Comprehensive Medical Assessment Tool (CMAT)

NJ FamilyCare Community Based Palliative Care

Palliative care is extra support for people with serious illnesses. It helps manage symptoms, reduce stress, and works alongside other treatments. An interdisciplinary care team (IDT) listens to what matters to the member and supports their choices—so they can focus on quality of life.

The Community Based Palliative Care (CBPC) benefit provides team-based support for people with serious disease and helps members manage symptoms and navigate the care system. CBPC is not hospice care. Members do not need a terminal diagnosis to receive services and may continue curative or disease-directed treatments while enrolled in the benefit.

Provider Guidance

This assessment form is intended to support eligibility determinations and health plan authorization of care for the Community-Based Palliative Care (CBPC) benefit. Please review the following instructions carefully before completing and submitting this form. In addition to submitting this form to the member's health plan, please retain a copy of this assessment in the member's electronic health record. If member was referred to assessment, note the referral source in the member's record and inform member's health plan.

This form is used to:

- Evaluate whether a member meets clinical and disease severity criteria for CBPC
- Document the severity of a member's serious illness
- Identify physical, psychosocial, spiritual, and social needs
- Capture goals for care
- Facilitate development of a personalized care planning document
- Re-evaluate members already receiving CBPC benefit if member condition has changed, using Section C: Ongoing Care Information (in addition to sections D-I)

Any licensed, Medicaid enrolled healthcare provider (i.e., MD, DO, APN, PA, LCSW) may complete this assessment. The assessing provider **does not need to be the provider rendering ongoing CBPC services.**

General Guidance

- For **first assessment of eligibility**, complete sections D-I
- For **reassessment of eligibility** (members previously assessed and approved for CBPC), complete sections C-I
- Complete all sections **in person** with the member and, if appropriate, their caregiver/family
- Use plain language and a culturally sensitive approach to gather responses
- Document relevant findings objectively and accurately
- If you identify urgent needs or safety concerns during the assessment, take immediate clinical

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action according to local policy

- **The member qualifies for CBPC based on indications in sections E and F.** However, providers/MCOs have discretion to recommend someone for palliative care who may not qualify based on the information collected in sections E and F alone. Sections G and H provide additional information that may be valuable when making this determination; any major findings from these four sections should be included in the Summary of Major Findings in section J.

- Provider indication of member eligibility does not necessarily guarantee enrollment in CBPC. MCOs/DMAHS will use the CMAT to conduct prior authorization and confirm member enrollment in the benefit.

Next Steps After Completing Tool

- **For all members:** Store the completed assessment in the member's electronic health record and send the CMAT to the member's specialty palliative care provider, if already identified
- **For MCO members only:** Submit this completed form to the member's health plan according to MCO-specific guidelines for tool submission (e.g., Provider Portal, fax) within 5 business days. Include any relevant attachments (e.g., referral source, clinical notes, signed advance directives). If you choose to request authorization to deliver CBPC based on this assessment, follow MCO-specific guidelines on prior authorization request submission. If you are unsure where to send this form, contact the health plan's provider services team.
- **For Fee-For-Service (FFS) members only:** Email MAHS.CBPC@dhs.nj.gov to request prior authorization. DMAHS will respond with a PA-15 request form that includes a unique PA number. Providers should submit the completed PA-15 form and this assessment to MAHS.CBPC@dhs.nj.gov as scanned attachments. DMAHS will notify the provider once an approval has been issued. If not requesting prior authorization, send the completed assessment to MAHS.CBPC@dhs.nj.gov.
- If the member and provider are authorized to start the CBPC Per-Member Per-Month bundle, provider should initiate CBPC activities such as creating a care plan and scheduling follow-up meetings with the member and the IDT. See DMAHS CBPC guidance for more detail.

Section-by-Section Guidance

SECTION A: MEMBER INFORMATION

- Complete member, caregiver, and primary care provider demographics.

SECTION B: ASSESSMENT CADENCE

- Confirm information related to whether the assessment completed is an initial assessment or a reassessment.

SECTION C: ONGOING CARE INFORMATION

- If the form completed is a reassessment, provide information related to the member's current palliative care team, the reason for the reassessment, and the member's length of stay on service with the palliative care team.

SECTION D: MEDICAL ASSESSOR INFORMATION

- Provide information about the provider completing the assessment or reassessment.

SECTION E: QUALIFYING CLINICAL CONDITION

- Provide information related to the member's qualifying condition, including level of disease severity and any inpatient or emergency department utilization.

SECTION F: INDICATION OF DISEASE SEVERITY

- Provide information related to the member's level of disease severity for their qualifying condition, including the quality of life impacts qualifying the member for palliative care services. Please indicate whether this is a change from a previous assessment.

SECTION G: OTHER INDICATORS OF DISEASE SEVERITY

- Provide any documentation on clinical progression of the disease, including co-morbid conditions, clinical biomarkers, and durable medical equipment use.

SECTION H: WHOLE-PERSON NEEDS ASSESSMENT

A1. Physical Assessment

- Use validated tools provided (e.g., ESAS, FAST, PPS, KPS) to document symptom severity and functional status.
- If performance status is ≤50%, consider hospice referral and document discussion with the member/family.

A2. Psychosocial Assessment

- Administer PHQ-2 initially. If positive, complete PHQ-9 to assess depression severity.
- Screen for caregiver burden with the Zarit Burden Interview (ZBI).
- If moderate to severe distress or burden is identified, include this in the care plan and consider referral to mental health or supportive counseling resources.

A3. Spiritual Assessment

- Use the FICA framework to explore spiritual needs.
- Document the person's faith/beliefs, importance of spirituality, participation in a spiritual community, and preferences for spiritual support in their care.

SECTION I: GOALS OF CARE

- Indicate completion of a goals of care discussion, advance care planning document, POLST, or identification of a health care proxy.
- Ensure the person has opportunities to express their understanding of their illness, prognosis, and treatment options.
- Document preferences for treatment, including any advanced directives or surrogate decision-makers.

SECTION J: CLINICAL SUMMARY & ELIGIBILITY DETERMINATION

- Summarize findings from the assessment.
- Indicate determination of member eligibility based on the existence of a qualifying clinical condition and evidence of severe disease.

SECTION K: SIGNATURES

- Check box to confirm the form was filled out **in person** with the member by the provider.
- Ensure that the member or member's proxy and provider completing the assessment have signed and dated the document.

SECTION A: MEMBER INFORMATION			
Member Name: (last, first, mi)			Medicaid ID #:
Health Plan:	◯ Aetna Better Health of New Jersey ◯ Fidelis Care ◯ Fee-For-Service (FFS) ◯ Horizon NJ Health ◯ UnitedHealthcare (UHC) ◯ Wellpoint		Age: ◯ Adult (19 years or older) ◯ Child (0-18 years) DOB: (mm/dd/yyyy)
Preferred Language:	◯ English ◯ Spanish ◯ Chinese-Mandarin ◯ Chinese-Cantonese ◯ Portuguese ◯ Tagalog ◯ Korean ◯ Other:_____		
English Fluency: (Verbal)	Member:	◯ High ◯ Medium ◯ Low ◯ No Fluency	
	Caregiver/Family Member: (if applicable)	◯ High ◯ Medium ◯ Low ◯ No Fluency	
English Fluency: (Written)	Member:	◯ High ◯ Medium ◯ Low ◯ No Fluency	
	Caregiver/Family Member: (if applicable)	◯ High ◯ Medium ◯ Low ◯ No Fluency	
Healthcare Power of Attorney (POA)?	◯ Yes ◯ No		
Caregiver/Alternate Contact Information If no Caregiver, enter 'None'; if Healthcare POA is Yes, enter Medical Decision Maker information			
Name:			Relationship:
Email Address:			Cell Phone Number:
Primary Care Physician Information			
Name:			
Address: street address city state zip code			
Office Phone Number:			Fax Number:
SECTION B: ASSESSMENT CADENCE			
Form completed as member's:	◯ First assessment of eligibility → Complete sections D-I ◯ Reassessment of eligibility → Complete sections C-I		Date: (mm/dd/yyyy)

SECTION C: FOR REASSESSMENT ONLY - ONGOING CARE INFORMATION Only complete for reassessment of eligibility		
IDT Lead Clinician Name:		Clinician NPI #:
Clinician Medicaid ID #:		Clinician Phone Number:
Reassessment Justification:	◯ Scheduled 6-month reassessment ◯ Change in condition	Length of member's enrollment in palliative care with provider:
Description of change in condition: (if checked above)		

SECTION D: MEDICAL ASSESSOR INFORMATION	
Provider/Clinician Name:	NPI #:
Medicaid ID #:	Phone Number :

SECTION E: QUALIFYING CLINICAL CONDITION		
Primary Disease Diagnosis(es)	Primary ICD 10 Code	Date of Onset

Eligible Serious Illnesses	Adult:	☐ Alzheimer's or other dementias	☐ Cancer (Stage III or IV)	☐ COPD
		☐ Congestive Heart Failure	☐ Cirrhosis or liver disease	☐ Diabetes
		☐ ESRD or Chronic Kidney Disease	☐ Stroke	☐ AIDS
		☐ Degenerative neural condition (i.e. Parkinson's, severe neurodegenerative)		
		☐ Other *(explain below)*		
	Children:	☐ Pulmonary Disease	☐ Cardiac Disease	☐ Neonatal*
		☐ End-stage Liver Disease	☐ Genetic Disorders*	☐ Renal Disease
		☐ Metabolic/Inclusion Disease	☐ Infectious Disease	☐ Cancer
		☐ Orthopedic Disorders*	☐ Gastrointestinal Disease or Conditions*	
		☐ Neurological Disorder	☐ Other *(explain below)*	
		***For conditions marked with an *, children do not need evidence of disease severity to qualify for services.**		
Other Serious Illness Not Included Above & Description:				

Conclusions from Section E	
Serious disease criteria met: (select only 1)	◯ Yes – member has at least one of the serious diseases included above ◯ Yes – member has other serious disease not included above; provider judgment deems enrollment clinically appropriate ◯ No – member does not meet any criteria

What (if anything) has changed since last assessment? (if reassessment)	
SECTION F: INDICATION OF DISEASE SEVERITY	
Functional Status:	☐ MLTSS Enrollment ☐ PPS ≤ 70 ☐ FAST ≥ 5 ☐ ECOG grade ≥ 3 ☐ KPS ≤ 70 ☐ MELD > 19 ☐ Other *(specify)*:
	For provider: please attach any completed functional evaluation tools to this form and write the member's score in this section where appropriate.
Utilization of ER and hospital	If initial assessment: ☐ 1 or more acute hospitalizations within the past 12 months ☐ 2 or more emergency department visits within the past 6 months
	If re-assessment: ☐ 1 or more acute hospitalizations within the past 6 months ☐ 2 or more emergency department visits within the past 6 months
Other Functional Decline Not Included Above & Description:	
Conclusions from Section F	
Disease severity criteria met: (select only 1)	◯ Yes – member meets one or more criteria included above (functional decline, hospitalization/inpatient utilization, or emergency department visits) ◯ Yes – member does not meet Section F criteria included above, but provider judgment deems enrollment clinically appropriate ◯ No – member does not meet any criteria
What (if anything) has changed since last assessment? (if reassessment)	
SECTION G: OTHER INDICATORS OF DISEASE SEVERITY	
Durable Medical Equipment Utilization or Dependency:	☐ 24-hour oxygen requirement ☐ Wheelchair dependence ☐ Tracheostomy dependence ☐ Feeding tube dependence ☐ Catheter dependence ☐ Ventilator dependence ☐ Hospital bed
Clinical Biomarker:	☐ Severe airflow obstruction: Forced Expiratory Volume (FEV)1 < 35% predicted ☐ International Normalized Ratio (INR) without medications > 1.3 ☐ Estimated Glomerular Filtration Rate (eGFR) of 25 or less ☐ Ejection Fraction < 30 for systolic heart failure ☐ Albumin < 3.0
Evidence of Comorbid Conditions:	☐ Subacute bacterial peritonitis ☐ Hepatic encephalopathy ☐ Chronic infections ☐ Evidence of pressure ulcers ☐ Coronary artery disease ☐ Ascites ☐ Progressive weight loss ☐ Bronchiolitis obliterans ☐ Frailty ☐ Extracorporeal membrane oxygenation (ECMO) or transplant candidate

SECTION H: WHOLE-PERSON NEEDS ASSESSMENT	
H1. Physical Assessment Only one severity / functional assessment is required	
Edmonton Symptom Assessment (ESAS)	◯ Mild to Moderate Symptoms: 0-4 ◯ Moderate to Severe Symptoms: 4-6 ◯ Severe Symptoms: >7
Functional Assessment Staging Tool (FAST)	◯ Mild: Stage 3-4 ◯ Moderate: Stages 5-6 ◯ Severe: Stage 7
Palliative Performance Scale (PPS)	◯ >70% ◯ Greater than 50% but less than or equal to 70% ◯ <= 50% (if yes, consider referral to hospice care)
Karnofsky Performance Status (KPS)	◯ >70% ◯ Greater than 50% but less than or equal to 70% ◯ <= 50% (if yes, consider referral to hospice care)
What (if any) severity or functional change has occurred since last assessment? (if reassessment)	
H2: Psychosocial Assessment	
Patient Health Questionnaire-2 (PHQ-2)	◯ Less than 3 ◯ Greater than or equal to 3 (if yes, complete PHQ-9)
Patient Health Questionnaire-9 (PHQ-9)	◯ Minimal: 0-4 ◯ Mild: 5-9 ◯ Moderate: 10-14 ◯ Moderately Severe: 15-19 ◯ Severe: 20-27
Zarit Burden Interview (ZBI)	◯ Mild to Moderate: 21-40 ◯ Moderate to Severe: 41- 60 ◯ Severe Burden: 61-88
What (if any) psychosocial change has occurred since last assessment? (if reassessment)	
H3: Spiritual Assessment (FICA)	
F: What is your faith or belief?	
I: Is it important in your life?	
C: Are you part of a spiritual or religious community?	
A: How would you like me, your healthcare provider, to address these issues in your healthcare?	
What (if any) change has occurred since last assessment? (if reassessment)	

SECTION I: GOALS FOR CARE			
Advance Directive on File? ◯ Yes ◯ No		POLST on File? ◯ Yes ◯ No	
Health Proxy Identified? ◯ Yes ◯ No			
SECTION J: CLINICAL SUMMARY & ELIGIBILITY DETERMINATION Member is eligible if provider determines the existence of a qualifying clinical condition and evidence of severe disease (Yes for Section E and Section F) and member is not enrolled in hospice care.			
Summary of Major Findings:			
No Hospice Attestation: *(if unchecked, mark ineligible)*	☐ Check to confirm the member is NOT currently enrolled in hospice care		
Eligibility Determination: ◯ Eligible ◯ Ineligible			
SECTION K: SIGNATURES Member signature indicates consent to proceed to Palliative Care enrollment if care authorized			
☐ By checking this box, you certify that this form was completed **in person** with the member by the provider			
Provider Signature:		Date: (mm/dd/yyyy)	
Member Signature:		Date: (mm/dd/yyyy)	
Caregiver Signature: (if applicable)		Date: (mm/dd/yyyy)	