

# **Aetna<sup>®</sup> Medicare FIDE (HMO D-SNP) Community Based Palliative Care – Provider Frequently Asked Questions (FAQ)**

## **Q1. What is Community Based Palliative Care?**

A1. Community-Based Palliative Care (CBPC) is a new benefit within Aetna Medicare FIDE (HMO D-SNP). Under the Medicaid benefit, members receive longitudinal care from an interdisciplinary team to manage symptoms and navigate the healthcare system. Unlike hospice care, this program does not require a terminal prognosis or forgoing curative treatment. Rather, CBPC is designed to work in conjunction with curative treatments, broadening access to crucial support services.

## **Q2. Who is eligible for the benefit?**

A2. Members qualify based on serious illness and evidence of reduced quality of life. Examples of qualifying serious illnesses and quality-of-life changes are included below. Health plans may also approve CBPC based on an individual determination of medical necessity.

### 1. Diagnosis with serious illness:

Eligible conditions include (but are not limited to):

#### **Adult:**

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

#### **Pediatric:**

- Cardiac Disease

- Pulmonary Disease
- Neurological Disorder
- Cancer
- Renal Disease
- End-stage Liver Disease
- Genetic Disorders
- Metabolic/Inclusion Disease
- Gastrointestinal Disease or Conditions
- Orthopedic Disorders
- Neonatal
- Infectious Disease

2. Quality of life impairment, as indicated by one of the following:

- a. Documented functional decline (KPS  $\leq$  70, ECOG grade 3 or higher, PPS  $\leq$  70, MELD  $>$  19, FAST= $>$  5, MLTSS enrollment)
- b. Acute care utilization of either two or more emergency department visits in the past six months or at least one acute hospitalization in the past 12 months
- c. Other functional decline or indication of disease severity not captured above as determined by clinical judgement of MCOs and practitioners

**Q3. Is this benefit available for Pediatric population?**

A3. Generally, the demographics for Aetna Medicare FIDE (HMO D-SNP) would be above the age of 18. However, if there were a member under the age of 18 enrolled in the Aetna Medicare FIDE (HMO D-SNP) CBPC benefit would be available.

**Q4. What services are covered under the CBPC Benefit?**

A4. The CBPC benefit covers a comprehensive set of services delivered by an interdisciplinary team (IDT) to enhance the quality of life for eligible members. CBPC services can be delivered in any non-inpatient setting.

Covered services may include, but are not limited to:

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

#### **Q5. How can a member enroll in the benefit?**

A5. The enrollment process starts with the Referral Screen:

##### Referral/Screen

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

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

#### **Q6. Is Prior authorization required for the screener?**

A6. No, prior authorization is not required for the screener, assessment, or re-assessment. However, prior authorization is required for the CBPC PMPM bundle (S0311) and requires the submission of a completed CMAT for members that meet eligibility when requesting. Upon approval, a letter would be sent to the member. **Q7. What is the next step after completion of the screener?**

A7. After completion of the screener the member is referred for assessment, whether directly or using the Program Eligibility Screening Tool:

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

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

**Q8. Is the provider required to submit the assessment to Aetna Medicare FIDE (HMO D-SNP)?**

A8. Upon completion, the clinician must submit the Comprehensive Medical Assessment Tool to Aetna Medicare FIDE (HMO D-SNP) if requesting the CBPC bundle, and Aetna Medicare FIDE (HMO D-SNP) must store the Tool.

**Q9. Is Prior authorization required to complete the assessment?**

A9. Aetna Medicare FIDE (HMO D-SNP) does not require prior authorization to complete the assessment.

**Q10. Is the completion of the screener and assessment reimbursable?**

A10. Completion of the screening tool is not reimbursable. Comprehensive Medical Assessment is a reimbursable activity.

**Q11. What is the Care planning requirements?**

A11. Once authorized by Aetna Medicare FIDE (HMO D-SNP), the member moves to the care planning & maintenance stage of the benefit. The purpose of the member care plan is to use insights from the member's Comprehensive Medical Assessment and build a comprehensive palliative care strategy.

Providers are encouraged to share finalized care plans with the designated assessor and other involved relevant healthcare providers to ensure continuity of care and coordinated, comprehensive care delivery.

The Lead IDT Clinician is to meet with the member and create a care plan. The first palliative interaction must be in person.

Care planning helps identify which IDT practitioners will be involved in the member's care. Care planning also facilitates care coordination and referrals, pain management, medication management, and advance care planning for the member (if the care planning is the first interaction with the member then it must be in person).

**Every month during the six-month authorization window, the IDT must meet at least once internally (including the CM) and at least once with the member.** The meetings serve to discuss member care and update the care plan as needed. A new Care Plan must be drafted upon reauthorization, and if a significant change triggers a reassessment, a new Care Plan should also be drafted.

**Q12. What is needed for the member to remain in the benefit?**

A12. To remain in the benefit, members must be reassessed every six months.

If a member's condition changes significantly within the six-month authorization window (e.g., their

condition progresses or they suffer a fall), that member should be reassessed. That reassessment should be emailed to Case Management Aetna Medicare FIDE (HMO D-SNP) at [NJ\\_FIDE\\_SNP\\_CM@Aetna.com](mailto:NJ_FIDE_SNP_CM@Aetna.com) for reauthorization, accompanied by an updated care plan addressing the member's change in condition. At the end of the six-month authorization the member must be reassessed for continued eligibility. A new CMAT must be submitted for reauthorization of the bundle (S0311) within 5 business days after completing the assessment. If Aetna Medicare FIDE (HMO D-SNP) reauthorizes care, that reauthorization is valid for an additional six months of care. For re-assessments (S0281) received during an existing 6-month authorization window, we will process the claim (per billing guidelines) and maintain the existing 6-month authorization time period. A reassessment during the authorization window does not reset or extend the existing 6-month authorization period unless Aetna issues a new authorization consistent with program requirements. A member may only be reassessed a maximum of once per month.

If reassessment determines the member is no longer eligible, the member will be discharged from the benefit. The provider should submit (re)assessments to Aetna Medicare FIDE (HMO D-SNP), regardless of the eligibility determination.

### **Q13. What are the conditions for discharge from the benefit:**

A13. When a member leaves the benefit (e.g., in case of exit to hospice or discharge after determined ineligible), the provider must submit the **Discharge Tool** to Aetna Medicare FIDE (HMO D-SNP) Care Management at [NJ\\_FIDE\\_SNP\\_CM@aetna.com](mailto:NJ_FIDE_SNP_CM@aetna.com). The IDT should review the member's concurrent services and request to extend those that are still needed. If the member is switching providers or MCOs, the same process applies. For switching, the IDT must transmit the member's care plan to all relevant providers and the Care Manager and ensure there are no caps in care.

### **Q14. What are Care Manager's responsibilities?**

Q14. The responsibilities of the CM include but are not limited to:

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

### **Q15. How are services reimbursed?**

A15. Providers may bill based on the member's enrollment status, with required documentation and expectations for payment clearly defined. Aetna Medicare FIDE (HMO D-SNP) must reimburse providers at or above the FFS floor.

Key components of the payment structure include:

- **Initial Assessment:** Paid upon completion of the Comprehensive Medical Assessment Tool; no prior authorization. Limit: one per member per quarter.

- **Per Member Per Month (PMPM) Bundle:** Monthly payment for six months covering all IDT services in the care plan. Requires at least one IDT-member interaction and one IDT meeting (including Care Manager) per month.
- **Reassessment:** At least every six months or upon significant condition changes; max one per month.

**Q16. What is the process for Provider Enrollment/Credentialing?**

A16. Providers who are interested in joining Aetna Medicare FIDE (HMO D-SNP) Network for Community Based Palliative Care should reach out the Aetna Medicare FIDE (HMO D-SNP) Network Team at [AetnaBetterHealth-NJ-ProviderServices@aetna.com](mailto:AetnaBetterHealth-NJ-ProviderServices@aetna.com)

- In your email, please include a letter of intent with the information outlined below.
  - Group Name
  - Group NPI
  - Group TIN
  - Service address (including county)
  - Provider Name(s)
  - Individual NPI
  - Specialty
- The Contract Manager that handles the County in which you are located will contact you with the documents required to initiate the contracting/credentialing process.

**Q17. Do the CBPC services continue if a member changes Health Plans?**

A17. In the case of a member switching health plans or switching from FFS to Aetna Medicare FIDE (HMO D-SNP), the member’s new health plan is expected to honor the existing palliative care authorization for at least 60 days. After this period, the health plan may order a reassessment to determine a member’s continued eligibility. In the case of a member switching providers or health plans, the member’s current provider must transmit all relevant medical information, including assessments and care plans, to the member’s new provider or health plan. If the member switches to a new MCO and their existing provider is out of network, the health plan must honor their existing authorization for a period of 60 days to ensure care of continuity with no gaps in care.

**Q18. What are the requirements for reassessment if a member’s condition changes?**

A18. If a member’s condition changes significantly within the six-month authorization period (e.g., progression or a fall), they must be reassessed. The reassessment, for change in condition should be emailed to Aetna Medicare FIDE (HMO D-SNP) Care Management at [NJ\\_FIDE\\_SNP\\_CM@aetna.com](mailto:NJ_FIDE_SNP_CM@aetna.com) If Aetna reauthorizes care, the member will need to be reassessed for another six months of care. For reassessments (S0281) received during an existing 6-month authorization window, we will process the claim (per billing guidelines) and maintain the existing 6-month authorization time period. A reassessment during the authorization window does not reset or extend the existing 6-month authorization period unless Aetna issues a new authorization consistent with program requirements. Providers are reimbursed for only one reassessment per member per month (PMPM). Aetna will manage and maintain the processing of claims and authorizations within the approved timeframe.

Aetna Medicare FIDE (HMO D-SNP) may audit documentation and recoup payments if necessary.

If a member is discharged after being deemed ineligible, the provider must submit the completed reassessment form to Aetna Medicare FIDE (HMO D-SNP). Services outside the palliative care plan (e.g., home health for acute or preventive needs) may be billed separately.

**Q19. Where can providers call for additional information?**

A19. To learn more about CBPC, call Provider Services at **1-844-362-0934**.