NEW JERSEY HUMAN SERVICES

Community-Based Palliative Care (CBPC)

Provider Training Session #3

FEBRUARY 26, 2026

Welcome! Today is our third training in a three-part training series

COMPLETE - Jan 20 – review recording at tinyurl.com/CBPCtraining1

- CBPC benefit overview
- Covered populations
- Provider requirements
- Key dates and resources

COMPLETE - Jan 27 – review recording at tinyurl.com/CBPCtraining2

- Brief recap of benefit
- Overview of Enrollment
- Overview of Contracting & Credentialing
- Frequently asked questions

TODAY - Feb 26

- CBPC care model
- Provider tools
- Service authorization
- Billing and claims

Provider Office Hours will be held Wednesday, March 11 - register at tinyurl.com/DMAHSCBPCofficehours

Meeting logistics and important updates

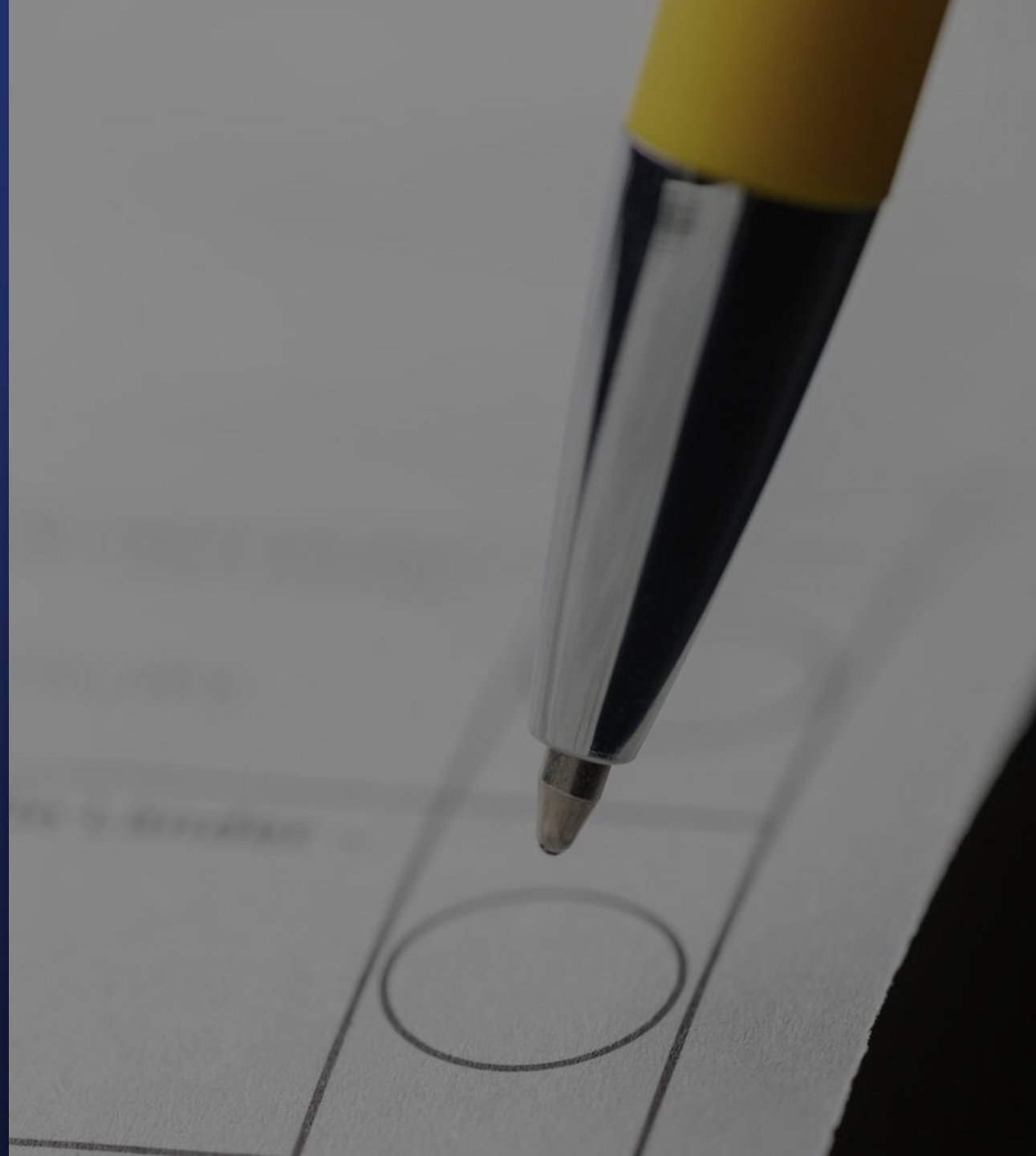
Housekeeping

- Feel free to **ask questions via the Q&A feature**; depending on time, we will either answer these live or respond to them offline after the call
- Session will be recorded
- **Recording and meeting materials will be circulated** after the call

Applications to become a CBPC provider are open!

- **Enrollment in Fee-For-Service systems & MCO contracting and credentialing are live!**
- Providers **must first enroll with NJ Medicaid FFS** as CBPC providers before contracting and credentialing with MCOs
- **Apply via NJMMIS website under "Provider Enrollment Application" –** download the base provider type application and search "FD-439" to see CBPC-specific sections

Poll | Where are you in your CBPC journey?



Agenda

- Quick recap of benefit and provider qualifications
- Care model and provider tools
- Authorization
- Billing and concurrent services
- Next steps for providers

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Community-Based Palliative Care (CBPC) is designed to improve quality of life for Medicaid members with serious disease

The community-based palliative care benefit will provide team-based support for persons with serious disease:

- Help members with serious illness manage symptoms and navigate the care system by providing them an interdisciplinary care management team
- Unlike hospice, members do not need a terminal prognosis or to forgo curative treatment
- Available for both adult and pediatric members, MCO and FFS

Goals of the benefit:

- Improve quality of life
- Reduce acute care use

Enrollment is open – providers can apply now!

Contracting & credentialing is open for all 5 MCOs

Enrolled providers can begin billing services starting April 1

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Recall | Interdisciplinary teams (IDTs) deliver a broad set of services to improve quality of life for people living with serious illness

Member eligibility

Both Managed Care Organization (MCO) and Fee for Service (FFS) members qualify for the benefit if they:

- Have a **serious disease**
- Show evidence of **reduced quality of life:**
  - In functional decline(e.g., significant difficulty with one (1) or more activities of daily living) , OR
  - 2+ emergency department visits in past 6 mo., OR
  - 1+ acute hospitalization in past year
- A terminal diagnosis is not required
- NOTE: members may not simultaneously be in hospice and palliative care

Services & settings

CBPC services can be **delivered in any non-hospital setting** (e.g., at home, Skilled Nursing Facility, Assisted Living Facility)

Example services 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
- 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

See DMAHS Benefit Guidance for full detail on member eligibility and eligible services

Provider qualifications | In order to qualify for and participate in the CBPC benefit, providers must meet several criteria

Be a **hospice agency, home health agency, physician group, or independent clinic**

- Hospitals and SNFs are not eligible to enroll
- FQHCs are excluded from year 1 of the program

Interdisciplinary Team (IDT) practitioner requirements: Be able to **deploy all required IDT practitioners**

Palliative care proficiency: Meet all requirements to **demonstrate sufficient proficiency in palliative care by following one of these 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)[1] **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[2]

Offer a **24/7 telephone line** to triage member issues

1. By a provider's re-validation after 3 years in the benefit, they must hold entity-level certification; individual practitioner proficiency will no longer be accepted at that point. 2. To count toward the 12 CEU requirement, training must have been competed in the last 12 months prior to application and must cover topic(s) from the DMAHS-approved list detailed in program guidance. Not all topics must be covered for a practitioner's training to be considered sufficient. Note: SNF = Skilled nursing facility, IDT = Interdisciplinary team

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IDT practitioners | Providers must be able to deploy all required IDT roles; Lead IDT must be employed, all other roles may be employed or contracted

Medical Director (MD, DO)

Serves as resource to team, including medical direction and facility oversight

Lead Clinician (MD, DO, PA, NP)[1]

Serves as team lead; responsible for directly rendering care and prescribing

Registered Nurse (RN)

Manages day-to-day care for member based on care plan

Mental Health Professional (LCSW, LPC, LMFT)

Provides mental health counseling for member based on care plan

Chaplain[2]

Provides spiritual and emotional support to member and their families/caregivers[3]

Only required if serving pediatric patients

Child Life Specialist (CCLS)

Supports children and adolescent, as patients or as family of a patient receiving CBPC

Must be directly employed by provider entity

See DMAHS CBPC Program Guidance / FAQs for additional information on the specific requirements for required practitioners

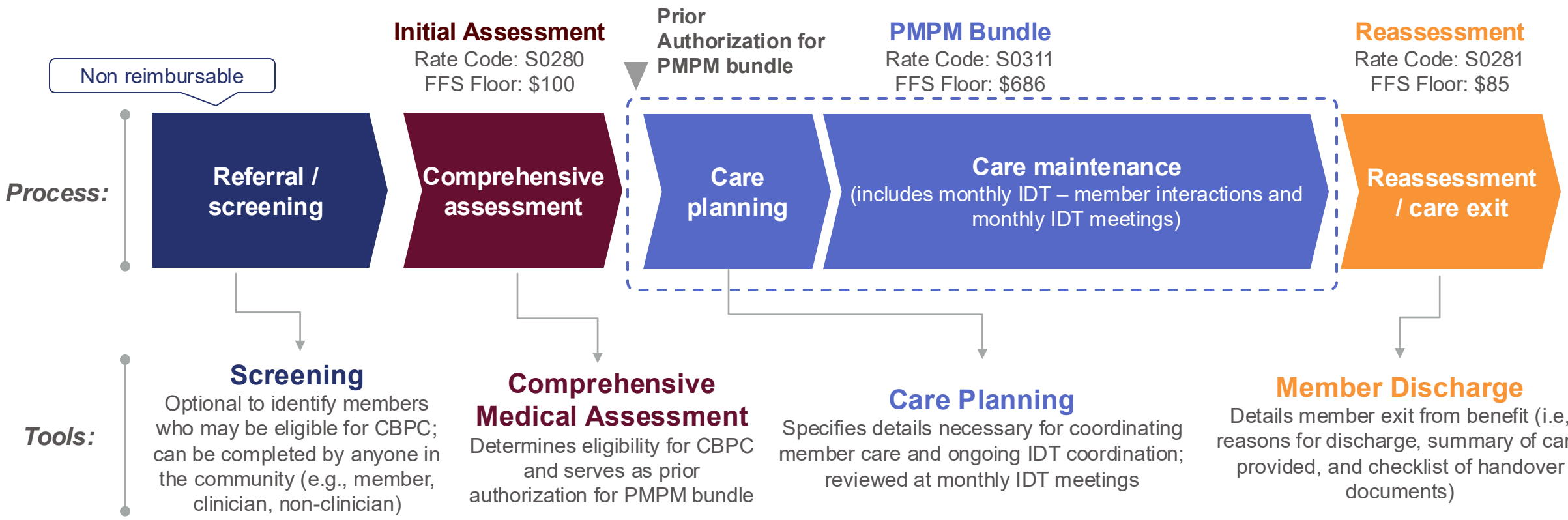
1. Lead IDT clinicians must hold one of four accepted hospice/palliative medicine certification types: MD/DOs (HPM, HMDC); NPs (ACHPN); PAs (CAQ).
2. Chaplains may qualify by either (a) holding an approved individual credential--Level II Clinical Pastoral Education (from an ACPE-accredited program) or healthcare chaplaincy certification (ACCC: BCC; NAVAC: BCC; SCA: BCC/Advanced Practice BCC; CASC: Certified Spiritual Care Practitioner; NAJC: BCC; APC: BCC; NACC: BCC), or (b) the entity holds hospice/palliative certification
3. Chaplains may be excused from a member's IDT at member request.

Note: IDT = Interdisciplinary team; LCSW = Licensed Clinical Social Worker; LPC = Licensed Professional Counselor; LMFT = Licensed Marriage and Family Therapist

Agenda

- Quick recap of benefit and provider qualifications
- **Care model and provider tools**
- Authorization
- Billing and concurrent services
- Next steps for providers

The CBPC care model is accompanied by four tools to support members' evolving health needs and care preferences



Referral / Screening | Members can be identified and referred to the benefit via a DMAHS-standardized Screening Tool

Purpose

- Supports **identification and referral of members who may be potentially eligible** for the CBPC benefit
- Serves as an **optional tool to promote access** to CBPC

Who can administer?

Can be **self-completed by member or anyone in the community**, including clinicians and non-clinicians (e.g., providers, care managers, caregivers)

Is it reimbursable?

The Program Eligibility Screening Tool is **non-reimbursable**

Comprehensive Assessment | Once referred or otherwise identified, members undergo a comprehensive assessment to determine eligibility

Purpose

- Documents the **severity of a serious illness**
- Identifies **physical, psychosocial, spiritual, and social needs**
- Captures **goals of care**
- Facilitates the **development of a personalized care plan**
- Serves as **Prior Authorization for the PMPM bundle**

Who can administer?

May be completed **any Medicaid-enrolled MD, DO, APN, PA, or LCSW** (does not need to be participating in a CBPC IDT)

Is it reimbursable?

- FFS Floor is **$100 (Rate Code: S0280)**
- **Assessment must be submitted to member's MCO (or DMAHS for FFS members)** to authorize the PMPM Bundle

Comprehensive Medical Assessment Tool (CMAT) | Serious disease diagnosis & evidence of reduced quality of life determine eligibility for CBPC

Key sections allow providers to capture full view of needs:

Section E: Qualifying Clinical Condition
- Describes member's serious illness diagnosis

Section F: Indication Of Disease Severity
- Describes member's level of disease severity, including quality of life impacts; notes any changes from a previous assessment

Sections E & F – Primarily used to determine member eligibility

Section G: Other Indicators Of Disease Severity
- Documents clinical progression of the disease (i.e., co-morbid conditions, clinical biomarkers, durable medical equipment use)

Section H: Whole-person Needs Assessments
- Physical (e.g., functional status)
- Psychosocial (e.g., PHQ-2, PHQ-9, ZBI for caregiver)
- Spiritual (e.g., FICA framework)

Sections G & H – Providers and MCOs may recommend member eligibility based on individual determinations of medical necessity, even if criteria in Sections E & F are not met

Section I: Goals Of Care (e.g., advance care planning, POLST, health care proxy)

Section J: Clinical Summary & Eligibility Determination

Care planning | After being authorized and finding a provider, the Interdisciplinary Team (IDT) must develop a care plan within 30 days

Purpose

- Outlines an individualized, **interdisciplinary plan of care** for CBPC members
- Documents **member's goals, preferences, and priorities** for palliative care
- **Supports coordination** between the IDT, member, caregivers, and MCO CM
- To be developed within member's first month, **often across multiple visits with member and IDT practitioners**

Who can administer?

- **CBPC IDT**, led by Lead IDT Clinician
- Must be **signed by Lead IDT Clinician, MCO CM, Member, & Caregiver** (if applicable) when finalized (e.g., initial authorization, reauthorization)

Is it reimbursable?

Use of the Care Planning tool is **not directly reimbursable**, but creation of **Care Plan is required to initiate billing for PMPM bundle**

1. If Lead IDT Clinician did not administer initial assessment, Care Plan must be completed in-person with member

Care Planning | The Care Planning tool translates findings from the comprehensive assessment into a personalized plan of care

Key sections document the member's goals and needs:

A. Administrative information
- Essential member and provider information

B. Qualifying Clinical Condition & Functional Decline
- Clinical eligibility for CBPC and description of functional decline

C. Medications
- Current medications and palliative-specific medication changes

D. Care Coordination & Support Services
- Interdisciplinary referrals and service needs (e.g., social work, durable medical equipment)

E. IDT Involvement
- IDT roster information and meeting frequency
- Member consent and access to telehealth

F. Advance Care Planning & Goals Review
- Member's goals, code status, and advance care planning documentation

G. Palliative Care Plan of Care
- Comprehensive, symptom-based plan tailored to palliative needs

H. Authorization & Signatures
- Care Plan must be signed by Lead IDT Clinician, Care Manager, Member, and Caregiver (if applicable)

The Care Plan should be reviewed by the IDT and MCO CM at monthly IDT meetings and updated every 6 months / upon member change in condition

Care maintenance | Three features of care maintenance phase; IDT-member interaction and IDT meeting with MCO CM required to bill PMPM bundle

Required to bill PMPM bundle

IDT-member interaction

To monitor progress, deliver services, and adjust Care Plan as needed (e.g., depression screening, medication review)

At least monthly

IDT meeting with MCO Care Manager (CM)

Review IDT staffing and changes in CBPC member panel, address significant changes to member care needs, and answer billing or operational questions

Monthly

Internal IDT meetings

To review the CBPC member panel, discuss clinical needs, new enrollments, discharges, and coordinate care across team

At least monthly

Role of the Care Manager | What to expect from a Care Manager throughout the member journey

Prior Authorization for PMPM bundle is approved and member enters CBPC benefit

Process:

Prior authorization ***(if applicable)*** → **Care planning** → **Care maintenance** → **Reassessment / care exit**

Role of MCO CM[1] :

Prior Authorization

Once approved, initiates phone or email communication with the provider to establish ongoing communication

Care Planning

Sign off on Care Plan when finalized (i.e., initial authorization, reauthorization, upon change to member condition)

Care Maintenance

Attend monthly meetings with IDT to address changes to IDT staffing, CBPC member enrollment, or revised care plans (if applicable)

Referral coordination: MCO CM may support if referral authorization must be expedited to ensure timely access to urgent member needs (e.g., home oxygen, controlled substances)

Care Exit

Review Member Discharge Tool, including member next steps and ensure handoff of relevant medical information

1. For FFS, Lead IDT Clinician assumes the role of MCO CM

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Re-assessment | Members must be reassessed for CBPC every 6 months or upon changes to their condition using the CMAT

Purpose

- **Reassess members at regular intervals to confirm continued eligibility** for the benefit or if condition changes
- Member remains in benefit **unless reassessment shows they no longer meet the eligibility criteria or they voluntarily exit** (e.g., to hospice)
- Members should be **reassessed every 6 months and no more than once a month**

Who can administer?

- Any **Medicaid-enrolled MD, DO, APN, PA, or LCSW** (does not need to be participating in member's IDT), though may be typically conducted by IDT in case of re-auth request
- Must be completed **in person** with the member

Is it reimbursable?

- FFS Floor is **$85 (Rate Code: S0281)**
- **Reassessment must be submitted to MCO** for bundle reauthorization
- **MCO may make individual determinations to extend** member authorizations

Discharge | Upon exiting the benefit or switching providers, IDT must complete Member Discharge tool to ensure continuity of care

Purpose

- Support **appropriate closure of services and continuity of care for members** exiting benefit (e.g., end of palliative care, entry into lower level of care, entry into hospice)
- Ensure **safe handoff and coordination** with receiving providers or programs
- **Gather required documentation** for program oversight and audit purposes

Who can administer?

CBPC IDT, with oversight from the Lead IDT Clinician

Is it reimbursable?

- The Member Discharge Tool is **non-reimbursable**
- Providers should **submit the discharge tool to member's MCO** (or DMAHS for FFS members)

Discharge | The Discharge tool documents reasons for discharge, summary of care provided, and a checklist of handover documents

Not exhaustive

A member may exit CBPC for several reasons:

- **End of palliative care:** Member ceases palliative care, by choice, or after reassessment
  - Provider must submit reassessment to MCO
- **Entry into lower level of care:** Member exits palliative care and receives non-palliative supports (e.g., health home, MCO CM)
- **Entry into hospice:** Member elects for hospice entry; curative care stops and hospice care begins

The Member Discharge Tool documents relevant medical information

- Discharge Summary
- Goals of Care and Advance Care Planning
- Services Provided
- Handoff and Transitions
- Caregiver/Family Support
- Documentation Checklist

If a member **switches providers or MCOs, current provider must transmit all relevant medical information**, including assessments and care plans, to new provider or MCO

Summary (I/II) | DMAHS standardized tools align to the CBPC member journey, from eligibility to discharge

	Purpose	Documentation	Who can administer?	Telehealth allowance
Screening	• **Identifies potentially eligible members** based on illness and quality of life impairment • **Optional,** to promote access to CBPC	**Screening Tool**	Can be **self-completed by member or by anyone in the community**, including clinicians and non-clinicians	May be completed **in-person or virtual**
Comprehensive Assessment	• Determines **CBPC eligibility based on serious illness, indications of disease severity**, or provider and MCO judgement • Serves as **prior authorization** for the PMPM bundle	**Comprehensive Medical Assessment Tool**	**Any MD, DO, APN, PA, or LCSW** (does not need to be part of a CBPC IDT)	Must be completed **in-person**
Care Planning	• Completed within first month to capture **member preferences, medications, care coordination, IDT involvement, palliative care planning, and goals**	**Care Plan**	Care Plan must be **signed by Lead IDT Clinician, Care Manager, Member, and Caregiver** (if applicable)	Lead IDT must meet with member **in-person** to sign off on care plan

Summary (II/II) | DMAHS standardized tools align to the CBPC member journey, from eligibility to discharge

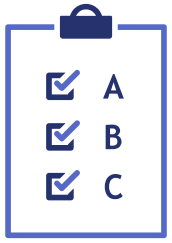
	Purpose	Documentation	Who can administer?	Telehealth allowance
Care Maintenance	• **Monthly IDT – member interactions** to deliver CBPC services • **Monthly internal IDT** meetings to review CBPC member panel needs and coordination of care across team • **Monthly IDT – MCO CM** meetings to address changes to IDT staffing, CBPC member enrollment, or revised care plans (if applicable)	**Care Plan** should be reviewed monthly by internal IDT and updated every 6 months / upon change to member condition; **EHR chart notes**	**CBPC IDT**	IDT – member interactions **may be in person or via telehealth**, if deemed acceptable by both member and provider; Internal IDT and meetings with MCO CM may be **virtual**
Reassessment	• **Required for reauthorization every 6 months** and/or upon member change in condition	**Comprehensive Medical Assessment**	**Any MD, DO, APN, PA, or LCSW** (does not need to be part of a CBPC IDT)	Must be completed **in-person**
Care exit	• In the case of member exit from benefit or change in provider / MCO, **documents reasons for discharge, summary of care provided, and checklist of handover documents**	**Member Discharge**	**Completed by CBPC IDT**, with oversight from Lead IDT Clinician	May be completed **in person or virtual**

Agenda

- Quick recap of benefit and provider qualifications
- Care model and provider tools
- **Authorization**
- Billing and concurrent services
- Next steps for providers

Now that we've reviewed the CBPC Care Model, let's discuss how authorization works

Overview | No prior authorization required for assessment and re-assessment; only required for the PMPM bundle



Assessment and re-assessment

The Comprehensive Medical Assessment is used to determine member eligibility for CBPC and for re-assessment. Any **Medicaid-enrolled MD, DO, PA, APN, or LCSW may complete** assessment and re-assessment.

Requires prior authorization

PMPM bundle

The **Comprehensive Medical Assessment will serve as the basis for prior authorization** and must be submitted to the member's MCO. PMPM **authorizations are valid for six months**.

Authorization | For Fee-For-Service, submit requests directly to DMAHS; for managed care, follow each MCO's process

For Fee-For-Service:

1. **Email MAHS.CBPC@dhs.nj.gov to request a PA** (Providers may also request pre-printed forms from Gainwell)
   - DMAHS will respond with a PA-15 form that includes a unique PA number

2. **Submit the completed PA-15 and Comprehensive Medical Assessment Tool to DMAHS** via scan and attachment

3. DMAHS will review the PA-15 and CMAT; **if approved, an approval letter will be sent to the email address on file**

For Managed Care:

- All five MCOs will apply prior authorization for the PMPM bundle
- **Please do not wait to reach out to MCOs** for specific guidance on process for submitting PA requests

Authorization | Frequently asked questions (I/II)

Questions	Answers
Are there any **limits on the number of initial assessments / re-assessments** that can be billed?	Providers may only submit for reimbursement for **one initial assessment per member per quarter** (for each member-provider combination) Members may be **reassessed a maximum of once per month, typically due to change in condition** **At the end of the of six-month authorization period, providers should complete a re-assessment** to re-authorize PMPM bundle for additional six-months
Are **initial assessments allowed for members currently receiving the PMPM?**	**Initial assessments are typically not conducted for members who are not already in the benefit** However, if a **member chooses to switch providers, new provider may conduct an initial assessment using the CMAT** (Rate Code: S0280) and should submit the assessment with a prior authorization request before beginning to bill for PMPM If the **same provider is continuing care due to change of condition or need for reauthorization**, provider should submit CMAT using sections C-I and bill for re-assessment (Rate Code: S0281)

Authorization | Frequently asked questions (II/II)

Questions	Answers
How will **MCOs determine whether to approve the request** for authorization?	The submission of the **completed Comprehensive Medical Assessment serves as the prior authorization request** **MCOs may apply Medical Necessity** judgement when reviewing the authorization request, based on criteria of CMAT and clinical best practice (e.g., if there is a better-fit benefit for member, or if member has rare disease not listed in Assessment tool)
If a **re-assessment occurs while the bundle is ongoing, is the authorization 6-month window re-started**?	**Reassessment claims received during an existing 6-month auth window will maintain the existing auth time period** **Example:** If the current auth period is 4/1/26 – 10/31/26, and a re-assessment is processed 6/2/26; auth continues until 10/31/26 and member is re-assessed in October for extension **Member still must be reassessed every six months** to extend the PMPM bundle

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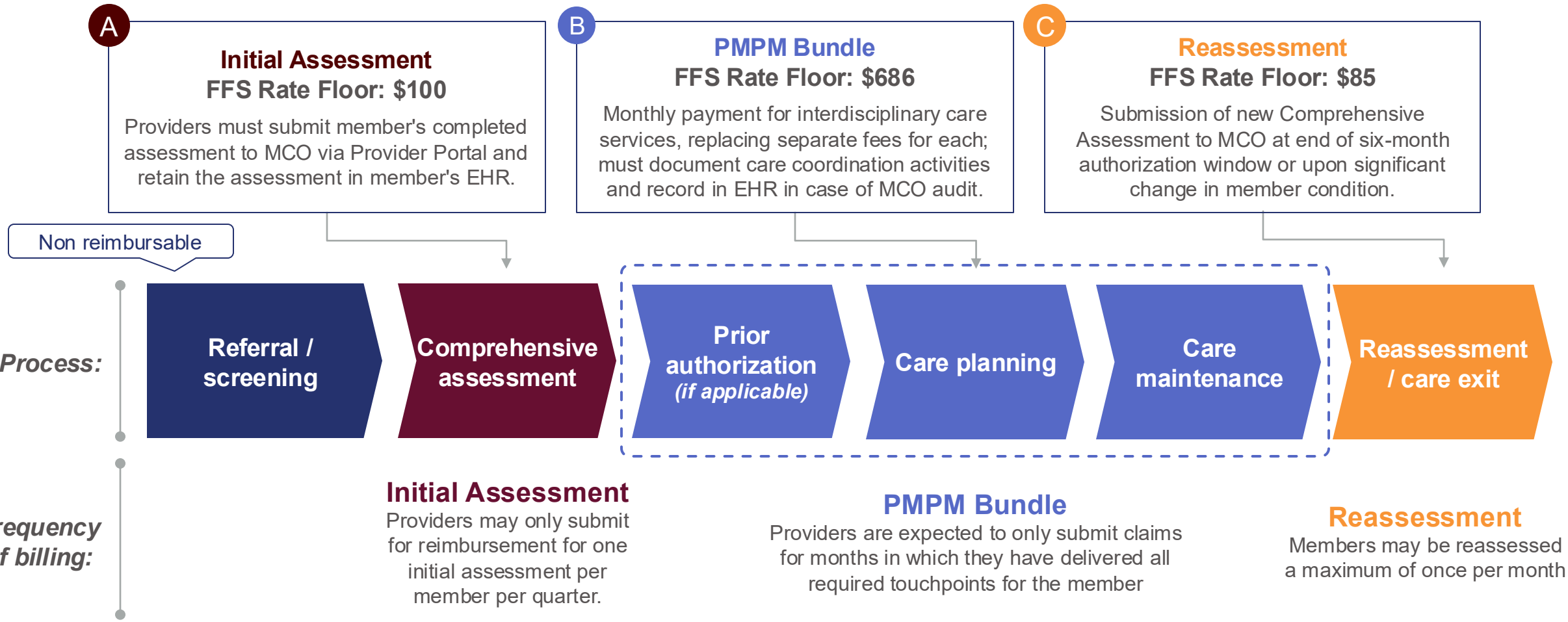
Recall | Three codes for CBPC billing: initial assessment, ongoing Per Member Per Month (PMPM) bundled services, and periodic reassessments



Billing | Providers can bill for CBPC using either CMS claim form 1500 or 1450 (UB-04)

Providers should refer to DMAHS CBPC Guidance for additional details on CMS forms 1500 and 1450 (UB-04)

Providers can submit claims using either of the following CMS claim forms:

- **CMS 1500**
- **CMS 1450 (UB-04)**
  - **For assessment / re-assessment:** Include revenue code 0693 and relevant HCPCS code (S0280 for assessment and S0281 for reassessment)
  - **For PMPM bundle:** Include revenue code 0690 and HCPCS code S0311

Key billing reminders:

- Claims must include the member's qualifying serious disease as the primary diagnosis code and secondary diagnosis code Z51.5 (Palliative Care Encounter)
- **Assessment / re-assessment:** May be conducted by any MD, DO, APN, PA, or LCSW (does not need to be palliative care certified or part of a CBPC IDT)
- **PMPM bundle:** The billing provider must be the CBPC-credentialed entity (Type 2 NPI), and the rendering provider must be the Lead IDT Clinician (Type 1 NPI)

Services | The PMPM bundle covers a wide range of services that can be delivered by members of the IDT

Not exhaustive

What should be billed within the PMPM bundle?

- Services **provided by a member of the IDT to coordinate, assess, or deliver palliative care** are included in the PMPM bundle and should not be billed separately

Example services covered within the PMPM bundle:

- Care planning and coordination
- Symptom assessment and management
- Medication reviews
- Home-based or clinic-based visits by licensed IDT practitioners
- Psychosocial and caregiver support (e.g., mindfulness exercises)
- Spiritual and emotional care
- Referral coordination to Medicaid-covered services
- Access to a 24/7 telephone line

CBPC members may continue to receive curative treatments for their serious disease and other benefits, which should be billed outside the PMPM bundle (e.g., home health, prescriptions, behavioral health, DME)

Services | Example service codes covered within the PMPM bundle

Code	Description
98966 - 98968	Telephone assessment and management service provided by a qualified nonphysician
98008 - 98015	Telephone assessment and management service provided by a physician
99202 - 99205, 99211 - 99215	OP visit for evaluation and management
99341 - 99342, 99344 - 99345, 99347 - 99350	Home or domiciliary visit for evaluation and management
99490	Chronic care management services
99495 - 99496	Transitional care management services
99497 - 99498	Advance care planning
G0155	Clinical Social Worker (CSW) services
G0156	Home Health Aide (HHA) services
Q5001 - Q5010	Hospice or home health care[1]
S9123 - S9124	General nursing care

Starting list of codes – Please refer to DMAHS Guidance for further detail

DMAHS will be adding a more exhaustive list of codes to future iterations of the Guidance in the coming weeks.

1. Codes Q5001-Q5010 cover hospice and / or home health care provided in various CBPC-eligible (e.g., patient's home, Assisted Living Facility); Please note, a member may not be simultaneously enrolled in hospice care and palliative care.

Policies may vary by MCO; please refer to MCO - specific guidelines

Services | Members may continue to receive services outside of the bundle, and ongoing care should not be interrupted

What should be billed outside of the PMPM bundle?

- **Medically necessary services beyond the assessment and care maintenance** of a member's qualifying diagnosis should be billed **separately from the PMPM bundle**
- **IDT practitioners may deliver services that fall outside of CBPC PMPM bundle,** and may bill those services outside the PMPM bundle
- **Providers not participating in the IDT may continue billing** for their services (e.g., those delivering curative care)
- **MCOs will apply existing prior authorization requirements** to services billed outside the PMPM bundle
- **Services billed outside the bundle with the palliative care diagnosis code (Z51.5) may be pended** – policies will vary by MCO so refer to MCO-specific guidance and trainings

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Policies may vary by MCO; please refer to MCO - specific guidelines

Services | Example scenarios of services where providers should bill within vs. outside the PMPM bundle

Not exhaustive

Category of service	Billed within PMPM Bundle	Billed outside PMPM bundle
Evaluation and management (E/M) visits	IDT member conducts **telehealth, home-, or clinic-based visit to assess symptoms**	**Visits by non-IDT providers** (e.g., primary care physician, specialty care provider)
Psychosocial support	Mental Health Practitioner **administers PHQ-9** for depression screening	Ongoing **Cognitive Behavioral Therapy or formal psychotherapy** to treat depression
Medication management	**Registered Nurse reviews medication** during monthly member interaction	**Cost of prescribed medication**
Home health aide (HHA)	**HHA conducts home visit** to assess personal care needs (e.g., assessment for fall risk, other in-home assessment)	Member **suffers hip fracture (separate from primary diagnosis for palliative care) and receives HHA services** to assist with daily living
Lab and imaging services	During E/M visit, IDT **identifies need for imaging** and initiates referral	Lab provider performs **diagnostic imaging services** (e.g., X-ray, CT scan)
Durable medical equipment	During E/M visit, IDT **identifies need for wheelchair** and initiates referral	**Cost of wheelchair**

Billing and Services | Frequently asked questions (I/III)

Questions	Answers
What **diagnosis codes should be included on assessment and reassessment** claims?	The **primary diagnosis code should be the member's qualifying serious disease** Assessment and reassessment claims **must include the Palliative Care Encounter diagnosis code Z51.5 as the secondary diagnosis code**
What **activities are required to bill PMPM bundle**?	A **minimum of 2 monthly activities** are required for providers to bill the PMPM bundle: • At least one interaction between the member and any IDT practitioner • At least one CBPC IDT meeting with the MCO CM **The IDT practitioners should also meet internally on an at least monthly basis to discuss clinical needs of member panel and care coordination,** but this is not required to take place before billing the PMPM bundle

Billing and Services | Frequently asked questions (II/III)

Questions	Answers
When should the PMPM bundle be billed?	The PMPM bundle is **billed retrospectively, on a calendar-month basis each month** (i.e., may not be billed sooner than the first day of the following month) If the member **enters CBPC mid-month**, set the **start date** as the **date of the first required interaction in that month** (the earlier of the **IDT–member interaction** or the **IDT meeting that includes the MCO CM**), and keep the **end date as the last day of that month** **Example:** If member enters CBPC on 4/15 and first interacts with the IDT on 4/18, PMPM bundle should be set to 4/18 – 4/30 and billed no earlier than 5/1
How should providers **bill for services outside the PMPM bundle?**	Medically necessary services (e.g., DME, imaging services) that fall outside the PMPM bundle should be **billed per existing MCO-specific policy** **MCOs will apply existing prior authorization requirements** to services billed outside the PMPM bundle; **CBPC enrollment does not add incremental prior authorization** requirements to services outside the PMPM bundle

Billing and Services | Frequently asked questions (III/III)

Questions	Answers
How will MCOs know whether a service should be billed within the PMPM bundle or outside?	MCOs will identify duplicative services within the PMPM bundle by **differentiating using the revenue code associated with those services or using the palliative care encounter diagnosis code (Z51.5)** Providers should refer to the **example service codes listed in the DMAHS CBPC Guidance** to ensure services within the PMPM bundle are billed appropriately
Should services billed outside the PMPM bundle be documented in the Care Plan?	Yes, **all services required for member care**, including referrals for those paid outside the PMPM bundle, **should be documented in the member's Care Plan** to ensure comprehensive and coordinated care delivery If a member is receiving additional services or benefits prior to entering CBPC, these **services should be documented in the Care Plan but otherwise not disrupted**

Agenda

- Quick recap of benefit and provider qualifications
- Care model and provider tools
- Authorization
- Billing and concurrent services
- Next steps for providers

Please complete this DMAHS CBPC Provider Interest Survey

tinyurl.com/CBPCinterest

Provider checklist | What should providers do now to prepare for entry into the CBPC benefit?

- ☑ **Review previous DMAHS trainings**
  - **Jan 20** — covered CBPC benefit overview, covered populations, provider requirements, and key dates and resources → View recording at CBPC Training 1 Recording
  - **Jan 27**— covered NJMMIS enrollment, MCO credentialing forms, and application documentation requirements → View recording at CBPC Training 2 Recording
  - **Feb 26 (Today)** — topics include CBPC care model, provider tools, service authorization, and billing → View recording at CBPC Training 3 Recording
- ☑ **Register for DMAHS Provider Office Hours with Gainwell and MCOs to be held on Wednesday, March 11 from 9 – 10 AM** → register here
- ☑ **Review Interdisciplinary Team (IDT) requirements and begin hiring or contracting key roles, if needed** (Lead IDT Clinician must be employed; can employ or contract RN, chaplain, licensed mental health professional, CLS, Medical Director)
- ☑ **If entity is not certified in palliative care - ensure all required IDT members have completed necessary CEUs of training** *(can take ~1 month to complete)* **or hold palliative care certification**
- ☑ **Review DMAHS guidance and other resources** (see next slide) **for details of the benefit**
- ☑ **Prepare supporting documentation for enrollment and credentialing applications – opened February 2** (clean applications can take ~45–60 days to process, so we recommend starting now to be in-network by April 1)

Review DMAHS-shared resources

CBPC Infosheet

A brief, three-page overview of the CBPC benefit outlining covered services and populations, provider requirements, and next steps

Comprehensive Program Guidance

Comprehensive overview of the benefit, including covered populations and services, member journey, payment and billing, provider enrollment and credentialing, quality and reporting, and MCO care management

FAQs

Concise answers to common provider questions about CBPC eligibility, services, billing, documentation, and operational requirements

Training Resources

A non-exhaustive list of training organizations offering CEUs for practitioner education on approved palliative care topics

CBPC FD-439 Enrollment & Credentialing Add-On

A standardized, CBPC-specific form used by Gainwell and all MCOs to collect and validate required provider entity and interdisciplinary team licensure and certification information for both enrollment and credentialing

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Contact Information

CBPC Program Resources

For questions or concerns regarding the **CBPC benefit:**

- Email: MAHS.CBPC@dhs.nj.gov
- Website: DMAHS resources such as program guidance, FAQs, and training information are published on the DMAHS website – tinyurl.com/DMAHSCBPC

Gainwell Technologies

For questions related to **provider enrollment** in NJMMIS:

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

MCO	Contact information for providers
Aetna	**Credentialing:** Bree Lange, Sr. Manager Credentialing Ops (LangeB@aetna.com / 860-273-5220) **Network:** • 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)
Fidelis	**Credentialing:** • Tina Launhardt, Sr. Manager, Credentialing Ops (tlaunhardt@centene.com) **Network:** • Connie Taveras, Director, Network Management (Consuelo.Taveras@fideliscarenj.com) • Shaniece Scott, Contract Negotiator (Shaniece.Scott@fideliscarenj.com / 973-513-2300) • Mailbox - wc_njpr@fideliscarenj.com
Horizon	**Credentialing:** Jill Volarich (jill_volarich@horizonblue.com / 973-466-7065) **Network (Contracting):** • Cesar Anicama (cesar_anicama@horizonblue.com) • Lori Bembry (lori_bembry@horizonblue.com / 609-537-2427)
United Health Care	**Credentialing:** Chat or Provider Services – linked here **Network:** Chat or Provider Services – linked here
Wellpoint	**Credentialing:** Jeanine Fuetterer (Jeanine.Fuetterer@wellpoint.com) **Network:** Rhonda Talton (Rhonnda.Talton@wellpoint.com)

Thank you!

DMAHS invites you to apply to join CBPC today!

Enrollment and credentialing / contracting with MCOs is open now! Scan the QR code below to access the NJMMIS website.

Use the drop-down under "Provider Enrollment Applications" to select your provider type; to see the CBPC section, search for FD-439 in the form.

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Appendix: Incremental materials from CBPC Training #2

Palliative care proficiency | Certification and training requirements for required IDT practitioners

1

Does the provider entity hold palliative care certification from one of three nationally recognized bodies specializing in palliative care?:

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

YES: no further verification of practitioner training or palliative care certification, **except for Lead IDT Clinician**[1]

NO: proceed to verify practitioner palliative care certifications and/or training completion

2

Entities without palliative care certification will need to demonstrate for each member of the required IDT:

Individual certifications in hospice & palliative medicine

OR

Completion of 12 CEUs of palliative care-specific training within 12 months prior to application, among a DMAHS-provided list of approved topics[2]

Exact certifications accepted vary by individual practitioner

1. Regardless of an entity's palliative care certification, the Lead IDT Clinician must always hold practitioner certifications in hospice & palliative medicine. 2. To count toward the 12 CEU requirement, training must have been competed in the last 12 months prior to application and must cover topic(s) from the DMAHS-approved list detailed in program guidance. Not all topics must be covered for a practitioner's training to be considered sufficient.

Optional IDT practitioners| Providers may supplement the core IDT with optional practitioners based on the individual needs of members

*Palliative care certification and/or 12 CEUs of training are **NOT** required for optional practitioners*

Example optional practitioners:

- **Physician Assistant** (non-rendering)
  - *May not be subcontracted*
- **Nurse Practitioner** (non-rendering)
  - *May not be subcontracted*
- **Pharmacist**
- **Home Health Aide**
- **Certified Nursing Aide or Assistant**
- **Licensed Practical Nurse**
- **Community Health Worker**
  - *Must complete Colette Lamothe-Galette training; email interest to CLGI@doh.nj.gov*

FAQs | Which services must be in-person vs. telehealth?

- The **initial assessment and all reassessments** must be conducted **in-person** by any MD, DO, APN, PA, or LCSW
- Once a member is receiving the benefit, the **Lead IDT Clinician must meet in person** with the member for the **first interaction**
  - If the Lead IDT Clinician conducted the initial assessment, this may count as the first in-person interaction
- **After the first in-person interaction,** the monthly IDT-member interactions may be completed 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

Backup | Assessments must be completed in-person; telehealth is allowable at the member's discretion for regular interactions

Required activity	Details	In-person vs. telehealth	Documentation	Frequency
Initial assessment & re-assessment	• Initial assessment, done via the Comprehensive Medical Assessment Tool, determines a member's eligibility for CBPC • Assessment captures diagnosis and severity, recent utilization or decline, key needs, and care goals • Can be completed by any MD, DO, APN, PA, or LCSW	**In-person**	Submission of Comprehensive Medical Assessment Tool to MCO	**Once**; reassessment is required at least every six months for benefit reauthorization
Care plan	• Individualized plan created by the IDT using the standard Care Planning Tool across symptom domains and addresses social factors and resource needs • Documents interventions, referrals, resources provided, upcoming IDT meetings, and patient follow-up dates • Lead IDT clinician must meet with the member and sign off on the care plan • Care plan should be shared with MCO CM for signoff	**In-person** (for Lead IDT-member interaction)	EHR chart note and fields in care plan document maintained by provider entity	**At least every 6 months**; must be done within 1 month of member enrollment and re-assessment
IDT-member interaction	• Monthly meetings between the member and practitioner(s) from the IDT	**In-person or telehealth**, *if deemed acceptable by both the member and provider*	EHR chart note	**Monthly** – required for PMPM claim to be accepted
IDT Meeting	• Internal IDT meetings with the MCO CM to discuss care planning	May be **virtual**	EHR chart note; updates sent to other providers and MCO	**Monthly** – required for PMPM claim to be accepted