

## 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

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](mailto: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](mailto: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](mailto: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  $\leq 50\%$ , 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:	<input type="checkbox"/> Aetna Better Health of New Jersey <input type="checkbox"/> Fidelis Care <input type="checkbox"/> Fee-For-Service (FFS) <input type="checkbox"/> Horizon NJ Health <input type="checkbox"/> UnitedHealthcare (UHC) <input type="checkbox"/> Wellpoint	Age: <input type="checkbox"/> Adult (19 years or older) <input type="checkbox"/> Child (0-18 years)
		DOB: (mm/dd/yyyy)
Preferred Language:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese-Mandarin <input type="checkbox"/> Chinese-Cantonese <input type="checkbox"/> Portuguese <input type="checkbox"/> Tagalog <input type="checkbox"/> Korean <input type="checkbox"/> Other: _____	
English Fluency: (Verbal)	Member:	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> No Fluency
	Caregiver/Family Member: (if applicable)	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> No Fluency
English Fluency: (Written)	Member:	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> No Fluency
	Caregiver/Family Member: (if applicable)	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> No Fluency
Healthcare Power of Attorney (POA)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> First assessment of eligibility → Complete sections D-I <input type="checkbox"/> 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:	<input type="checkbox"/> Scheduled 6-month reassessment <input type="checkbox"/> 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:	<input type="checkbox"/> Alzheimer's or other dementias <input type="checkbox"/> Cancer (Stage III or IV) <input type="checkbox"/> COPD <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Cirrhosis or liver disease <input type="checkbox"/> Diabetes <input type="checkbox"/> ESRD or Chronic Kidney Disease <input type="checkbox"/> Stroke <input type="checkbox"/> AIDS <input type="checkbox"/> Degenerative neural condition (i.e. Parkinson's, severe neurodegenerative) <input type="checkbox"/> Other ( <i>explain below</i> )
	Children:	<input type="checkbox"/> Pulmonary Disease <input type="checkbox"/> Cardiac Disease <input type="checkbox"/> Neonatal* <input type="checkbox"/> End-stage Liver Disease <input type="checkbox"/> Genetic Disorders* <input type="checkbox"/> Renal Disease <input type="checkbox"/> Metabolic/Inclusion Disease <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Orthopedic Disorders* <input type="checkbox"/> Gastrointestinal Disease or Conditions* <input type="checkbox"/> Neurological Disorder <input type="checkbox"/> Other ( <i>explain below</i> )
	<b>*For conditions marked with an *, children do not need evidence of disease severity to qualify for services.</b>	
Other Serious Illness Not Included Above & Description:		
Conclusions from Section E		
Serious disease criteria met: (select only 1)	<input type="checkbox"/> Yes – member has at least one of the serious diseases included above <input type="checkbox"/> Yes – member has other serious disease not included above; provider judgment deems enrollment clinically appropriate <input type="checkbox"/> No – member does not meet any criteria	

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



SECTION I: GOALS FOR CARE	
Advance Directive on File? <input type="checkbox"/> Yes <input type="checkbox"/> No	POLST on File? <input type="checkbox"/> Yes <input type="checkbox"/> No
Health Proxy Identified? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Check to confirm the member is <b>NOT</b> currently enrolled in hospice care <i>(if unchecked, mark ineligible)</i>	
Eligibility Determination: <input type="checkbox"/> Eligible <input type="checkbox"/> Ineligible	
SECTION K: SIGNATURES	
Member signature indicates consent to proceed to Palliative Care enrollment if care authorized	
<input type="checkbox"/> By checking this box, you certify that this form was completed <b>in person</b> 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)