

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:
If the services are provided to houseless members, please indicate how the services are compliant with the MQD Street Medicine requirements.
 - 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	Certification in Palliative Care or Related Specialty? Provide Certification Information.	Prescribing Clinician? Y/N

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.

Billing Provider Organization Name:

Billing Provider Name

Billing Provider Title

Billing Provider Signature:

Date: