JOSH GREEN, M.D.
GOVERNOR
KE KIA'ĀINA

RYAN I. YAMANE
DIRECTOR
KA LUNA HO'OKELE

JOSEPH CAMPOS II
DEPUTY DIRECTOR
KA HOPE LUNA HO'OKELE

TRISTA SPEER
DEPUTY DIRECTOR
KA HOPE LUNA HO'OKELE

STATE OF HAWAII
KA MOKU'ĀINA O HAWAI'I
DEPARTMENT OF HUMAN SERVICES
KA 'OIHANA MĀLAMA LAWELAWE KANAKA
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

December 31, 2024

MEMORANDUM

MEMO NO.
QI-2430
CCS-2410
FFS 24-12

TO: QUEST Integration Health Plans
Community Care Services
Fee-For-Service Providers

FROM: Judy Mohr Peterson, PhD JMP
Med-QUEST Division Administrator

SUBJECT: COMMUNITY PALLIATIVE CARE BENEFIT IMPLEMENTATION

The purpose of the memorandum is to notify health plans of a new community palliative care benefit. The Med-QUEST Division (MQD) is the first Medicaid agency to receive approval for this benefit. As expected, there likely will be changes with the implementation of this first-in-the-nation benefit and MQD encourages health plans to seek clarification and provide feedback on this memo for quality improvement purposes.

I. INTRODUCTION

The Department of Human Services (DHS) Med-QUEST Division (MQD) received approval from the Centers for Medicare and Medicaid Services (CMS) to provide a community palliative care

benefit (SPA Memo 22-13) in non-hospital settings for QUEST Integration (QI) beneficiaries experiencing serious illnesses.

II. PROBLEM AND BACKGROUND

MQD embarked on a robust stakeholder engagement process to identify evidence-based practices that better support individuals with serious illness, and to assess if there are gaps in access to quality care across the continuum of care. The finding from this work include:

- Palliative care was identified as a high-value approach that improves the quality of care and lowers costs;
- Inpatient palliative care services were a covered benefit;
- Hospice care is covered and addresses the needs of individuals at the end of life; and
- A gap in care was identified: There was not a palliative care benefit to support members with serious illness in their homes and/or community settings that do not meet criteria for hospice.

As a result, MQD continued the robust stakeholder engagement to develop a community palliative care benefit to better address the needs of this vulnerable population.

III. PALLIATIVE CARE AND SERIOUS ILLNESS DEFINED

Palliative care is:

- Specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. **The goal is to improve the quality of life for both the individual and the family.** It is appropriate at any age and at any stage of illness, and it can be provided along with curative treatment.[1]
- Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.[2]

[1] https://www.capc.org/about/palliative-care/

[2] 42 CFR 418.3

- Provided by a specialty trained team of physicians, nurses, social workers, and others that work together with the member's other providers to provide an added layer of support.[3]
- Provided to individuals experiencing serious illness. A serious illness is defined as a health condition that carries a high risk of mortality and negatively impacts daily functioning, or quality of life, or excessively strains caregivers.[4]

IV. PALLIATIVE CARE IS AN ADDITIONAL OPTION ACROSS THE CONTINUUM OF CARE

Community palliative care is designed to be an additional option across the continuum of care for people with serious illness. Health plans are responsible for educating providers and members about the service array across the continuum of care that supports members with serious illnesses (e.g., Hospice, Home and Community Based Services [HCBS], home health, health coordination services, case management, etc.). It is important to note that receiving palliative care does not exclude members from receiving HCBS, home health services, and health coordination services if the members meet the criteria and receive all required prior approvals or authorizations from the health plans.

V. DIFFERENCE BETWEEN COMMUNITY PALLIATIVE CARE AND HOSPICE CARE

Palliative care and hospice are both forms of care aimed at improving the quality of life for individuals with serious illnesses, but they differ in terms of timing, scope, goals, and reimbursement.

Table 1. Differences between Community Palliative Care and Hospice Care

	Community Palliative Care	Hospice
Timing	Provided to members when diagnosed with a serious illness and when they experience impact to daily function, quality of life, or caregiver burden, even alongside curative treatment.	Provided to members who are in the final stages of a terminal illness when life expectancy is six months or less. It begins when curative treatment is no longer pursued, and the focus shifts entirely to comfort care. Note: Children may receive curative treatment while in hospice.
Scope	Focuses on relieving symptoms, managing pain, and addressing	Encompasses comprehensive care, including pain and symptom

[3] https://www.capc.org/about/palliative-care/

[4] Population with Serious Illness: The "Denominator" Challenge. J Palliat Med. 2018 Mar;21(S2):S7-S16. doi: 10.1089/jpm.2017.0548. Epub 2017 Nov 10. PMID: 29125784; PMCID: PMC5756466.

	Community Palliative Care	Hospice
	the holistic needs of the member and advance care planning. Can occur anywhere outside of the acute hospital setting.	management, emotional and spiritual support, and assistance with end-of-life planning. It is typically provided in the member's home, but can be offered in hospice centers, hospitals, and nursing homes.
Goal	Improve the quality of life for the member and their family by addressing symptoms and providing support. It is not dependent on prognosis and can be integrated with curative treatment.	Provide comfort and dignity at end of life, focusing on the quality of life rather than extending life. It emphasizes support for the member and the family.
Reimbursement	Community Palliative Care Bundle is a monthly per member per month (pmpm) payment that includes the services in Section XV. Note: Durable Medical Equipment (DME), Supplies, prescription medications, and personal assistance services are not included in the bundle payment. However, the member may receive these services outside of the bundled rate if approved by the member's health plan.	Generally, hospice agencies are paid a daily rate, often referred to as the "per diem" rate, for each day a member is enrolled in the hospice benefit. The per diem rate includes all services a member would access, including clinical services, DME, prescription medications, personal assistance services, etc.

VI. IMPLEMENTATION DATE

The implementation start date for the community palliative care benefit is **January 1, 2025**. Health plans are required to continue to provide palliative care services in hospital settings as this has been and continues to be a covered service.

VII. TRANSITIONS FROM VALUE-ADDED BENEFIT TO NEW BENEFIT

The QI health plans that are providing supportive care/palliative care as a part of value-added services in their QI contract must continue to provide these services through **June 30, 2025**. QI health plans must ensure a smooth transition of care and avoid gaps in care and services when transitioning members to the new benefit.

QI health plans that include DME, personal care services, and medications in their value-added benefit reimbursement bundle must ensure these services and supplies are transferred and authorized, if necessary, prior to the member transitioning to the new benefit.

Supportive care/palliative care providers often provide these services and supplies, and may not be a part of the health plan's network to provide these specific services (e.g., DME, supplies, medications). The health plan may seek pathways to allow these providers to continue to provide these services through June 30, 2025 to support smooth transitions of care. Again, services may be provided by the palliative/supportive care provider but they may not be in network.

QI health plans must ensure there is a smooth transition of care and avoid gaps in care and services for these members with serious illnesses.

QI health plans may transition the member to the new benefit prior to June 30, 2025 if the following conditions are met:

- This is aligned with the member choice;
- All transition of care needs are identified and resolved; and
- The community palliative care provider can start providing services.

If a plan transitions to the new benefit prior to June 30, 2025, they are not still required to provide the value-added services.

VIII. BENEFITS OF PALIATIVE CARE SERVICES

There are many benefits of providing palliative care services to Medicaid beneficiaries, and some of the benefits include the following:

- Health Equity – Individuals with serious illnesses experience significant health disparities and often need additional support to attain the highest level of health. The palliative care benefit provides additional support needed for optimal outcomes.
- Aligned with CMS' Strategic Vision for Medicaid[5] – CMS published a policy agenda that identified strategies and priorities for Medicaid. Providing a palliative care benefit is aligned with the strategy of innovations in value-based care and whole-person care.
- Sustainable Costs – Individuals with serious illnesses often are understandably high users of health care system that results in high utilization and costs. This benefit will provide additional supports aimed at decreasing preventable utilization and fragmented care.

[5] https://www.healthaffairs.org/do/10.1377/forefront.20211115.537685/

MQD is conducting a rapid cycle evaluation to assess if these benefits are realized (see Section XXII for more information).

IX. GOALS

MQD identified the goals of the benefit, which include the following:

- Improve health equity for individuals with serious illnesses;
- Improve access to high-quality serious illness care throughout the state;
- Improve the quality of life for individuals with serious illness;
- Decrease symptom burden for individuals with serious illness; and
- Decrease avoidable utilization and spending.

X. PALLIATIVE CARE IN HOSPITAL SETTINGS VERUS COMMUNITY PALLIATIVE CARE

As previously mentioned, palliative care services in hospital settings are currently a covered benefit. This benefit will continue. The specifications described in this memo are referring to the new community palliative care benefit that is provided in non-hospital settings.

XI. CLINICAL CRITERIA

The clinical eligibility criteria require a diagnosis of a qualifying health condition and evidence of ongoing functional decline. See Appendix A for a list of condition categories and clinical eligibility criteria and approved assessment tools or utilization indicators with diagnostic benchmarks to determine functional decline.

For those members no longer eligible or appropriate for the palliative care services, it is expected that members be discharged from utilizing the palliative care services benefit and that care be coordinated according to their eligibility for services and need. For those eligible for and accepting of hospice or transplant services, members must be discharged from the Palliative Care Services benefit and transitioned to receive services under the new benefit or program. MCOs must document the reason for discharge as part of services.

XII. SERVICES

The services required to be delivered include, but are not limited, are described below. Note the scope of services is focused on the conditions for which the member is clinically eligible to receive community palliative care.

- Care plan development and implementation that is aligned with the member and family/caregivers goals;

- Clinical services provided through an interdisciplinary team (See Appendix B) that address the holistic needs of the member and their family/caregiver(s), focusing on relieving pain and symptoms associated with the serious illness;
- Comprehensive management; and
- Care coordination and communication.

Services shall be delivered as medically necessary and follows an interdisciplinary care plan agreed upon by the member, caregiver, health plan care coordination team, and the member's primary care provider. Services shall be delivered in alignment with person-centered planning and practice principles. Special focus should be made to ensure that providers are available to deliver care that reflects the culture of the member receiving it and that language preferences are addressed and met.

Table 2. Required Minimum Services and Frequency of Services

#	Standards of Care	Services	Required Frequency
1	Access	There shall be unlimited access to care for when member and family/caregiver needs arise, via in-person visits, or via telemedicine.	24/7/365
2	Access, Clinical and Billing	A prescribing clinician shall conduct an in-person visit to address the physical and clinical needs of the member and family/caregiver.	At least quarterly
3	Access, Clinical and Billing	At a minimum, a telehealth or in-person visit with a required interdisciplinary team member and/or prescribing clinician (see Appendix B) shall be completed. Other required or optional interdisciplinary team members may also attend the telehealth or in-person visit.	At least monthly
4	Clinical and Billing	The palliative care team will hold interdisciplinary team meetings. The meetings will include assessing the member's appropriateness for hospice care and assessing the need for other services available for the member and family/caregiver.	At least bi-weekly
5	Clinical and Billing	The palliative care provider and the health plan shall hold regular care coordination meetings. A lead care coordinator is required to be identified at the health plan or provider organization for purposes of timely care coordination (see Section XVII). The health plan must coordinate with care coordinators to ensure access to additional services in a timely manner.	At a minimum quarterly, preferably monthly, and ad hoc as needed

#	Standards of Care	Services	Required Frequency
6	Access, Clinical, and Billing	A comprehensive interdisciplinary assessment: 1. The assessment shall be conducted in alignment with person-centered planning and practice principles. 2. The assessment shall include an in-person visit by the prescribing clinician with additional assessments completed by the required interdisciplinary team members, as identified by the prescribing clinician (see Appendix B). The in-person assessment should be based on the member's needs and schedule. Visits by the required team members do not need to occur at the same time or on the same day. 3. The assessment shall include a social risk factor screening tool, and the care plan shall reflect and address issues identified in the social risk factor screening tool. 4. The assessment shall cover domains of care included in the most recent edition of the national Consensus Project Clinical Practice Guidelines. 5. The assessment shall also include referrals to additional services available to the member based on eligible and need. Some of these services may need to be coordinated through the health plan. 6. Care plan shall be developed based on the assessment.	Shall be completed on each member receiving palliative care within four (4) weeks of receiving prior approval from the health plan.
7	Access, Clinical and Billing	A reassessment shall be completed regularly, and the care plan shall be updated based on the outcomes from the reassessment.	At least every six (6) months, or if there is a condition of condition (e.g. improvement or decline) and a reassessment is appropriate.
8	Access and Clinical	The interdisciplinary team shall provide additional services needed to meet the needs of the members and family/caregiver.	As needed.

The above standards of care requirements shall be met for the provider to receive the bundled payment (see Section XV) each month. The health plans are required to monitor palliative care services to ensure all required services are provided (see Section XXII).

XIII. COMMUNITY PALLIATIVE CARE SETTINGS

Allowed Settings

Community palliative care is a set of services that are provided by an interdisciplinary team (see Appendix B). These services are delivered in non-hospital settings including, but not limited to:

- The member's residence;
- Wherever the member resides or is located, including houseless members.
- Clinics/office settings;
- Community Health Centers;
- Assisted living facilities;
- Long-term care facilities;
- Skilled nursing facilities; and
- Other residential settings.

All providers shall render the services in at least one setting listed above. MQD encourages providers to deliver at least some of the services at the member's residence and/or wherever the member resides or is located in alignment with member preference.

XIV. PROVIDER CREDENTIALS, QUALIFICATIONS, AND TYPES

The billing provider is responsible for providing community palliative care. Rendering providers are the employees or contractors within the billing provider's interdisciplinary team (Appendix B). Reimbursement for palliative care services is provided to the billing provider through a bundled payment (see Section XV). The billing provider determines how it will pay the providers that render services.

Requirements include:

Table 3. Service Provider Requirements

#	Billing Provider Requirements Description	Employment Status	Required to be Full-Time?	Required to Work Exclusively on QI	Comment
1	Shall have at least one physician that delivers	Can be employed by	No	No	If the physician is full-time, this can

#	Billing Provider Requirements Description	Employment Status	Required to be Full-Time?	Required to Work Exclusively on QI	Comment
	direct clinical care and program oversight	or contracted with the billing organization			also meet requirement #2 below.
2	Shall have at least one prescribing clinician (Physician, Advanced Practice Registered Nurse or Physician Assistant)	Must be employed (not contracted) by billing organization	Yes, at least one shall be full-time	No	May also satisfy requirement for #1 if the full-time prescribing clinician is a physician.
3	Shall have at least one prescribing clinician with a specialty certification in hospice or palliative care	Can be employed or contracted	No	No	
4	Shall have a training plan in place that includes the services required under the benefit.	Contracted and employed team members	N/A	N/A	
5	Shall have an interdisciplinary team as described in Appendix B.	Can be employed or contracted	No	No	All members of the team must be registered with MQD (HOKU) as a Medicaid provider.
6	Shall be contracted with the health plan and receive approval to provide community palliatives care services through the attestation process prior to the delivery of services as described in Appendix C.	N/A	N/A	N/A	It is expected that health plans will contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. For example, health

#	Billing Provider Requirements Description	Employment Status	Required to be Full-Time?	Required to Work Exclusively on QI	Comment
					plans may contract with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in palliative care if all the requirements described in this memo are met.
7	Shall have a licensed clinical social worker (LCSW) as part of the interdisciplinary team to perform clinical assessments, develop treatment plans, and provide support for individuals and their families.	Can be employed or contracted	No	No	The LCSW may refer members to other professionals for specialized care, such as psychiatry or other doctors, as appropriate. The LCSW may oversee other social workers such as LSWs to provide case management, advocacy, and resource coordination and to conduct needs assessments for social services. LSWs may refer members to

#	Billing Provider Requirements Description	Employment Status	Required to be Full-Time?	Required to Work Exclusively on QI	Comment
					additional social services resources. In the case of children with serious illness, LCSWs may also oversee child life specialists.
8	Other required members of the IDT not mentioned above (Registered Nurse, Child Life Specialist, and Grief Counselor)	Can be employed or contracted	No	No	
8	May include optional providers as described in Appendix B	Can be employed or contracted	No	No	

The billing provider shall be registered with MQD as a Medicaid provider. All members of the interdisciplinary team that can enroll in HOKU must be enrolled in HOKU, including required and optional providers. All members if the interdisciplinary team that can enroll in HAP/HFA must be enrolled in HAP/HFA, including required and optional providers.

XV. ACCESSING SERVICES AND MEMBER CONSENT

If a plan so chooses, a provider shall receive a prior authorization from the member's health plan to get paid for the monthly bundled payment associated with community palliative care services. Plans shall only prior authorization one provider at a time to deliver palliative care services to any member. A referring provider should consult with the member's health plan on how to refer a member for an assessment and how to seek a prior authorization.

Any healthcare provider who can be reimbursed independently for services can be paid for a palliative care assessment. Assessments and reassessments for palliative care services do not require a prior authorization and assessment results can serve as justification for provider prior authorization. The assessing provider does not need to be a palliative care services provider. Health plans shall provide a clear pathway for referrals to community palliative care services

when a palliative care assessment has been completed and palliative care needs that meet the qualifying criteria are identified.

Members are required to consent to receiving palliative care services. Palliative care providers shall document member consent. Consent may be verbal with documentation.

XVI. BILLING CODES AND REIMBURSEMENT

Assessment

Prior to utilizing palliative care services, all members must be assessed for eligibility and submit documentation for authorization by the provider billing for the bundled payment. Documentation must demonstrate that the member meets eligibility criteria for the benefit and has consented to receiving services.

For assessing providers billing on a CMS-1500, the following billing codes are proposed to reimburse and monitor utilization of the initial assessment for palliative care services:
S0280: Medical home program, comprehensive care coordination and planning, initial plan
For providers billing on a UB-04, the following combination of billing codes must be used to be reimbursed for the initial assessment for services:

Revenue Code	Major Category Description	HCPCS Code
0693	Pre-hospice/Palliative Café Services	S0280: Medical home program, comprehensive care coordination and planning, initial plan

On both the CMS-1500 and UB-04, providers must use diagnosis code Z51.5, Palliative Care Encounter, to specify that the assessment is for palliative care services.

This code or combination of codes can only be billed once per member, per provider for each unique episode of care. For these purposes, an episode of care means continuous, longitudinal utilization of the Palliative Care Services Benefit without member discharge or disenrollment.

Re-assessment

To further ensure that members are receiving the right level and type of care at the right time, a member must be reassessed for services every six (6) months.

For assessing providers billing on a CMS-1500, the following billing codes are proposed to reimburse and monitor utilization of the initial assessment for palliative care services:

S0281: Medical home program, comprehensive care coordination and planning, ongoing maintenance

For providers billing on a UB-04, the following combination of billing codes must be used to be reimbursed for the initial assessment for services:

Revenue Code	**Major Category Description**	**HCPCS Code**
0693	Pre-hospice/Palliative Café Services	S0281: Medical home program, comprehensive care coordination and planning, ongoing maintenance

On both the CMS-1500 and UB-04, providers must use diagnosis code Z51.5, Palliative Care Encounter, to specify that the assessment is for palliative care services.

Re-assessments cannot be reimbursed more than one time per month but must be completed every six (6) months or when a member's goals for care change, as documented in the initial care plan developed by the palliative care interdisciplinary team. It is expected that re-assessments will result in continued utilization for members that continue to qualify and consent to services and in discharge for members needing and consenting to a higher level of care or who no longer meet eligibility criteria under the benefit. The reassessment shall yield a revised care plan for the member based on outcomes from the assessment performed.

Palliative Care Services Bundled Payment

Following the initial assessment for eligibility for care under the Palliative Care Services Benefit, all associated services delivered by the palliative care team shall be reimbursed through a monthly bundled payment rate. While being reimbursed through this benefit providers delivering care must not bill for additional services a la carte that would be included as part of the payment rate, as the fee-for-service codes associated with individual billable services are factored into the bundled payment – see Appendix D for included Medicaid-only codes and Appendix E for included dual-eligible codes. For example, palliative care teams are required to perform care planning and assessment, including advanced care planning, as part of care under the palliative care services benefit. Palliative care teams shall not bill separately for advance care planning visits during months where the member is receiving care under the benefit. Reimbursement for services included as part of the case rate payment shall not be duplicated by billing separately. To account for services rendered under the benefit, it is encouraged that providers track member visits performed by provider or team while a member is enrolled in the benefit.

Electronic Visit Verification (EVV) is not required for services delivered by providers as part of the bundled payment.

For providers who are billing on a CMS-1500, the following billing codes shall be used when billing for the Palliative Care Services Benefit bundled payment:

> S0311: Comprehensive management and care coordination for advanced illness, per calendar month

For providers who are billing on a UB-04, the following billing codes shall be used when billing for the Palliative Care Services Benefit bundled payment:

Revenue Code	Major Category Description	HCPCS Code
0690	Pre-hospice/Palliative Care Services	S0311: Comprehensive management and care coordination for advanced illness, per calendar month

Providers cannot be reimbursed more than one time per month for services and must deliver services by members of the interdisciplinary care team during that month. It is expected that members will enroll at any time during the month. Providers may be reimbursed in full for each month that a member is enrolled and receiving services, regardless of the day the member enrolled. MQD will have the option to develop tiered case management rates based on patient complexity as well as a partial month bundled rate, as we develop experience on who will utilize this benefit.

Table 4. Fee Schedule for Palliative Care Services

Procedure Codes	Modifier	Description of Procedure Code	Maximum Allowable Amount
S0311	HB	Comprehensive management and care coordination for advanced illness, per calendar month FOR DUAL ELIGIBLES (Medicare and Medicaid)	$775/month
S0311	HC	Comprehensive management and care coordination for advance illness, per calendar month FOR NON-DUAL ELIGIBLE	$900/month
S0280		Medical home program, comprehensive care coordination and planning, initial plan - Initial Assessment	$250 (maximum of one assessment per member, per provider per year;

Procedure Codes	Modifier	Description of Procedure Code	Maximum Allowable Amount
		Providers must use diagnosis code Z51.5, Palliative Care Encounter, to specify that the assessment is for palliative care services	can be billed during the same month that S0311 is billed)
S0281		Medical home program, comprehensive care coordination and planning, ongoing maintenance – Reassessment Providers must use diagnosis code Z51.5, Palliative Care Encounter, to specify that the assessment is for palliative care services	$200 (maximum is once every three month)

Billing Outside the Bundled Services

Clinicians delivering services not covered by the bundled payment may continue to bill for services delivered in accordance with their regular scope of practice. For example, licensed clinical social workers and child life specialists may bill independently for behavioral health services and therapy performed for the member receiving community palliative care services that are not included in the bundled payment calculation. Physicians, nurse practitioners, and physician's assistants may bill independently for annual wellness visits and other services unrelated to palliative care and not covered through the code set in Appendices D and E. It is anticipated that home visits and other services related to home health services will increase when a member has dual eligibility status. For dual eligible members, those services may be billed in addition to the bundled payment rate to ensure adequate services are available for the member and their caregiver(s). Health plans may continue to offer Medicare supplemental benefits and supportive services to dual eligible members in addition to community palliative care services covered by this benefit.

The bundled payment rate for community palliative care services is in addition to the skilled nursing facility per diem rate and can be billed concurrently.

XVII. UTILIZATION CONTROLS

Health Plans are allowed to incorporate utilization controls such as preauthorization, sometimes referred to as prior approvals (PA) as described in the QI contract.

XVIII. CARE COORDINATION

Why Care Coordination is Important

When providers and health plans work together to share information and coordinate care, member's needs and preferences are known and communicated at the right time to the right people, and the information is used to provide safe, appropriate, and effective care. This can help to keep members healthier longer, better manage chronic conditions, and experience care that is consistent with their goals.

When providers and health plans don't communicate and coordinate care effectively, members receive fragmented care. Members are more likely to experience negative health outcomes, use the emergency room more often, experience medication errors, and experience poor transitions of care.[6]

"Coordinating the Coordinators"

Members experiencing serious illnesses often experience multiple entities coordinating their care. This may result in confusion regarding roles and responsibilities and accountability. To address this, the health plans, other entities providing care coordination or case management, and the palliative care providers are required to meet regularly when members are concurrently receiving community palliative care benefits and other care coordination or case management services. Some of the goals of the meetings include establishing accountability, agree on roles and responsibilities, and agreeing how information will be shared. MQD recommends that a lead care coordinator be identified. The lead care coordinator will monitor the overall care plan and often may be the individual who communicates directly with the member. The lead coordinator is not responsible for doing the work of the other care coordinators but rather steers the team of coordinators to ensure the overall care plan is developed and implemented. Because the palliative care team is likely closest to the member, it may be best if the lead coordinator is the palliative care provider. MQD also encourages that the member be allowed to choose the lead coordinator when appropriate. If a health plan or other entity disagrees with the components of the overall care plan developed, MQD expects the various teams to work in the best interest of the member. MQD expects the health plans and other entities will collaborate with all care coordinators in developing the overall care plan and ensuring that the member's needs are met in a timely manner.

The timeliness of receiving care coordination services is also important. When a member experiences a transition of care (e.g., a discharge from a hospital), the health plans should prioritize these cases so the care coordination can start before or right after the transition.

[6] https://www.cms.gov/priorities/innovation/key-concepts/care-coordination

A critical component of community palliative care is supporting people with serious illness across transitions of care. As such, it is expected that community palliative care providers ensure continuity of care by supporting members and their families during hospitalizations and facility stays and work to facilitate timely discharge and care planning following admission. Discharge from community palliative care services can be considered after a member is hospitalized in the inpatient setting or a facility for a prolonged period of time and the member is not expected to return to the community. Community palliative care providers may continue billing for services to support timely transition back into the community and continuity of care while a member is hospitalized if they meet frequency criteria met as part of required minimum services.

MQD will monitor issues related to care coordination because this is critical to safe, appropriate, and effective care for seriously ill members.

XIX. QUALITY ASSURANCE

In addition to the rapid cycle evaluation and data and monitoring requirements (see Section XXII), MQD may convene meetings to discuss challenges or opportunities for improvement on the implementation of this new benefit. If a provider or health plan has tried to resolve issues with their colleagues and is unable to achieve a resolution, the health plan or provider may contact HCSBinquiries@dhs.hawaii.gov. Members and providers may also submit grievances and/or appeals by following current grievance and appeal protocols.

XX. MEDICAL NECESSITY VERSUS COMFORT CARE

The QI contract requires health plans to pay for services that meet the definition of medical necessity as described in the contract. "Comfort care" meets the definition of medical necessity.

Comfort care is defined as a 'patient care plan that is focused on symptom control, pain relief, and quality of life. It is typically administered to patients who have already been hospitalized several times, with further medical treatment unlikely to alter prognosis'. Comfort care is integral to both palliative care delivered in the hospice setting and palliative care outside of the hospice setting.[7]

The National Institute on Aging considers comfort care, "an essential part of medical care at the end of life," and people who are dying or suffering from a serious illness need care in four areas: physical comfort, mental and emotional needs, spiritual issues, and physical tasks. Comfort care addresses symptoms including:

[7] https://www.cancer.gov/publications/dictionaries/cancer-terms/def/comfort-care

- Pain
- Breathing problems
- Skin irritation
- Digestive problems
- Temperature sensitivity
- Fatigue
- Other issues that may arise as a result of a serious illness diagnosis

Because community palliative care does not cover supplies, durable medical equipment, and medications under the bundled payment rate, the health plans are required to expedite prior authorizations for the following services/supplies for members receiving community palliative care including but not limited to:

- Home oxygen and associated supplies
- Hospital beds
- Comfort medications
- Durable medical equipment aiding a member's ambulation or assisting with acitivities of daily living

MQD encourages the health plans and providers to work collaboratively to ensure needed services are received in a timely manner.

XXI. HEALTH PLAN RESPONSIBILITIES

The health plans are required to:

- Evaluate and determine if providers meet the requirements listed in this memo before allowing them to provide community palliative care services (See Appendix C).
- Contract with providers that meet the stated palliative care services requirements.
- Submit data as requested in this memo, as a part of health plan reporting and monitoring (refer to the Health Plan Manual), and as a part of the rapid cycle assessment.
- Educate providers and members on how to access community palliative care services.
- Include a separate list of community palliative care providers that meet the community palliative care requirements and are contracted with the health plan in their provider directories.

XXII. PROVIDER AVAILABILITY AND "RAMP UP TIME"

When there is a new benefit, it often takes time for providers that choose to provide the services to develop the necessary credentials. It also takes time for providers and members to

learn about the new service and start referring members. That means that there will be a "ramp up" time on this benefit. There may be times when the supply of providers is greater or lesser than the need identified by or for members.

In order to facilitate a quick ramp up time, MQD has contracted with Hui Pohala utilizing American Rescue Plan Act (ARPA) funds to accelerate workforce development, member education, and other supports to make the "ramp up" time period as short as possible. Other community organizations including Kōkua Mau are also improving the implementation process by working on communications, messaging, and education to better support members and providers.

XXIII. REPORTING AND MONITORING AND RAPID CYCLE EVALUATION

Health plans shall follow existing program integrity responsibilities in the health plan contract regarding the following:

1. Encounter Data Analysis
2. Visit Verification Procedures
3. Recoupment of Overpayments
4. Suspension, Withhold, Sanctions and Termination Activities
5. Auditing Compliance

Additionally, MQD is contracting with the University of Hawai'i to conduct a rapid cycle evaluation. As a part of the rapid cycle evaluation, health plans shall participate in quarterly "learning communities" with providers and MQD to foster exchange of best practices and promote continuous improvement throughout the implementation of the benefit. During the initial rollout phase, the frequency of these "learning communities" may increase to monthly or as needed. Health plans shall also participate in MQD-led quarterly rapid cycle assessments to evaluate the implementation and achievement of the desired goals and outcomes. The rapid cycle assessment will provide systematic feedback, enabling health plans, providers and MQD to make necessary adjustments to enhance the likelihood of the new benefit successfully achieving the goals.

XXIV. FUTURE EDUCATION EVENTS

Events are being organized to provide information about the new benefit to providers, members, and stakeholders once this memo is issued.

Appendix A
CLINICAL CRITERIA

The intent of the clinical criteria is to identify members with conditions across the spectrum of serious illnesses that also experience functional decline. This includes "upstream" conditions when members are in the earlier stages of their serious illness and functional decline.

The information below provides the minimum clinical standards. The qualifying conditions and accepted evidence for functional decline. The member shall have one or more condition in the Qualifying Conditions table (Table 50) **AND** meet one or more of the eligibility thresholds included in Table 100.

It is impossible to identify all conditions that may be appropriate for palliative care, so the health plans may approve other conditions with evidence of functional decline on a case by case baisis. The health plan may use the reference guides such as the **Clinical Practice Guidelines** and/or the **Standards of Practice for Pediatric Palliative Care** in making their determinations.

Members would qualify for palliative care services through an assessment that would determine eligibility if a member meets one of the following qualifying condition criteria in Table 5 AND one of the following elements indicating functional decline in Table 6. Providers must qualify a member for functional decline using the validated instruments and thresholds documented in Table 6. A provider referral can serve as a positive screen for eligibility for authorization by the member's health plan.

Children are a unique subset of patients in palliative care and the clinical criteria for children has some overlap with the adult criteria but there are some differences for which flexibilities should be allowed. For reference, examples of diagnostic categories for children can be found in the Standards of Practice for Pediatric Palliative Care. Children with a Qualifying any condition in Table 5 can also be considered for palliative care. For conditions marked with an *, children do not need evidence of functional decline to qualify for services.

Table 5: **Qualifying Conditions**

#	Qualifying Condition (QC)
1	**Cancer**, with evidence of malignant disease (e.g., locally advanced, relapsed or metastatic cancer; – Hematologic Malignancies (leukemia, lymphoma, myeloma, other)
2	**Cardiac Disease/Conditions** (e.g., chronic heart failure, complex congenital heart disease or acquired cardiovascular disease*, other congenital syndromes which significantly affects cardiac status *)
3	**Pulmonary Diseases/Conditions** (e.g., COPD, compromised pulmonary status also known as respiratory compromise,*, Examples would include but not limited to severe bcystic fibrosis, or oxygen dependence.
4	**Renal Disease** (e.g., Chronic kidney disease stage 5 or end-stage renal disease
5	**End-Stage Liver Disease** (Diagnosis of ESLD or Decompensated Cirrhosis)
6	**Neurologic/Neuromuscular/ Neurodegenerative Disease or Conditions** (e.g., Diagnosis of motor neuron disease, Parkinson's Disease, Muscular Dystrophy,*, Multiple Sclerosis, progressive neurologic disorder* or other neurodegenerative condition,*, traumatic or anoxic brain injury,*, brain reduction syndromes, etc.)
12	**Genetic Disorders*** (Diagnosis of Trisomy 13, 15, 18, Asphyxiating thoracic dystrophy, etc.)
13	**Metabolic/Inclusion Disease*** (such as Tay Sachs Disease, Krabbe's Disease, Hunter's Disease, or other severe mitochondrial or metabolic disorder, etc.)
14	**Gastrointestinal Disease or Conditions*** (chronic gastrointestinal dysfunction with multi-visceral organ transplant under consideration, biliary atresia, progressive hepatic, or uremic encephalopathy, TPN dependence, etc.)
15	**Orthopedic Disorders*** (Thanatophoric dwarfism, severe progressive scoliosis, severe osteogenesis imperfecta, etc.)
16	**Neonatal*** (complications of extreme prematurity or birth asphyxia, hypoxic ischemic encephalopathy, etc.)
17	**Infectious Disease** (HIV/AIDS, Hepatitis, long-COVID)

Table 6: *Evidence-Based Assessment Tools and Eligibility Thresholds*

#	Assessment Tool or Evidence of Functional Decline	Eligibility Threshold
1	**Karnofsky Performance Scale (KPS)**	• Score ≤ 70
2	**Eastern Cooperative Oncology Group (ECOG) Status**	• Grade of 3 or higher
3	**Palliative Performance Scale (PPS)**	• Score ≤ 70
4	**Model for End-Stage Liver Disease (MELD)**	• Score > 19
5	**Functional Assessment Staging Tool (FAST)**	• Score of 5 or higher
6	**Durable Medical Equipment Utilization or Dependency**	At least one of the following: • 24-hour oxygen requirement • Hospital bed • Wheelchair dependence • Ventilator dependence • Feeding tube dependence • Catheter dependence • Tracheostomy dependence
7	**Clinical Biomarkers**	At least one of the following: • Severe airflow obstruction: Forced Expiratory Volume (FEV)1 < 35% predicted • Albumin < 3.0 • International Normalized Ratio (INR) > 1.3 • estimated Glomerular Filtration Rate (eGFR) of 25 or less • Ejection Fraction < 30 for systolic heart failure
8	**Evidence of Comorbid Conditions**	At least one of the following: • Chronic infections • Progressive weight loss • Evidence of pressure ulcers • Ascites • Subacute bacterial peritonitis • Hepatic encephalopathy • Coronary artery disease • Diabetes • Dementia • Underlying neurologic/chromosomal diagnoses • Frailty

		• Extracorporeal membrane oxygenation (ECMO) or transplant candidate • Bronchiolitis obliterans
9	**Acute Healthcare Utilization**	At least one of the following: • 1 or more acute hospitalizations within the past 12 months • 1 or more skilled nursing facility stays within the past 12 months • 2 or more emergency department visits within the past 6 months • Home health episode within the past 6 months • Member has already received two lines of standard chemotherapy • Consideration of lung transplant

Exclusion Criteria

- Children and adults receiving hospice care since one cannot receive both hospiceand palliative care at the same time; and
- Individuals in the State of Hawai'i Organ and Tissue Transplant (SHOTT) program.

Children

Palliative care is currently provided as a part of the hospice care for members under the age of 21 if their prognosis for life expectancy is less than twelve (12) months. MQD adopted the concurrent care provisions of Section 2302, of the Affordable Care Act, which amended Section 1905(o)(1) of the Social Security Act. Under this provision, members under the age of 21 may receive hospice services concurrently with curative treatment.

All providers that provide community palliative care services to children under 21 from the effective date in this memo are subject to the guidance provided in this memo. Also note that children are covered for all services that are medically necessary under the Early and Periodic Screening, diagnosis, and Treatment (EPSDT) benefit and the Medicaid State Plan, and shall provide those services in compliance with all MQD and health plan guidance. Providers may only bill for community palliative care services, or hospice services with concurrent palliative care for children under 21.

Appendix B

Table 7. PALLIATIVE CARE INTERDISCIPLINARY TEAM

#	Interdisciplinary Team Member (IDT)	Brief Description of Services Performed	Scope of Practice	Minimum Qualifications	Adult and/or Pediatric Care	Required or Optional Member of the IDT
1	Physician (Medical Doctor, MD and Doctor of Osteopathy, DO)	Provides direct clinical care and oversight of patient care.	Legally authorized to practice medicine or osteopathy by the State and acts within their scope of license.	Licensed physician (MD or DO)	Adult and pediatric care.	Required.
2	Registered Nurse (RN)	Provides and coordinates patient care and educates patients about their health.	Legally authorized to provide nursing care by the State and acts within their scope of license.	Licensed to provide services.	Adult and pediatric care.	Required.
3	Licensed Clinical Social Worker (LCSW)	Promotes social change and development, social cohesion, and the empowerment and liberation of patients. Engages patients and structures to address life challenges and enhances wellbeing.	Legally authorized to provide clinical social work services by the State and acts within their scope of license.	Licensed to provide services.	Adult and pediatric care.	Required.
4	Grief Counselor	Grief counseling with consent of the member. Addressing spiritual needs and	Grief counseling care commensurate with the needs, desires, and	Bachelor's degree in theology or counseling or equivalent.	Adult and pediatric care.	Required.

		existential suffering as part of a serious illness, on behalf of the member and/or caregiver.	voluntary consent of the member.			
5	Child Life Specialist (CLS)	CLS work with children and families to help them cope with the challenges of hospitalization, illness, and disability. They provide children with age-appropriate coping strategies, play and self-expression activities, etc.	Accountable for the planning and implementation of child life services.	Bachelor's degree in Child Develop-ment, Child Life, or related field.	Pediatric only.	Required.
6	Advanced Practice Practitioner - Nurse Practitioner (NP) or Physician Assistant (PA)	Diagnose, treat, and prescribe medications wide variety of medical concerns.	Legally authorized to provide services by the State and acts within their scope of license.	Licensed to provide services and prescribe medications.	Adult and pediatric care.	Optional.
7	Licensed Practical Nurse (LPN) or Licensed Vocational Nurses (LVN)	Conduct focused nursing assessments, administer medications, maintain patient care records and collaborate with other healthcare professionals.	Provide basic medical care under the direction of registered nurses, advance practice registered nurses, physicians, and other healthcare professionals.	Licensed to provide services.	Adult and pediatric care.	Optional.
8	Certified Nursing Aid (CNA) or Home Health Aid	Working under the direct supervision of a licensed healthcare	Legally authorized to provide services by the States	Licensed to provide services.	Adult and pediatric care.	Optional.

		professional, they assist patients with activities of daily living such as grooming, bathing, and eating.	and acts within their scope of license.			
9	Community Health Worker	Serves as a liaison/link/ intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of services delivery.	Outreach, community education, informal counseling, social support, and advocacy.	Lived experience and a trusted member of the community; the State may require additional qualifications such as experience or certifica-tion(s).	Adult and pediatric care.	Optional.
10	Licensed Mental Health Professional (Counselor)	Provide mental health and substance use care.	Legally authorized to provide services by the States and acts within their scope of license.	Licensed to provide services.	Adult and pediatric care.	Optional.
11	Social Worker - Master of Social Work (MSW)	Provides macro-, mezzo-, and micro- aspects of professional social work practice.	Legally authorized to provide services by the States and acts within their scope of license.	Licensed to provide services.	Adult and pediatric care.	Optional.
12	Pharmacist – Doctor of Pharmacy (PharmD)	Dispense prescription medications and provide information to patients about the drugs and their use.	Legally authorized to provide services by the States and acts within their scope of license.	Licensed to provide services.	Adult and pediatric care.	Optional.

Appendix C

Community Palliative Care Provider Attestation Form

The Med-QUEST Division (MQD) received approval from the Centers of Medicare and Medicaid Services (CMS) to provide a Community Palliative Care benefit to improve access to quality care for QUEST Integration (QI) members with serious illnesses. In order for providers to offer this service to members, the providers shall:

1. **Contract with QI Health Plan(s)**: Providers interested in delivering the community palliative care benefit shall be contracted with QI health plan(s). This means the provider must already have an established agreement (contract) with the health plan(s) to provide services. If a provider does not have an existing contract, the provider shall initiate the contracting provides with the health plan(s). This ensures the provider meets the general requirements for network adequacy, compliance, quality as stipulated by the health plan(s), etc.

2. **Application for Community Palliative Care Services Approval**: In addition to being contracted, providers shall seek specific approval from a health plan the provider is contract with and wants to offer community palliative care services. This is a separate step to ensure the providers have the necessary expertise, staffing, and capacity to deliver specialize palliative care. To ensure the providers meet the necessary standards and can deliver high-quality community palliative care, MQD is providing this standardize attestation form as a part of the approval process for providers to offer community palliative care service. Providers shall complete and submit this attestation form to the contracted health plan(s) for evaluation and approval. Providers cannot provide community palliative care services unless a health plan approves the providers to offer these services.

   Once submitted, the health plan will review the attestation from for completeness and compliance with all community palliative care benefit requirements as described in the Health Plan Manual. The health plan may request additional information if necessary. If approved, and the provider is contracted with the health plan, the provider will be able to offer the community palliative care benefit to eligible members that receive prior approval from the health plan.

   After the health plan completes its review, the provider will be notified of the outcome. If the attestation is approved, the provider will be authorized to deliver community palliative care services for a five-year period. If any deficiencies are identified, the health plan will provide feedback, and the provider will need to address these issues before approval is granted.

3. **Acceptance by one health plan denotes acceptance by all health plans.** Providers may submit the
   approval notice from one health plan to other health plan(s) that the provider is contracted with, and the receiving

health plan must accept the approval. This process decreases the administrative work required of providers and
health plans while still ensuring providers meet a high standard of community palliative. This process will also help
decrease administrative burden on providers and health plans because there is a standardized form for all QI
health plans. Please contact the health plan(s) to find out how to submit this form.

4. **Periodic Renewal Requirement**: Every five years, providers that have been approved to deliver community palliative care services shall renew their approval by resubmitting an updated attestation form. Once submitted, the health plan(s) will review the attestation form to verify that the provider continues to meet all necessary requirements. After the health plan completes its review, the provider will be notified of the outcome. If the attestation is approved, the provider will continue to be authorized to deliver community palliative care services for another five-year period. If any deficiencies are identified, the health plan will provide feedback, and the provider will need to address these issues before re-approval is granted. Providers shall submit the attestation form on time every five years to avoid any lapse in their approval status, ensuring that Medicaid beneficiaries consistently receive high-quality palliative care services without interruption. Please contact the health plan(s) to find out when the attestations are due.

   This process ensures that all providers continue to meet the requirements and maintain standards necessary for delivering high-quality community palliative care.

Please fill out the information below.

Part A: Provider Information

Section 1: Provider Information

1. Billing Provider Name:
2. Provider Type: Check all that apply
    a. Primary Care Provider
    b. Federally Qualified Health Center
    c. Rural Health Center
    d. Specialist – Please Specify
    e. Hospital
    f. Assisted Living Facility
    g. Skilled Nursing Facility
    h. Home Health Agency
    i. Long Term Care Facility
    j. Adult Residential Care Home
    k. Expanded Adult Residential Care Home
    l. Other:

3. Provider National Provider Identifier (NPI):
4. Tax ID Number:
5. Medicaid Provider Number:
6. Contact Information:
    a. Address
    b. City
    c. State
    d. Zip Code
    e. Phone Number
    f. Fax Number
    g. Email Address
7. Office Manager/Primary Contact
    a. Name
    b. Phone Number
    c. Email Address

Section 2: Credentialing Information

1. State Licensure Information for Billing Organization:
    a. State
    b. License Number
    c. Expiration Date
2. Board Certification(s) for billing Organization:
    a. Specialty
    b. Certification Board
    c. Certification Number
    d. Expiration Date
3. DEA Number(s)

Section 3: Service Information

1. Service Location(s):
    a. Primary Service Location Address:
    b. Additional Service Location Address (if any)
    c. Will the services be provided in the members' residences, where the member resides, where the member resides including houseless members, or in the community? If yes, please describe.
    d. Languages Spoken:
    e. Hours of Operation:

Section 4: Provider Information

1. Does the billing organization have at least one physician that delivers direct clinical care and program oversight? Notes: The physician can be staff or have a contract with the billing organization. This physician doesn't not need to be full-time, work exclusively on palliative care, or exclusively see QI members. If the physician is full-time, this can used to meet the next requirement below (#2). If yes, describe provide the name of the provider, title and role.
2. Does the billing organization billing organization have at least one employed, full-time prescribing clinician? Notes: Examples of providers that can meet this full-time requirement include a physician, a prescribing Advanced Practice Registered Nurse (APRN), or a prescribing Physician Assistant (PA). It is not expected that the prescribing clinician exclusively work on palliative care or exclusively treat QI members. have a physician that delivers direct clinical care and program oversight? If yes, describe provide the name of the provider, title and role.
3. Does at least one prescribing clinical on the interdisciplinary team have a specialty certification in hospice, palliative care, or related specialty? If yes, who? Describe the certification and the entity that provides the certification.
4. Does the billing provider have a training plan in place that includes the services required under the benefit? If yes, please describe.

Interdisciplinary Team

#	Provider Name	Specialty	Required or Optional Team Member	Prescribing Clinician? Y/N	Certification in Palliative Care or Related Specialty? Provide Certification Information.

Section 5: Services

1. Are services available to members 24/7/365 for symptom management when a member and family caregiver needs care? If yes, please describe how services are access and what services are provided.
2. Does the provider hold interdisciplinary team meetings at least bi-weekly? If yes, describe the meetings, participants, and the frequency.
3. Will the provider participate in care coordination meetings with QI health plans? If yes, please provide contact information of the participant(s).

Section 6: Provider Attestation

I hereby attest that the information provided in this form is accurate and complete to the best of my knowledge. I understand that any false or misleading information may result in termination of my ability to provide community palliative care services.

Bill Provider Organization Name:
Billing Provider Name
Billing Provider Title
Billing Provider Signature:
Date:

Appendix D

Table 8. CPT CODES INCLUDED AS PART OF BUNDLED PAYMENT RATE FOR PALLIATIVE CARE SERVICES FOR MEDICAID-ONLY MEMBERS

Procedure Code	Procedure Code Description
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional, established patient, parent, or guardian; 5-10 minutes of medical discussion.
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional, established patient, parent, or guardian; 11-20 minutes of medical discussion.
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional, established patient, parent, or guardian; 21-30 minutes of medical discussion.
99201	Office or other outpatient visit for the evaluation and management of a new patient; typically 10 minutes are spent face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient; typically 20 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient; typically 30 minutes are spent face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient; typically 45 minutes are spent face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient; typically 60 minutes are spent face-to-face with the patient and/or family.
99211	Office or other outpatient visit for the evaluation and management of an established patient; typically 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient; typically 10 minutes are spent face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient; typically 15 minutes are spent face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient; typically 25 minutes are spent face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient; typically 40 minutes are spent face-to-face with the patient and/or family.

99324	Domiciliary or rest home visit for the evaluation and management of a new patient; typically 20 minutes are spent with the patient and/or family or caregiver.
99325	Domiciliary or rest home visit for the evaluation and management of a new patient; typically 30 minutes are spent with the patient and/or family or caregiver.
99326	Domiciliary or rest home visit for the evaluation and management of a new patient; typically 45 minutes are spent with the patient and/or family or caregiver.
99327	Domiciliary or rest home visit for the evaluation and management of a new patient; typically 60 minutes are spent with the patient and/or family or caregiver.
99328	Domiciliary or rest home visit for the evaluation and management of a new patient; typically 75 minutes are spent with the patient and/or family or caregiver.
99334	Domiciliary or rest home visit for the evaluation and management of an established patient; typically 15 minutes are spent with the patient and/or caregiver.
99335	Domiciliary or rest home visit for the evaluation and management of an established patient; typically 25 minutes are spent with the patient and/or caregiver.
99336	Domiciliary or rest home visit for the evaluation and management of an established patient; typically 40 minutes are spent with the patient and/or caregiver.
99337	Domiciliary or rest home visit for the evaluation and management of an established patient; typically 60 minutes are spent with the patient and/or caregiver.
99341	Home visit for the evaluation and management of a new patient; typically 20 minutes are spent face-to-face with the patient and/or family.
99342	Home visit for the evaluation and management of a new patient; typically 30 minutes are spent face-to-face with the patient and/or family.
99343	Home visit for the evaluation and management of a new patient; typically 45 minutes are spent face-to-face with the patient and/or family.
99344	Home visit for the evaluation and management of a new patient; typically 60 minutes are spent face-to-face with the patient and/or family.
99345	Home visit for the evaluation and management of a new patient; typically 75 minutes are spent face-to-face with the patient and/or family.
99347	Home visit for the evaluation and management of an established patient; typically 15 minutes are spent face-to-face with the patient and/or family.

99348	Home visit for the evaluation and management of an established patient; typically 25 minutes are spent face-to-face with the patient and/or family.
99349	Home visit for the evaluation and management of an established patient; typically 40 minutes are spent face-to-face with the patient and/or family.
99350	Home visit for the evaluation and management of an established patient; typically 60 minutes are spent face-to-face with the patient and/or family.
99354	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual 1 hour.
99355	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual additional 30 minutes.
99441	Telephone evaluation and management service; 5-10 minutes of medical discussion.
99442	Telephone evaluation and management service; 11-20 minutes of medical discussion.
99443	Telephone evaluation and management service; 21-30 minutes of medical discussion.
99490	Chronic care management services, at least 20 minutes of clinical staff time per calendar month.
99495	Transitional care management services; moderate complexity; face-to-face visit within 14 calendar days of discharge.
99496	Transitional care management services; high complexity; face-to-face visit within 7 calendar days of discharge.
99497	Advance care planning including explanation and discussion of advance directives; first 30 minutes.
99498	Advance care planning including explanation and discussion of advance directives; each additional 30 minutes.
G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes.
G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes.
G0182	Physician supervision of a patient under a Medicare-approved hospice; 30 minutes or more.
Q5001	Hospice or home health care provided in patient's home/residence.
Q5002	Hospice or home health care provided in assisted living facility.
Q5003	Hospice care provided in nursing long-term care facility.
Q5004	Hospice care provided in skilled nursing facility.
Q5007	Hospice care provided in long-term care facility.
Q5009	Hospice or home health care provided in place not otherwise specified.
Q5010	Hospice home care provided in a hospice facility.

S9122	Home health aide or certified nurse assistant, providing care in the home; per hour.
S9123	Nursing care, in the home; by registered nurse, per hour.
S9124	Nursing care, in the home; by licensed practical nurse, per hour.

Appendix E

Table 9. CPT CODES INCLUDED AS PART OF BUNDLED PAYMENT RATE FOR PALLIATIVE CARE SERVICES FOR DUAL ELIGIBLE MEMBERS

Procedure Code	Procedure Code Description
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional, established patient, parent, or guardian; 5-10 minutes of medical discussion.
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional, established patient, parent, or guardian; 11-20 minutes of medical discussion.
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional, established patient, parent, or guardian; 21-30 minutes of medical discussion.
99201	Office or other outpatient visit for the evaluation and management of a new patient; typically 10 minutes are spent face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient; typically 20 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient; typically 30 minutes are spent face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient; typically 45 minutes are spent face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient; typically 60 minutes are spent face-to-face with the patient and/or family.
99211	Office or other outpatient visit for the evaluation and management of an established patient; typically 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient; typically 10 minutes are spent face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient; typically 15 minutes are spent face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient; typically 25 minutes are spent face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient; typically 40 minutes are spent face-to-face with the patient and/or family.

99324	Domiciliary or rest home visit for the evaluation and management of a new patient; typically 20 minutes are spent with the patient and/or family or caregiver.
99325	Domiciliary or rest home visit for the evaluation and management of a new patient; typically 30 minutes are spent with the patient and/or family or caregiver.
99326	Domiciliary or rest home visit for the evaluation and management of a new patient; typically 45 minutes are spent with the patient and/or family or caregiver.
99327	Domiciliary or rest home visit for the evaluation and management of a new patient; typically 60 minutes are spent with the patient and/or family or caregiver.
99328	Domiciliary or rest home visit for the evaluation and management of a new patient; typically 75 minutes are spent with the patient and/or family or caregiver.
99334	Domiciliary or rest home visit for the evaluation and management of an established patient; typically 15 minutes are spent with the patient and/or caregiver.
99335	Domiciliary or rest home visit for the evaluation and management of an established patient; typically 25 minutes are spent with the patient and/or caregiver.
99336	Domiciliary or rest home visit for the evaluation and management of an established patient; typically 40 minutes are spent with the patient and/or caregiver.
99337	Domiciliary or rest home visit for the evaluation and management of an established patient; typically 60 minutes are spent with the patient and/or caregiver.
99341	Home visit for the evaluation and management of a new patient; typically 20 minutes are spent face-to-face with the patient and/or family.
99342	Home visit for the evaluation and management of a new patient; typically 30 minutes are spent face-to-face with the patient and/or family.
99343	Home visit for the evaluation and management of a new patient; typically 45 minutes are spent face-to-face with the patient and/or family.
99344	Home visit for the evaluation and management of a new patient; typically 60 minutes are spent face-to-face with the patient and/or family.
99345	Home visit for the evaluation and management of a new patient; typically 75 minutes are spent face-to-face with the patient and/or family.
99347	Home visit for the evaluation and management of an established patient; typically 15 minutes are spent face-to-face with the patient and/or family.

99348	Home visit for the evaluation and management of an established patient; typically 25 minutes are spent face-to-face with the patient and/or family.
99349	Home visit for the evaluation and management of an established patient; typically 40 minutes are spent face-to-face with the patient and/or family.
99350	Home visit for the evaluation and management of an established patient; typically 60 minutes are spent face-to-face with the patient and/or family.
99354	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual 1 hour.
99355	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual additional 30 minutes.
99441	Telephone evaluation and management service; 5-10 minutes of medical discussion.
99442	Telephone evaluation and management service; 11-20 minutes of medical discussion.
99443	Telephone evaluation and management service; 21-30 minutes of medical discussion.
99490	Chronic care management services, at least 20 minutes of clinical staff time per calendar month.
99495	Transitional care management services; moderate complexity; face-to-face visit within 14 calendar days of discharge.
99496	Transitional care management services; high complexity; face-to-face visit within 7 calendar days of discharge.
99497	Advance care planning including explanation and discussion of advance directives; first 30 minutes.
99498	Advance care planning including explanation and discussion of advance directives; each additional 30 minutes.