerns), and connect the member to appropriate care (including their IDT if necessary).

Subcontracted practitioner enrollment
To support access and maintain compliance with federal requirements, provider entities may subcontract optional IDT practitioners under the following framework:

- **Initial Enrollment**: Provider entities must submit attestation specifying which practitioner roles will be subcontracted (i.e., deployed by another entity that is subcontracted by the primary provider entity). The attestation must include the Medicaid ID of the subcontracted organization (which must be Medicaid-enrolled).
- **Verification**: Gainwell will verify completion of all necessary components of the attestation. DMAHS may audit compliance as needed.

MCO Credentialing

For providers who seek to bill and render CBPC services for members covered by MCOs, providers must join the MCO's network, i.e., become a "participating provider." While not required, providers are recommended to join all five MCOs to support member access, as members' MCO enrollment may change.

Joining an MCO network involves completing two processes: credentialing and contracting. Providers must first enroll with NJ Medicaid FFS as CBPC providers before being able to complete MCO contracting and credentialing. To credential with MCOs, providers will use each MCO's individual credentialing form for the provider's entity type (e.g., hospice, HHA, etc.) and the DMAHS-standardized FD-439 Palliative Care Add-On Form. In-network providers already participating as one of the four accepted provider types need only complete the CBPC add-on form and provide required palliative care documentation to the MCO.

MCOs are requested to expedite the contracting and credentialing process for CBPC providers to 30-45 days to support accelerated network building ahead of launch.

Credentialing Process

MCOs will collect a similar set of information to what providers submit during Medicaid enrollment via Gainwell. MCOs will include the FD-439 in their credentialing packets for providers that have expressed interest in delivering the CBPC benefit and have been approved for the CBPC specialty code in NJMMIS. Providers should plan to submit FD-439 to NJMMIS, then once Medicaid enrollment is approved, submit the FD-439 separately to MCOs.

Please see the FD-439 Palliative Care Add-On Form for further details on the

information and documents collected.

Contracting:

Following credentialing, providers must sign formal contracts with each MCO that they are a participating provider to define payment terms, authorization processes, and responsibilities for care coordination.

Both new contracts and contract addendums are acceptable and must receive state approval through the ERR process.

Some MCOs require contracting before credentialing, while others conduct both processes concurrently:

- Aetna, Fidelis Care, Horizon, and Wellpoint conduct credentialing and contracting concurrently.
- United Healthcare conducts credentialing before contracting.

Providers are encouraged to work with the network contracting teams at each MCO to confirm and initiate the contracting process relative to the credentialing process.

IDT Roster Maintenance

DMAHS recommends providers to maintain 2 or more members of each IDT role on staff and plan in advance for organizational turnover to ensure there is coverage for unexpected outages or organizational departures. Entities are expected to maintain a full roster of all required roles and replace any IDT practitioners who depart. MCO CMs are expected to oversee and ensure IDT completeness. In the case of turnover on an entity's IDT roster, providers must follow all state and MCO policies listed below regarding notification and maintenance of clinician information.

Lead IDT Clinician Turnover: When a Lead IDT departs the provider, providers must notify MCO CMs, DMAHS, and Gainwell Technologies immediately.

When a Lead IDT departs the provider, but there is another Lead IDT on staff who can absorb the departing clinician's panel, then the authorizations must be updated to tie to the replacement Lead IDT.

In the adverse case where a Lead IDT Clinician departs the provider, and there is no other enrolled, in-network Lead IDT on staff with CBPC specialty code to absorb the patient panel, providers should take the following steps:

- Notify DMAHS, Gainwell Technologies, and MCOs immediately.
    - **DMAHS**: Email MAHS.CBPC@dhs.nj.gov and include:
        - Provider entity name, Medicaid ID, and NPI

- Lead IDT Clinician name, Medicaid ID, and NPI
- Clarify whether the clinician is leaving Medicaid as a whole, or just leaving the group / entity

- **Gainwell Technologies**: Email njmmisproviderenrollment@gainwelltechnologies.com and include:
  - Provider entity name, Medicaid ID, and NPI
  - Lead IDT Clinician name, Medicaid ID, and NPI
  - Clarify whether the clinician is leaving Medicaid as a whole, or just leaving the group / entity
- **MCOs:** Please use the following contact information:

MCO	How to notify the MCO if the Lead IDT Clinician departs
Aetna	Notify Marta Aquino Account Manager, Network Relations- MLTSS Housing Program Liaison Aetna Better Health of New Jersey-Medicaid Email: Marta.Aquino@Aetna.com Phone: 551-302-8772
Fidelis	Notify the MCO of clinician turnover through established channels: • Fidelis Care Provider Portal • Fidelis Care Palliative Care email inbox, FC_PalliativeCare@fideliscarenj.com • Fidelis Care Customer Service Phone Number, 855-642-6185 • Fidelis Care Faxline, 855-573-2346 • Care Management (CM) notification when turnover impacts active members Notifications must include: • Effective date of departure • Replacement clinician (if applicable) • Impacted member panel (if applicable)
Horizon	Email a completed copy of the **CBPC Lead IDT Clinician Notice of Termination form** to: AncillaryContracting@HorizonBlue.com. (Form to be provided in Horizon provider trainings and channels).
UHC	Notify NJ_CBPC_CM@uhc.com
Wellpoint	Notify the CM team: • **Core Medicaid Phone:** 833-420-2195 (TTY 711) • **Core Medicaid Email:** NJCarecoordinationCM@wellpoint.com • **MLTSS Phone:** 855-661-1996 (TTY 711) • **LTSS Email:**

	LTSS_CommunityBasedPalliativeCare@wellpoint.com • **FIDE SNP Phone:** 833-731-2147 (TTY 711) • **FIDE CM Email:** CMHealthSolutions@elevancehealth.com

- Providers must work with the MCO to end the current authorization for the PMPM for the departed Lead IDT
- Determine, with MCO CM support, whether the member wishes to stay with the same provider and be seen by the rest of the Interdisciplinary Team or switch providers.
- If the member wishes to switch providers, the provider should support the member to do so (e.g., by collaborating with MCO CMs, transferring care plan, CMAT, other documents)
- Please note, if the member wishes to stay with their current provider, and the provider seeks to continue administering palliative care, **the provider can no longer bill the bundle; a Lead IDT with specialty code is required to bill the PMPM.** Instead, the provider may bill palliative care services a la carte (i.e., bill individual service codes) using the Z51.5 diagnosis code and existing prior authorization processes for those codes. Contact MCOs for specific billing guidance during this transition to 'bill a la carte.'

If a Lead IDT Clinician departs the provider, and there is no other enrolled, in-network Lead IDT on staff with CBPC specialty code to absorb the patient panel, MCOs should:

- Consult the member to find an alternative provider, or, support them in maintaining their existing IDT, if preferred
- If the member chooses to stay with their current provider:
    - End authorization for the CBPC bundle under the departed Lead IDT
    - Allow for a la carte billing of palliative care codes (i.e., not the bundle) by in-network providers, following existing prior authorization processes.
    - Ensure only one payment type, either the PMPM bundle or a la carte codes, is paid per member per month
        - The MCO should monitor for duplicate billing and review manually as needed
    - Ensure MCO CMs continue meeting with members and IDTs, even if the provider is not billing the CBPC PMPM bundle, to confirm care is being delivered as needed
- Once a new Lead IDT is enrolled, credentialed, and in-network with the MCO:
    - Issue a new prior authorization
    - If 30 or more days have passed since the member's last assessment, an assessment must be conducted before the new PA can be issued

All other IDT roles: Providers must maintain an up-to-date roster and submit roster

updates at least annually. This must include information on each member of the IDT, including verification that the required 12 CEUs, if applicable, were completed within the last year. Gainwell and MCOs will verify all newly updated practitioners and relevant clinician Medicaid enrollment (Medical Director, Lead IDT Clinician, Licensed Mental Health Professional).

Please note: DMAHS will explore more frequent updates in the future, when electronic enrollment verification is available, to align to NPPES and CAQH standards.

Network Reporting

DMAHS will also provide a monthly network reporting template for MCOs to complete. The report will collect data on the latest status of all providers who have engaged the MCO to contract and credential for CBPC. Monthly report submissions should account for the month prior to submission due date. Submissions are requested every other week from March through June to support benefit ramp up (e.g., 4/15, 4/30, and so on).

DMAHS may request additional updates post-launch.

Quality Strategy, Monitoring & Reporting

Overview

Quality monitoring within the CBPC benefit involves regular tracking by DMAHS of key metrics that align with DMAHS-established member-centered priorities and program goals. In designing the monitoring approach, DMAHS sought to balance administrative burden with ensuring benefit integrity.

Goals

Quality monitoring ensures the CBPC benefit consistently delivers high-value care aligned with member needs and program objectives. The strategy is grounded in three key pillars:

- **Access:** Validate members' timely access to services throughout their care journey, ensuring equitable and responsive care provision.
- **Quality:** Evaluate member and provider satisfaction with the benefit.
- **Governance:** Maintain robust oversight and accountability mechanisms, ensuring consistent care delivery, effective utilization of resources, and transparency in program operations.

Metrics Collected

Using a targeted and efficient monitoring strategy, DMAHS will collect and analyze the following metrics on a quarterly schedule, leveraging data from DMAHS' Shared Data Warehouse (SDW) and MCO Utilization Management (UM) data, among other sources.

Member Enrollment & Discharge Metrics:

- Number of members enrolled (from SDW data)
- Enrolled member demographic data (from SDW data)
- Average length of member enrollment and reasons for discharge (from SDW & MCO data)

Provider Network Metrics:

- Number of enrolled providers and associated approval rates and turnaround time (from Gainwell)
- Number of providers credentialed and associated approval rates and turnaround time (from MCO network data / PNU)

Please note, MCOs are expected to collect data on counties serviced by providers in

order to report on network adequacy requirements. This is in line with MCO contractual expectations for other specialties. Please await further update from DMAHS on network adequacy requirements for CBPC.

Care Standards Metrics:

Completeness of interdisciplinary team (IDT) interactions (from MCO data)

- Completion of care plans (from MCO data)
- Average wait time between PA approval and 1st monthly interaction (from SDW claims data)

Please note, MCOs are expected to collect data on counties serviced by providers in order to report on network adequacy requirements. This is in line with MCO contractual expectations for other specialties. Please await further update from DMAHS on network adequacy requirements for CBPC.

Prior Authorization Metrics:

- Volume of prior authorizations submitted, including proportions approved, modified, or denied (from SDW claims data)

Payment Metrics:

- Assessments and re-assessment volume (from SDW claims data)
- Claim approval, pending, and denial rates along with turnaround times (from MCO data)

Care Management Metrics:

- For each MCO CM serving CBPC members:
    - Number of CBPC members and non-CBPC members served (from MCO data)
    - Co-enrollment and acuity tiers of members in CM panel (from MCO data)
- Number of CMs per CBPC member (from MCO data)

Additionally, DMAHS will regularly engage with stakeholders (including MCOs, providers, members, etc.) post benefit launch to identify and address quality issues as they emerge. Stakeholder engagement will serve to refine forms and tools, address potential benefit design and process improvements, and improve the member and provider experience.

Data collection will begin at go-live, with quarterly reports released at the end of each quarter, starting with the first report at the end of Q2 2026. DMAHS will provide standard templates for MCO reporting on quality.

MCO and Provider Requirements

MCOs and providers will both play important roles in ensuring that the benefit is delivering the most value for members. MCOs must comply with DMAHS reporting requirements, using report templates to be developed and shared by DMAHS. Providers must respond to MCO and DMAHS data requests (e.g., as part of audits) in a timely manner.

Contact Information & Additional Resources

State Contact Information

CBPC program resource account

For questions or concerns regarding the CBPC benefit and/or to submit prior authorization requests for the CBPC bundle for FFS members, providers should contact the CBPC resource account: MAHS.CBPC@dhs.nj.gov

General NJ FamilyCare information

For general NJ FamilyCare information, contact: **NJ FamilyCare's Medicaid Hotline** at 1-800-356-1561 (TTY: 1-800-701-0720)

Office of Managed Health Care

If providers cannot reach a resolution to an issue after contacting the above resources or outreaching to the member's MCO, providers should contact the DMAHS Office of Managed Health Care (OMHC). OMHC focuses on provider inquiries and/or complaints in relation to MCO contracting and credentialing, claims and reimbursement, authorization, and appeals.

- Email: mahs.provider-inquiries@dhs.nj.gov
- Include detail regarding your issue, including but not limited to the provider ID/NPI and contact information, MCO, service requested, service date, units, specifics of issue and supporting documentation.

Gainwell Technologies

For questions related to provider enrollment in NJMMIS:

- Email: njmmisproviderenrollment@gainwelltechnologies.com
- Phone: (609) 588-6036

MCO Contact Information

MCO	Contact information for providers
Aetna	• **Credentialing contact:** ○ Bree Lange, Sr. Manager Credentialing Ops – LangeB@aetna.com / 860-273-5220

	• **Network contact:**
	  ○ Mailbox - NJMedicaidNetworkContracting@AETNA.com
	  ○ Kim Lees, Sr. Network Manager – LeesK1@aetna.com / 856-271-7446
	  ○ June-Delina Parkes, Sr. Network Manager – ParkesJ@aetna.com / 845-427-1261
	  ○ Angelica Miranda, Sr. Network Manager – MirandaA2@aetna.com / 609-515-4817
	• **Referral contact:**
	  ○ ABHNJ Member and Provider Services – 1-855-232-3596 (TTY: 711)
	• **Authorization/Utilization Management contact:**
	  ○ Natasha Sealey, Manager Clinical Health Services – SealeyN@cvshealth.com / 617-488-0401
	  ○ Jen Coleman, Manager Clinical Health Services – ColemanJ2@cvshealth.com / 813-663-3827
	• **Care Management contact:**
	  ○ *Integrated Care Management (ICM)* | Amy Klassen, Sr. Manager Clinical Health Services – KlassenA@aetna.com / 959-299-3228
	  ○ *Managed Long Term Services and Supports* (MLTSS) | Jamila Vasquez, Director of MLTSS – VasquezJ5@aetna.com / 609-480-4302
	• **Other contacts:**
	  ○ Dr. Sajidah Husain, Chief Medical Officer – HusainS@aetna.com; 609-282-8230

Fidelis Care	• **Credentialing contact:**
	  ○ Tina Launhardt, Sr. Manager, Credentialing Ops tlaunhardt@centene.com
	• **Network contact**:
	  ○ Mailbox - wc_njpr@fideliscarenj.com
	  ○ Connie Taveras, Director, Network Management Consuelo.Taveras@fideliscarenj.com
	  ○ Shaniece Scott, Contract Negotiator Shaniece.Scott@fideliscarenj.com | 973.513.2300
	• **Referral contact**:
	  ○ Mailbox: FC_PalliativeCare@fideliscarenj.com
	  ○ Fax: 855.573.2346
	  ○
	• **Authorization/Utilization Management contact**:
	  ○ Ashley Espinoza, Director, Clinical Operations FC_PalliativeCare@fideliscarenj.com | 855.642.6185
	  ○ Eileen Urban, Manager, Care Coordination FC_PalliativeCare@fideliscarenj.com | 855.642.6185
	• **Care Management contact**:

	○ Tracia Thompson, Sr. Manager, Care Management (MLTSS) FC_PalliativeCare@fideliscarenj.com | 855.642.6185 ○ Noralisa Santiago, Sr. Manager, Care Management (Core) FC_PalliativeCare@fideliscarenj.com | 855.642.6185 • **Other contacts:** N/A
Horizon	• **Credentialing contact:** ○ Jill Volarich - jill_volarich@horizonblue.com / 973-466-7065 • **Network (Contracting) contact**: ○ Cesar Anicama - cesar_anicama@horizonblue.com ○ Lori Bembry - lori_bembry@horizonblue.com / 609-537-2427 • **Network (Relations) contact**: Laurie Kerrigan - laurie_kerrigan@horizonblue.com / 973-945-0821 • **Referral contact**: ○ Melissa Samuel, Core CM - melissa_samuel@horizonblue.com / 973-902-1147 ○ Pamela Persichilli, MLTSS CM - pamela_persichilli@horizonblue.com / 862-754-3167 • **Authorization/Utilization Management contact**: ○ Margaret Lacy - Margaret_Lacy@HorizonBlue.com / 856-638-3107 • **Care Management contact**: ○ Melissa Samuel, Core CM - melissa_samuel@horizonblue.com / 973-902-1147 ○ Pamela Persichilli, MLTSS CM - pamela_persichilli@horizonblue.com / 862-754-3167
United Healthcare	• **Credentialing contact:** ○ For credentialing inquiries: palliativecarecred@uhc.com • **Network contact:** ○ For contracting inquiries: nj_uhccp_pcs@uhc.com • **Referral contact:** NJ_CBPC_CM@uhc.com • **Authorization/Utilization Management contact:** ○ For general inquiries: NJ_CBPC_CM@uhc.com ○ For escalations/urgent needs: Tyvonia Cauthen - tyvonia_cauthen@uhc.com • **Care Management contact:** ○ For general inquiries: Member Services 1-800-941-4647 ○ For member specific needs/care team support: NJ_CBPC_CM@uhc.com

	○ For escalations/urgent needs: ○ Tyvonia Cauthen - tyvonia_cauthen@uhc.com ○ Marjorie Nazaire - marjorie_nazaire@uhc.com • **Other contacts:** N/A
Wellpoint	• **Credentialing contact:** Jeanine.Fuetterer@wellpoint.com • **Network contact**: Rhonnda.Talton@wellpoint.com • **Referral contact**: ○ Vivian Binenstock, ***Core Medicaid*** ○ Email: vivian.binenstock@wellpoint.com ○ Phone: 732-590-3526 ○ Jennifer Iskandar, ***LTSS*** ○ Email: jennifer.iskandar@wellpoint,com ○ Phone: 862-441-2508 ○ Kisha McIntyre, ***FIDE*** ○ Email: kisha.mcintyre@wellpoint.com ○ Phone: 757-681-5013 • **Authorization/Utilization Management contact**: ○ Suzanne Veit, ***Core Medicaid Members*** ○ Email: suzanne.veit@wellpoint.com ○ Phone: 732-623-5861 ○ Keisha Woodson, ***LTSS Members*** ○ Email: keisha.woodson@wellpoint.com ○ Phone: 732-882-4606 ○ Patrick Alston, ***FIDE Members*** ○ Email: patrick.alston@wellpoint.com ○ Phone:757-268-6106 • Care Management contacts: ○ Vivian Binenstock, ***Core Medicaid*** ○ Email: vivian.binenstock@wellpoint.com ○ Phone: 732-590-3526 ○ Jennifer Iskandar, ***LTSS*** ○ Email: jennifer.iskandar@wellpoint.com ○ Phone: 862-441-2508 ○ Kisha McIntyre, ***FIDE*** ○ Email: kisha.mcintyre@wellpoint.com ○ Phone: 757-681-5013 • Other contacts: ○ Dr. Allison Duggan, Plan Program Medical Director ○ Email: allison.duggan@wellpoint.com ○ Phone:315-236-5632

MCO Resources

MCO	Additional resources for providers

Aetna	• Website (Provider Notices)
	  ○ Medicaid
	  ○ FIDE
	• Provider Portal
	  ○ Medicaid
	  ○ FIDE
	• Quick Reference Guide
	  ○ Medicaid
	  ○ FIDE
	• Provider Manual
	  ○ Medicaid
	  ○ FIDE
	• Network Directory
	  ○ Medicaid
	  ○ FIDE
	• New Provider Orientation
	  ○ Medicaid
	  ○ FIDE

Fidelis Care	Website Provider Manual Quick Reference Guide Provider Portal Network Directory New Provider Orientation
Horizon	Horizon NJ Health Website Horizon NJ Health Provider Administrative Manual Horizon NJ Health Quick Reference Guide to the Provider Administrative Manual Provider Portal: Availity Essentials Horizon NJ Health Doctor & Hospital Finder Horizon Educational Webinars: Working with Horizon NJ Health
United Healthcare	Website Provider Manual Quick Reference Guide Provider Portal Network Directory New Provider Orientation
Wellpoint	www.wellpoint.com

	Provider Manual Quick Reference Guide Provider Portal Network Directory Home - Provider News

Update history

Major changes to CBPC Guidance are included in this section since January 29, 2026 Guidance publication.

June 25, 2026 updates and relevant sections to reference:

- Updated list of service codes within the PMPM bundle (Covered Services – Example Service Codes)
- Added detail on process for managing turnover of Lead IDT and annual roster updates (Provider Enrollment & Credentialing – IDT Roster Maintenance)
- Document and submission requirements clarified as 5 business days for assessments, reassessment, care plan changes; EHR storage of all tools is clarified as required (Member Journey Processes)
- Clarified reassessment rules: only reassessments submitted in the final 30 days of an authorization period count as a reauthorization request. Hospitalization criteria for reassessment updated to be IP usage within past 6 months (not 12 months). (Member Journey Processes – Reassessment)
- Updated contact information and submission pathways for MCOs and FFS (Member Journey Processes – Assessment & Authorization; Contact Information & Additional Resources)
- Clarified The Joint Commission acceptable certification to be the Community-Based Palliative Care Certification (Provider Enrollment & Credentialing – Provider Qualifications)
- Eligible care settings clarified to include where the patient resides, such as SNF and Assisted Living Facilities (Covered Services)