Frequently Asked Questions

NJ FamilyCare Community-Based Palliative Care (CBPC)

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

For more information, please contact MAHS.CBPC@dhs.nj.gov

Last updated: January 29, 2026

[NEW] marks update since 12/22/25

NEW JERSEY HUMAN SERVICES

Table of Contents

MCO Readiness

Launch timelines

1. **When is launch, and how is it defined?**
    - **A.** Benefit launch will on **April 1, 2026.** By this date, **motivated providers should be in-network and ready for bill for services,** requiring: (1) **All systems ready to go** for service delivery, (2) **First wave of providers are in-network** with MCOs, (3) **Members can begin enrollment** in benefit, (4) **Providers can start billing** for the benefit.
2. **What about existing providers under value added palliative care benefits previously approved by DMAHS?**
    - **A.** Existing providers under value added palliative care benefits previously approved by DMAHS (prior to January ’26) will have until **July 1, 2026 to fully align to CBPC standards.**
3. **How is Year 1 of the program defined?**
    - **A.** Year 1 of the program will be from April 1, 2026 to December 31, 2026.

Contract and capitation

4. **Will palliative care be included in the MCO Contracts?**
    - **A.** Yes, the **January ’26 MCO Contract** will include an addendum for palliative care.
5. **Is there an impact to MCO capitation rates?**
    - **A.** No, MCO capitation rates will not be impacted by CBPC.

MCO workplan

6. **Is DMAHS requesting guidance sign-off at workplan deadlines, even if questions remain?**
    - **A.** Yes, DMAHS requests sign-off on current guidance, while welcoming questions/feedback. **If an item blocks readiness, identify it so it can be prioritized**; otherwise proceed with sign-off and DMAHS will incorporate updates in the next version.

7. **If an MCO has already submitted a deliverable for DMAHS review, should they update the new version of the workplan to reflect this?**

    A. Yes. For deliverables that were previously submitted, **please update the new workplan with the submission dates** and, if applicable, relevant files to help DMAHS track whether they are completed.

8. **When should an MCO resubmit deliverables?**

    A. Deliverables should be **resubmitted in case of material changes.** Minor changes in alignment with DMAHS feedback or updated Guidance do not require additional review from the state.

9. **What if I have a question that is not covered in the Guidance document or this FAQ document? [UPDATED]**

    A. Please share all questions with CBPC resource email (MAHS.CBPC@dhs.nj.gov), and DMAHS will aim to address it either live in an MCO 1:1 or, if relevant to all MCOs, in an updated version of this document. **For MCOs: If a question is urgent and delaying MCO progress, please flag it as high priority to Samantha Lord** (Samantha.Lord@nj.dhs.gov).

Member and provider-facing deliverables

10. **Do MCOs have to use DMAHS provided template language for the relevant member and provider-facing deliverables?**

    A. No, DMAHS template language is an **optional** resource for MCOs, but MCOs must include certain components at a minimum. Please consult the MCO Implementation Workplan for additional information.

11. **How will member/provider-facing deliverables be reviewed?**

    A. Plans must share all member/provider engagement deliverables with both Samantha.Lord@nj.dhs.gov and OMHC (Yemi.Johnson@dhs.nj.gov). OMHC will give final review and approval of these deliverables.

12. **When will the member notification letter be sent to members?**

    A. Step 1.3 in the Implementation Workplan requires MCOs to submit the draft letter to DMAHS (not to deliver to members). The letter will go to members **at/shortly after go-live date**.

Upcoming DMAHS engagements and template language

13. What engagement cadence should plans expect?

A. Please expect a **Mid-January Virtual Readiness Checkpoint** focused on credentialing and a **Mid-February Virtual Readiness Checkpoint** focused on authorization and claims (detailed agenda will be shared ~2 weeks ahead of time for both). All-MCO or 1:1 touchpoints will occur **at least monthly**, with more as needed / at MCO request.

14. When will DMAHS provide template language?

A. DMAHS will provide templates for: (1) Member notification letter, (2) Member handbook, (3) Provider manual, (4) Network reports, (5) Quality tracking. Please consult the Workplan for more detailed information – generally, templates will be given ~1 month ahead of associated deliverable due dates.

Member Journey

Eligibility

15. Can a member be in other programs and also palliative care?

A. The **only excluding enrollment is hospice.** A member cannot receive both hospice and palliative care services. All other programs (e.g., MLTSS, Behavioral Health, etc.) are acceptable.

16. Is the qualifying serious illness list in the Guidance exhaustive? [NEW]

A. The list is **"not limited to"** the conditions shown; MCOs and practitioners may apply **clinical judgement** to approve additional members based on individual medical necessity.

17. Can dual eligible members still receive CBPC though the NJ FamilyCare CBPC program? [NEW]

A. Yes CBPC is available to duals, **unless the member enters hospice**. CBPC payments for assessment, reassessment, and the PMPM bundle are **Medicaid only** as this is a Medicaid benefit. For any **concurrent services,** Medicare will be the primary payer as usual because Medicaid is the payer of last resort under standard TPL.

Screener

18. Does the MCO have to complete the Screening Tool before referring a member for assessment?

A. No, the Screening Tool is **not a prerequisite** for an MCO to refer a member to a provider to assess eligibility for the program. The MCO may refer a member to any Medicaid-enrolled provider to complete the Comprehensive Medical Assessment.

Comprehensive Assessment

19. Who can conduct the Comprehensive Assessment (S0280, S0281)?

A. The assessment may be completed by any **qualified, Medicaid-enrolled MD, DO, PA, APN, or LCSW** (does not need to be participating in a CBPC IDT).

20. Does the Comprehensive Assessment have to be done in person?

A. Yes, the Comprehensive Assessment Tool must be completed **in person.**

21. Can the Comprehensive Medical Assessment replace the Comprehensive Need Assessment (CNA)?

A. No, the Comprehensive Need Assessment is **still required** for palliative care members in Core Medicaid.

22. Once a member is assessed as eligible for CBPC, how many CBPC provider options should MCOs provide?

A. MCOs should provide a reasonable number of as many in-network providers in geographic proximity to the member; at least 3 providers is suggested.

Care Plan

23. How often does the Care Plan have to be updated?

A. The Care Plan must be completed within the **member's first month of enrollmen**t in the benefit. During the six-month authorization window, the IDT meets monthly 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.

24. Does the IDT have to interact with the member to determine the care plan? **[UPDATED]**

A. Yes, the **Lead IDT Clinician** must interact with the member to create the IDT care plan. If the care-planning meeting is the Lead IDT Clinician's **first palliative interaction with the member** (i.e., the Lead IDT Clinician did not complete the initial assessment for this member), that **meeting must be in person**. The Lead IDT Clinician may not conduct telehealth visits with the member until after an in-person interaction has occurred. After the first in-person interaction, subsequent visits may be conducted via telehealth, if agreed upon by the member and care team.

25. Who has to sign the Care Plan? When? How?

A. The Care Plan requires signatures from the **Provider, Member, MCO CM, and Caregiver** (if applicable). The order of signatures is not prescribed. Signatures are captured when the **plan is finalized** (e.g., initial authorization, reauthorization). The **format of signature is not prescribed** (e.g., acceptable formats include e-signature, or documentation of verbal signoff during IDT meeting).

26. Does the Care Plan have to be shared with the member's assessor or other providers?

A. No, it is not required for the Care Plan to be shared with the member's assessor or other providers; MCOs should not use this as a condition of payment. However, it is **recommended that the Care Plan is shared with all relevant providers** as clinically appropriate to support integrated care.

27. How should providers and MCOs communicate about changes to the Care Plan?

A. Regular communication occurs through the **monthly IDT meeting**, where the IDT will review the member's needs and update the Care Plan as needed. Providers maintain the Care Plan (and make it available upon audit); it is not submitted to MCOs. Communication at and between meetings should be **bidirectional**, with the MCO CM actively participating to refine the plan and coordinate complementary Medicaid services. Material care-plan changes should be communicated between providers and MCOs within **5 business days** and reviewed at the next IDT meeting.

Discharge Tool

28. When should the Discharge Tool be used?

A. Use the Discharge Tool **whenever a member leaves CBPC**. Reasons include: Transition to Primary Care, Condition Improved, Goals Completed, Compassionate Discharge, Patient/Family Preference, Transition to Hospice, or Other.

Tool Submission / Storage

29. What are the requirements for submission/storage of Screener, Comprehensive Assessment, Care Plan, and Discharge tools?

A. Screener: Optional tool, may be sent alongside a referral (e.g., in case of provider referral to MCO CM or MCO referral to provider). Providers must store in case of audit.

Comprehensive Assessment: Required for **providers to submit to MCOs and for MCOs to store**, regardless of whether MCO applies prior authorization (PA) for the PMPM bundle. If an MCO exercises PA for the bundle, that submission doubles as the PA request. If not, the same submission is used for eligibility documentation and payment.

Care Plan: Required for providers to complete, share with the MCO CM for signature upon finalization, and **maintain in EHR** in case of audit. Not required to be formally submitted to / stored by MCO beyond CM signature.

Discharge Tool: Required for **providers to submit to MCO** when a member leaves the benefit (e.g., in case of exit to hospice or discharge after determined ineligible). Storage is at MCO discretion.

30. Should the tools use the DMAHS logo, or each MCO's logo? [CONFIRMED]

A. The Tools are created by DMAHS, standardized, and should **use the DMAHS logo**, not each MCO's logo.

Required interactions

31. What is the minimum number of required monthly interactions? [UPDATED]

A. A minimum of two touchpoints are required each month: (1) at least **one IDT–member interaction** and (2) **at least one internal IDT meeting** that includes the MCO Care Manager. The monthly IDT-member interaction **may be conducted via telehealth** if acceptable to both the member and provider. Providers must ensure telehealth is accessible to the member if telehealth use is agreed upon.

32. How can MCOs verify the required IDT interactions are completed?

A. The MCO CM's attendance at least monthly at **internal IDT meetings** will verify that the care plan is being updated appropriately and the required interactions are taking place. **Manual review is only required if concerns arise from the MCO CM.** The CM may report these concerns to the claims team, and MCOs may audit and recoup payment if required interactions are not properly documented in the EHR.

33. Will EVV be required at launch?

A. No, EVV will **not be mandated at program launch** nor will an EVV pilot be conducted in Year 1**.** Status quo EVV requirements remain for concurrent services. DMAHS may revisit EVV use after Year 1 of implementation.

NEW JERSEY HUMAN SERVICES

Enrollment, Contracting, and Credentialing

Overview

34. When will credentialing and contracting begin?

A. MCOs must have **contracting & credentialing systems ready to accept provider applications** by February 1, 2026.

35. Are MCOs expected to prioritize CBPC applications?

A. Yes, MCOs should **prioritize CBPC applications** if possible, to reduce contracting & credentialing timeline to 30-45 calendar days and support network building ahead of April 1, 2026 launch.

36. If a provider is already credentialed with an MCO, do they need to re-credential or just add a CBPC specialty?

A. 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.

37. Are contract addendums acceptable?

A. Yes, **contract addendums are acceptable** but will still need to go through the ERR process. Please submit 4-11 forms to the DMAHS ERR team (Rita Smith, Rita.M.Smith@dhs.nj.gov) and keep the DMAHS Palliative Care team lead (Samantha Lord, Samantha.Lord@dhs.nj.gov) on cc.

38. Should the CBPC add-on credentialing form have the DMAHS logo, or the MCO logo? [UPDATED]

A. DMAHS has developed a standardized Community-Based Palliative Care add-on form (FD-439) that will be used for FFS enrollment *and* MCO credentialing. The FD-439 Palliative Care Add-On form outlines the CBPC-specific fields that the state and MCOs will verify for Fee-for-Service (FFS) enrollment and MCO credentialing, respectively.

The FD-439 is standardized with DMAHS and NJ FamilyCare logos; these logos should not be replaced with individual MCO logos. However, MCOs may place own logos on any other documents within credentialing packets or base entity application.

Entity-level requirements

39. Do I need to re-enroll if I am already enrolled? [UPDATED]

A. 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 of your 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 and offer CBPC services. Provider Enrollment Applications may be found at www.njmmis.com.

40. What types of provider entity can offer the benefit?

A. Acceptable provider types include: **hospice, home health agency, physician group, or independent clinic**. Note operationalization for FQHCs will not begin in Year 1 of benefit implementation. Neither hospital nor SNF license types are accepted. Additionally, assisted living facilities, adult day care, and other types of providers that are not included in one of the four provider types above are not eligible for this benefit. However, any **qualified, Medicaid-enrolled MD, DO, PA, APN, or LCSW** can conduct an initial assessment or screening and refer patients to CBPC (they do not need to be part of a CBPC IDT).

41. Do all practitioners listed in the application need to be Medicaid-enrolled?

A. No. Only the **Overseeing Physician, Lead IDT Clinician, Mental Health Professional**, and any optional **non-rendering NP/PA must be Medicaid-enrolled**. For others, the Medicaid ID is optional.

42. Do entities have to be able to deploy optional practitioners?

A. No, entities **may deploy optional practitioners based on individual needs** but are not required to employ, contract, or subcontract these optional practitioners.

Certification vs. training

43. Certification vs. training—what's acceptable, and by when?

A. Entities must **either** hold certification in palliative care (TJC, ACHC, CHAP), **or** each required practitioner must show evidence of palliative care proficiency.

To demonstrate this proficiency, practitioners may either hold certification (accepted certifications outlined in CBPC Credentialing Add-on) or submit certificates verifying completion of 12 Continuing Education Units (CEUs) in palliative care topics. The 12 CEUs need to be completed within the past 12 months prior to application.

However, individual practitioner evidence of proficiency will only be accepted once; entities are expected to hold **entity-level palliative care certification by revalidation** (i.e., after 3 years).

44. Do practitioners' 12 CEUs of training need to cover specific topics? What organizations can providers use?

A. Practitioners have options. Courses must focus on **topics from the approved palliative care list**, but practitioners may choose any mix of those topics based on their needs and role. Not all topics are required. **Recommended topics are**: Pain and symptom management, opioid safety, psychosocial support, spiritual care, cultural humility, serious illness communication, grief and bereavement, ethics and legal issues, advance care planning, crisis intervention, interdisciplinary teamwork, documentation standards, infection control, and staff wellness.

Providers may use any CEU-bearing training organization they like, as long as the courses cover the required topics. Center to Advance Palliative Care (CAPC) and several universities provide trainings / online programs; a longer list of training orgs can be found in the attachments. Please note, training is not limited to these orgs and can be received from other orgs as long as the minimum 12 CEU requirement is met.

45. Do practitioners need to complete these 12 CEUs only upon initial enrollment, or every year until entity has palliative care certification? [UPDATE]

A. Practitioners only need to submit proof of these 12 CEUs upon initial application, though it is recommended for all practitioners to maintain regular, up-to-date training in palliative care**. CEUs must have been completed within the prior 12 months to application**.

Please note, this practitioner-level evidence is accepted once, as all entities must hold palliative care certification upon revalidation in 3 years. Additionally, palliative care certifications for entities and individuals may require practitioners to continue meeting any continuing education requirements on an annual basis.

46. If the entity has ACHC/CHAP/TJC palliative care certification, do practitioners still need to show Certification or CEUs?

A. If an entity has palliative care certification from one of these three bodies, **required practitioners may skip the CEU/Certification requirement except the Lead IDT Clinician**, who must hold Certification (HPM, CHMD, ACHPN, or CAQ in HPM) regardless of entity certification.

47. Does the American Board of Family Medicine (ABFM) CAQ in Hospice & Palliative Medicine count as Board Certification for an MD/DO?

A. Yes. As an ABMS-recognized subspecialty certification, the ABFM Certificate of Added Qualifications in Hospice & Palliative Medicine **fully satisfies the Certification requirement.**

48. Does a Chaplain still need 12 CEUs if working for a Medicare-certified hospice?

A. Yes. Unless they hold individual chaplain certification (healthcare chaplaincy certification or Clinical Pastoral Education) or the entity has ACHC/CHAP/TJC palliative care certification, the Chaplain must complete 12 CEUs. **Medicare hospice status exempts the Chaplain from showing individual certification, but it does not waive the CEU requirement.**

49. If the Lead IDT Clinician is Hospice Medical Director Certified, what additional training is required when the entity is not palliative-certified? [NEW]

A. Because Hospice Medical Director Certification (HMDC / CHMD) does not mandate a palliative-care component, **an MD/DO who qualifies as Lead IDT Clinician via HMDC must also document 12 CEUs within the prior 12 months – unless the entity holds palliative care certification.** CEUs counted towards HMDC can count towards the training requirement for this benefit so long as the coursework falls within the list of DMAHS-approved palliative care topics and was completed in the last 12 months prior to application.

Medical Director

50. What is a Medical Director? What are their responsibilities?

A. The Medical Director is an MD or DO that **(1)** Provides clinical oversight by establishing care standards, approving clinical protocols, and ensuring care delivered is appropriate and high-quality; **(2)** Supervises practitioners (NPs, PAs, RNs) through chart review, case consultation, and ensuring compliance with scope-of-practice rules; **(3)** Leads clinical governance as the responsible physician for the program, ensuring documentation, coordination, and interdisciplinary care meet regulatory and payer expectations.

51. Why was this title changed from “Overseeing Physician”?

A. This new title more adequately captures the responsibilities of the role as outlined above.

52. Can the Medical Director be fulfilled by the same practitioner as the lead IDT clinician?

A. Yes, the overseeing physician **can be the same practitioner** as the lead IDT clinician if appropriately qualified and credentialed.

53. How is the Medical Director different from the lead IDT clinician?

A. Compared to the lead IDT clinician, the overseeing physician (1) must be an **MD or DO** (vs. MD, DO, PA, or NP), (2) can be either **employed or contracted** (vs. employed), (3) does **not need certification in hospice or palliative care** (vs. certification required for lead IDT clinician). The Medical Director can also be the Lead IDT Clinician, as long as both sets of criteria are met (i.e., employed MD or DO with certification in hospice or palliative care).

Lead IDT Clinician

54. What is a lead IDT clinician?

A. The lead IDT clinician serves as the primary clinical lead for the IDT and is responsible for overseeing care delivery and ensuring clinical appropriateness. They are **listed as the rendering/attending clinician** on PMPM bundle claims.

55. What credentials does the lead IDT clinician need?

A. The lead IDT clinician must be an **MD, DO, PA, or NP with the appropriate certifications in hospice or palliative care.** MD or DOs must have a Board Certification in Hospice and Palliative Medicine OR be a Certified Hospice Medical Director. NPs must be an Advanced Certified Hospice and Palliative Nurse (ACHPN). PAs must hold Certificate of Added Qualifications (CAQ) in Palliative Medicine & Hospice Care.

Note the Lead IDT clinician must always hold one of these certifications, regardless of whether the entity holds an entity-level certification in palliative care or not.

If the lead IDT clinician is an MD/DO with Hospice Medical Director Certification, then they must also document completion of 12 CEUs of palliative care training within the 12 months prior to application – unless the entity holds entity certification in palliative care.

56. If the lead IDT clinician information cannot be confirmed, should the facility's palliative care application be denied?

A. Yes, the application should be denied. Note the **entity only needs <u>one</u> lead IDT clinician with confirmed palliative care certification to meet CBPC standards.**

Chaplain

57. Is the entity required to have a chaplain from every faith?

A. As for all healthcare chaplains, the IDT chaplain is **non-denominational** and must certify non-proselytization in their work. If a member prefers an alternate religious representative on their IDT, the chaplain will help facilitate this connection.

58. What if the member does not want a chaplain on their team?

A. The chaplain is a **required role for the entity** to employ/contract but is **not a requirement for each patient's IDT** and can be excluded at patient request. If a member requests that a chaplain is not involved in their care planning, the chaplain must abstain from contributing to IDT discussions related to that member and will not interact with the member.

Child Life Specialist

59. What are the qualifications for the Child Life Specialist?

A. Child Life Specialist must have a Certified Child Life Specialist (CCLS) credential from the Child Life Certification Commission.

60. Is the Child Life Specialist always required on the IDT?

A. A Child Life Specialist is required **only when serving pediatric members**.

Provider outreach

61. Is there a target provider entity list for contracting? Will TINs be provided?

A. Yes, DMAHS has shared an Excel containing a list of **providers delivering palliative consultations/IDTs** in NJ. Because all providers in this list are **Medicaid-enrolled,** MCOs may use the NJMMIS provider file to find TINs.

62. Which providers already have palliative care certification?

A. Three entities in NJ are known to have palliative care certifications from the three nationally recognized bodies specializing in palliative care (TJC, ACHC,

CHAP): (1) **Osprey Hospice**, LLC dba Spero Hospice & Palliative Care, (2) **Holy Name Medical Center** dba Holy Name Hospital Hospice, (3) **Hunterdon Medical Center.**

MCO Care Management

Role and responsibilities

63. What is the MCO care manager's role with the IDT?

A. The MCO CM supports **plan navigation and coordination**; day-to-day case management and touchpoints are led by the provider IDT. At least **one IDT meeting per month** must include the MCO CM. Meeting **format is not prescribed** (e.g., virtual or panelized case reviews are acceptable).

64. What is the per member per monthly time commitment for the MCO CM?

A. DMAHS **does not prescribe a set number of hours** per member per month for the MCO CM. Rather, DMAHS **prescribes a set of activities** covering facilitating access to concurrent Medicaid-covered services, assisting with securing necessary Medicaid-covered services that complement the member's palliative care plan, and collaborating with the IDT by participating in monthly meetings to review, evaluate, and refine care plans.

65. Is RN licensure required for MCO CMs?

A. DMAHS does **not** prescribe a specific degree/licensure for MCO CMs.

66. If an MCO has previously submitted their CM training plan for DMAHS approval, can they continue with CM training?

A. Yes, if a training plan has been submitted to DMAHS and **all DMAHS feedback and Guidance changes** (e.g., 4/1 launch, removal of staffing ratios) have been incorporated, MCOs may move forward with CM training. In case of any material changes to the CM training, it should be resubmitted to DMAHS for review.

IDT meeting attendance

67. How will MCO CMs find out about IDT meetings?

A. Provider IDTs are expected to take the lead in scheduling MCO-specific meetings and streamlining with MCO CMs where possible. Once a member is enrolled in CBPC, the **MCO Care Manager 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.

68. What if the MCO CM cannot attend a scheduled provider IDT meeting?

A. This is left at **MCO/provider discretion**. In some circumstances, it would be appropriate to reschedule the IDT meeting; in other circumstances, it would be appropriate for another CM to be given the necessary context to fill in as an active participant.

69. How/when does the MCO CM sign off on the Care Plan?

A. The MCO CM must sign off on the Care Plan at finalization (e.g., at initial and reauthorization). The **format of signature is not prescribed** (e.g., acceptable formats includes documentation of verbal signoff during IDT meeting).

Member choice

70. Can a member opt out of care management as a service (either delivered by MCO CM or provider IDT)?

A. **No,** a core service of the palliative care benefit is care management. The member will have to be care managed by either the MCO CM or provider IDT.

71. Can a member opt out of having an MCO CM on their team?

A. Yes, the MCO CM can be excluded at **patient request.** In this case, IDT practitioners will manage care coordination and are expected to fulfill all MCO CM responsibilities internally as is done for FFS members.

Payment Model, Billing, and Claims

Note: Please see detailed Claims Configuration guidance reviewed at 12/2/2025 All MCO Call for additional information. Document: "2025.12.02--All MCO Community-Based Palliative Care Claims Configuration Presentation—vShare"

S-codes

72. Which codes are used? Are CPT codes used?

A. CBPC uses **HCPCS S-codes**: **S0280** (assessment), **S0281** (reassessment), **S0311** (PMPM bundle). **CPT codes are not used** for the bundle.

Revenue codes, diagnostic codes, modifiers

73. Which claim forms are used?

A. Claim forms **CMS-1500 or CMS-1450 (UB-04)** are acceptable. For those providers billing on a CMS-1450, they would bill a combination of the HCPCS with the revenue code associated with palliative care services.

74. Which revenue codes apply on CMS 1450 (UB-04)?

A. Use **0693** (pre-hospice or palliative care services) with **S0280/S0281** (assessment/reassessment) and **0690 (pre-hospice or palliative care services)** with **S0311** (PMPM bundle).

75. What diagnosis coding is expected? Is Z51.5 required?

A. DMAHS **requires Z51.5 as the secondary** diagnosis on **assessment/ reassessment** claims (i.e., S0280 and S0281), with the member's qualifying serious illness as the primary diagnosis. Because the PMPM bundle (i.e., S0311) is a palliative care-specific code, Z51.5 is **not required on PMPM claims**.

76. Is a modifier required on S0280 or S0281? How should plans differentiate palliative care assessments?

A. There is **no modifier** on (re)assessment (i.e., S0280 and S0281). Palliative care assessments will be distinguished using the palliative care diagnostic code Z51.5 (Palliative Care Encounter).

77. **Is a modifier required on S0311? How should plans differentiate palliative care services?**
    - **A.** There is **no modifier** on the bundle (i.e., S0311). This bundle is specific to the palliative care benefit and should not be used for any services outside of palliative care.

78. **If S0280, S0281, or S0311 is billed with a modifier, should it be set to pend/deny?**
    - **A.** Palliative care does not require a modifier (i.e., claims should not be set to pend/deny because of a modifier), but **MCOs may apply existing edits.** For example, if an MCO generally checks for the existing of telehealth modifiers (93 or 95) on services that must be delivered in person (e.g., the comprehensive assessment), MCOs may deny claims with this modifier.

79. **How can MCOs set up their system without DMAHS specialty code? [UPDATE]**
    - **A.** MCOs should configure their system so **providers that have completed their CBPC contracting can bill the PMPM;** no specialty code from DMAHS is needed for this set up, however, the palliative care specialty code is 999.

80. **Will Gainwell provide a data feed of Medicaid enrolled CBPC providers with the specialty code? [UPDATE]**
    - **A.** Please refer to the following NJMMIS provider files that Gainwell makes available on a weekly basis. MCOs may use these files to check a provider's enrollment with NJMMIS as a CBPC provider by linking the data (File 1 and File 2) by NJ Medicaid IDs. Information on these files was also shared with MCOs during the March 20, 2025 Contract Issues meeting. For reference: CBPC specialty code is **999.**

        16. File 1: Provider_Data
        17. File 2: Specialty_Data (please check both the FFS Specialty Code and Descriptions to confirm provider is CBPC-enrolled)
        18. File 3: MCare_Data
        19. File 4: IneligibleProviders (NPI and related data for providers with no NJ Medicaid ID)

        MCOs are requested to not solely use the enrollment letter to verify enrollment as it may not mention the CBPC specialty.

81. How can MCOs differentiate palliative vs. hospice care?

A. If palliative care provider entities also have a hospice care license, MCOs can differentiate palliative and hospice care by utilizing the **specified revenue code sets associated with each service.** This also applies to the differentiation between palliative care and home health services.

Timeframes

82. Is there a limit on the number of initial assessments or reassessments a provider can be reimbursed for?

A. **Initial assessments** are limited to 1 per quarter. MCOs can use 90-day windows for this authorization and may make exceptions when there is a valid reason for an additional assessment to be completed. **Reassessments are limited to** 1 per month. MCOs can use 30-day windows for this authorization and may perform audits to ensure that assessments and reassessments are not completed when not medically necessary.

83. Are these time limits per member, or per member and provider combination?

A. The (re)assessment time limits are based on **member and provider combination.** In other ones, one provider can be reimbursed a maximum of once a month for a given member's reassessment and a maximum of once a quarter for a given member's initial assessment.

84. Why can the initial assessment be repeated?

A. An initial assessment can be repeated in several circumstances, for instance the member **did not meet the clinical criteria** for the benefit, was **recently discharged** from the benefit, or **chose not to enroll** post assessment for some reason. Reassessments are only for members already in the benefit.

85. Are initial assessments allowed for members currently receiving the PMPM?

A. No, initial assessments are only for members who are not already in the benefit; reassessments are for members who are already in the benefit. It is recommended that MCOs **deny initial assessments that fall within service date period of the PMPM** (but not reassessments).

86. Is S0280 or S0281 based on calendar month increments?

A. No, S0280 and S0281 are one-time assessment codes not billed on a calendar-month basis. MCOs can use **operationalize maximum frequency using days** (e.g., 30-day windows for months, 90-day windows for quarters).

87. Is S0311 based on calendar month or 30-day increments?

A. S0311 is billed monthly on a calendar basis and retrospectively for each month during the six-month authorization. Authorizations and billing align with **calendar months**.

88. Can a provider bill before the required monthly interactions have been completed?

A. No, S0311 is billed monthly on a calendar basis and **retrospectively for each month** (i.e., no sooner than Day 1 of the next calendar month). Therefore, the required monthly interactions must have already taken place. For example, if CBPC services were rendered during the month of November, the provider may not bill sooner than Dec. 1.

Included services and concurrent services

89. What services are included in the CBPC PMPM bundle?

A. The **following services** are included: Comprehensive care planning and coordination; Advance care planning discussions; Symptom assessment and management; Medication review, titration, and 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.

90. What services are paid outside the CBPC PMPM? How do plans keep care integrated?

A. Medically necessary **concurrent services** (e.g., home health aide for a non-CBPC condition) are **distinct from the PMPM** and are billed **a la carte** per existing policy. These services may be rendered to address acute, chronic, or preventive care needs that fall outside the scope of the member's palliative care diagnosis or care plan. They are documented in the **Care Planning Tool** and reviewed in **monthly IDT meetings** to maintain a unified care plan.

91. Are concurrent services different for members in the CBPC benefit?

A. **No, concurrent services will continue through existing processes** regardless of whether a member is in the CBPC benefit (e.g., existing authorization processes). No incremental prior authorization (PA) is added solely by CBPC enrollment.

92. How can MCOs identify duplicative services with the PMPM bundle?

A. Most of the codes billed within the bundle can be billed by non-palliative care providers for other services, such as office visits or patient evaluation,

management, and treatment. **However, palliative care providers should not bill separately for codes included within the bundle.** Some codes might be included in other bundles, including home health and HCBS services. These services will be **differentiated using the revenue code** associated with those services or using the **palliative care encounter diagnosis code** (Z51.5). For codes within the CBPC bundle billed by CBPC member/provider combinations with palliative care diagnosis/revenue codes, MCOs can set these codes to pend/deny with option for manual override.

93. What other services may be billed with the palliative code diagnosis code (Z51.5)? Should MCOs pend/deny claims with these codes?

A. MCOs may see services outside of the CBPC bundle billed with this code – primarily outpatient palliative care consults, post-acute care, and hospital stays. **These claims should not be set to pend/deny** automatically as they are separate from the CBPC bundle. However, please consult the question above for how MCOs may potentially identify services that are duplicative with the CBPC bundle. **Additionally, Z51.5 is not required on the PMPM bundle but PMPM bundles with Z51.5 should not be set to pend/deny.**

Configuration

94. Should MCOs wait to start billing & claims system configurations until CMS approves the procedure codes used for the CBPC benefit?

A. The procedure and revenue codes specified for the CBPC benefit are existing codes on the Medicare fee schedule with claims configuration and processing rules already determined by CMS for use by managed care organizations and state Medicaid programs. **MCOs do not need to wait for CMS** to approve these codes as part of the SPA process.

95. What if MCO system has challenges setting up calendar-month cycles?

A. Please consult **more detailed configuration guidance provided by DMAHS.** If the steps outlined in that document are not feasible in MCO system or the claims system has not yet been configured, DMAHS suggests MCOs use the Comprehensive Medical Assessment authorization date to set a **6-month (i.e., 180 day) window** and allow no more than 6 PMPM per member/provider combination during this authorization window.

96. Is S0311 pro-rated? What if member joins or exists the benefit mid-month?

A. There is **no pro-rating.** Full reimbursement is allowed for partial months (e.g., if a member enters or exists the benefit mid-month) **when required monthly**

activities are completed and documented (at least one IDT–member interaction and at least one IDT meeting that includes the MCO care manager).

97. What date range should be used on S0311?

A. S0311 is based on calendar months. The date range will normally be **the first date of month until the last date of the month.** If a member enters the benefit mid-month, the first date should be set as the date of the first required interaction of that month (i.e., the sooner of the IDT meeting or an interaction between the IDT and the member). Note **the start date of the PMPM must be after the completion date of the Comprehensive Assessment.**

98. What if the member switches providers mid-month?

A. If a member switches CBPC providers mid-month, the **initial provider** may bill for that month. PMPM claims should only be paid to one provider for each member per month, as long as they have completed and documented the required monthly activities.

Example where Provider A (first provider) is paid: Member is served by Provider A from September 1-15. During this time, Provider A has 1 interaction with the Member and also meets once internally including the MCO CM. Member is served by Provider B from September 16-30. Because Provider A was the initial provider and completed all required interactions, Provider A is paid the PMPM.

Example where Provider B (second provider) is paid: Member is served by Provider A from September 1-15. During this time, Provider A has 1 interaction with the Member but does not meet once internally including the MCO CM. Member is served by Provider B from September 16-30. During this time, Provider B has 1 interaction with the Member and also meets once internally including the MCO CM. Because Provider A did not complete all required interactions but the subsequent Provider B did, Provider B is paid the PMPM.

99. What if two providers bill the PMPM in the same month?

A. PMPM claims should only be paid to one provider for each member per month. **The second provider to bill same month for a member should be set to pend/deny**. MCOs can make exceptions when there is a valid reason for mid-month provider switching that occurs.

Example exception where both Provider A and Provider B are paid: Member is served by Provider A in North Jersey from September 1-15. During this time, Provider A has 1 interaction with the Member and also meets once internally including the MCO CM. Member moves and is served by Provider B in South Jersey from September 16-30. During this time, Provider B has 1 interaction with the

Member and also meets once internally including the MCO CM. Because both providers completed all required interactions and there is a valid reason for mid-month switch (e.g., member change in geographic location), Provider A and Provider B may be paid the PMPM (at MCO discretion). MCOs should require that providers report enrollment date, disenrollment date, and disenrollment reason.

Payment

100. Are MCOs required to pay at/above minimum rates? Can plans negotiate alternatives?

A. Yes, plans must reimburse **at or above the FFS floor** for the three CBPC codes: assessment **$100**, reassessment **$85**, PMPM bundle **$686** (as of **January 1, 2026**). These rates have been finalized. MCOs and providers **may negotiate** alternative payment methodologies and incentives for the bundle, provided the **effective rate is not below the floor**.

101. How does coordination of benefits (COB) work (Medicare/DSNP/commercial)?

A. CBPC payments for assessment/reassessment and the PMPM bundle are **Medicaid only**. Concurrent services continue to bill **primary as usual**, with Medicaid as the **payer of last resort** under standard TPL.

NEW JERSEY HUMAN SERVICES

Provider Engagement

102. How are providers being engaged?

A. DMAHS is continuing to work with **NJ Home Care & Hospice Association** (HC&HA) and **Goals of Care Coalition** (GOCCNJ) to raise provider awareness of the benefit. DMAHS is conducting a series of **three provider trainings in the first months of 2026** to support provider readiness. Additionally, DMAHS plans to follow **standard notice process for State Plan Amendments.** This includes a notice published in newsletters and on DMAHS website and sent via email to various stakeholders.

103. Are providers aware of the benefit?

A. Yes, some providers may already be aware. **NJ Home Care & Hospice Association** (HC&HA) and **Goals of Care Coalition** (GOCCNJ) hosted an info session on October 22, 2025 and are continuing to raise provider awareness in their regular meetings. Additionally, a small working group of HC&HA providers has been engaged throughout the benefit design process to ensure the benefit is responsive to provider needs.

104. What provider trainings are planned?

A. DMAHS will host **three provider trainings ahead of benefit go-live**; MCOs will also host their own trainings. **Training 1 occurred on Tuesday, Jan 20 from 2-3pm** and focused on an overview of the benefit, provider qualifications, and best practices for the IDT – a recording is available here. **Training 2 occured on Tuesday, Jan 27 from 11am – 12 pm** and focused on NJMMIS enrollment and MCO credentialing forms – a recording is available here. **Training 3 is Thursday, February 26th** and will focus on Care Management, service authorization, and billing & claims; providers can register here.

Quality Strategy, Monitoring & Reporting

105. What are the Acuity Tiers and who is expected to supply them? [UPDATE]

A. Please await further updates on these metrics.