Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

http://www.dmas.virginia.gov

MEDICAID BULLETIN

TO: All Providers of Hospice Services, Nursing and Intermediate Care Facilities; Commonwealth Coordinated Care (CCC) Plus Managed Care Plans

FROM: Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services (DMAS)

DATE: 7/2/2019

SUBJECT: New Reimbursement for Hospice Services Provided in Nursing Facilities and Intermediate Care Facilities—Effective July 1, 2019

This bulletin informs providers of changes in the payment of hospice services provided for individuals who reside in a nursing facility (NF) or intermediate care facility, i.e., institutional hospice services.

Effective for dates of service on or after July 1, 2019, DMAS and CCC Plus health plans will pay 100 percent of the nursing facility rate for hospice services delivered in the NF or intermediate care setting. This change is in accordance with the 2019 Acts of Assembly, Item 303.WWW.

Billing procedures for institutional hospice services provided to Medicaid members enrolled under fee-for-service will not change. Hospice organizations will continue to bill DMAS for hospice-related NF services, and hospices will reimburse nursing facilities based on contracts between hospices and NFs.

For Medicaid members enrolled in the CCC Plus program, nursing facilities shall directly bill hospice-related NF services to the CCC Plus health plans. Providers should bill using the existing revenue code structure for Medicaid nursing facility services, i.e., using revenue code 190. These claims will not differ from other Medicaid NF Resource Utilization Groups IV (RUG-IV) Grouper 48 claims billed to CCC Plus health plans; NFs should not bill managed care plans using hospice revenue codes.

This change is for dates of service on or after July 1, 2019, and applies to all Medicaid members who reside in nursing facilities and receive hospice services regardless of NF admission date. NF services for dates of service through June 30, 2019, must be billed directly to the hospice.

Medicaid members enrolled under hospice prior to admission to a NF are exempt from the Medicaid Long Term Services and Supports (LTSS) screening process. Some Medicaid members may have been assessed prior to their hospice election; however, some members entering the NF with an existing hospice coverage election may not have been screened. The "no screening, no

payment" policy (12VAC30-60-308 and 12VAC30-60-303) does not apply to Medicaid members who have elected hospice coverage prior to their NF admission.

Hospices are still required to submit the *Hospice Enrollment/Disenrollment Authorization Request* (DMAS 421A) form to DMAS and the CCC Plus health plans for all Medicaid members electing the hospice benefit.

For questions regarding hospice reimbursement, please contact Beth Jones at Beth.Jones@dmas.virginia.gov. For questions regarding members electing hospice in CCC Plus health plans, please contact Elizabeth Smith at Elizabeth.Smith@dmas.virginia.gov.

Medicaid Expansion

New adult coverage begins January 1, 2019. Providers will use the same web portal and enrollment verification processes in place today to verify Medicaid expansion coverage. In ARS, individuals eligible in the Medicaid expansion covered group will be shown as "MEDICAID EXP." If the individual is enrolled in managed care, the "MEDICAID EXP" segment will be shown as well as the managed care segment, "MED4" (Medallion 4.0), or "CCCP" (CCC Plus). Additional Medicaid expansion resources for providers can be found on the DMAS Medicaid Expansion webpage at: http://www.dmas.virginia.gov/#/medex.

PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-for-service members.	https://dmas.kepro.com/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or call: 1-800-424-4046

Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627

Provider Update

Reimbursement Update: Hospice Room and Board

Date: June 20, 2019

In accordance with item 303.WWW of the 2019 Virginia Acts of Assembly, Virginia Premier will begin reimbursing nursing facilities for hospice room and board services.

What this means to you:

Hospice providers will no longer bill Virginia Premier for room and board (R&B) services. Instead, the nursing facility will bill Virginia Premier directly for R&B services for members who have elected the hospice benefit. Nursing facility providers should bill using the existing revenue code structure for nursing facility room R&B services as outlined in the DMAS nursing facility provider manual. Nursing facility providers should **not** bill Virginia Premier using hospice revenue codes.

Which products does this change apply to?

The reimbursement changes for hospice R&B applies to Virginia Premier's Medallion 4.0 FAMIS members and CCC Plus Program.

Representative Payment Rates:

Virginia Premier will reimburse nursing facilities for hospice R&B services according to 100% of the then current DMAS fee schedule in effect at the date of service.

Effective Date:

Reimbursement to nursing facilities for R&B services will go into effect on **July 1, 2019.**

If you have any questions, please contact Provider Services. We are available Monday through Friday from 8:00 am to 6:00 pm at 804-968-1529.

Sincerely,

Provider Services

VirginiaPremier. Powered by VCU Health ⇒ MCO

2019 VIRGINIA ACTS OF ASSEMBLY

CHAPTER 854

An Act for all amendments to Chapter 2 of the 2018 Acts of Assembly, Special Session I, which appropriated funds for the 2018-20 Biennium, and to provide a portion of revenues for the two years ending, respectively, on the thirtieth day of June, 2019, and the thirtieth day of June, 2020; and an Act to amend and reenact §§ 33.2-1904, 33.2-1907, 33.2-2502, 58.1-601 and 58.1-602, as they are currently effective, 58.1-604, as it is currently effective and as it may become effective, 58.1-605, as it is currently effective, 58.1-612, 58.1-615, as it is currently effective, 58.1-625, as it is currently effective and as it shall become effective, 58.1-635, as it is currently effective, and 58.1-638 of the Code of Virginia and the fourth enactment of Chapter 766 of the Acts of Assembly of 2013; to amend the Code of Virginia by adding a section numbered 58.1-612.1; to repeal § 58.1-638.2 of the Code of Virginia; to repeal the provisions of Chapter 766 of the Acts of Assembly of 2013 amending §§ 58.1-601, 58.1-602, 58.1-605, 58.1-606, 58.1-612, 58.1-615, and 58.1-635, as they may become effective; and to repeal the seventh and fifteenth enactments of Chapter 766 of the Acts of Assembly of 2013 and the twelfth enactment of Chapter 684 of the Acts of Assembly of 2015, as amended by Chapters 854 and 856 of the Acts of Assembly of 2018; submitted by the Governor of Virginia to the presiding officer of each house of the General Assembly of Virginia in accordance with the provisions of § 2.2-1509, Code of Virginia.

Approved May 2, 2019

ITEM 303.	Item Details($) First Year FY2019	Item Details($) Second Year FY2020	Appropriations($) First Year FY2019	Appropriations($) Second Year FY2020

TTT.1. The Department of Medical Assistance Services shall work with stakeholders to review and adjust medical necessity criteria for Medicaid-funded nursing services including private duty nursing, skilled nursing, and home health. The department shall adjust the medical necessity criteria to reflect advances in medical treatment, new technologies, and use of integrated care models including behavioral supports. The department shall have the authority to amend the necessary waiver(s) and the State Plan under Titles XIX and XXI of the Social Security Act to include changes to services covered, provider qualifications, medical necessity criteria, and rates and rate methodologies for private duty nursing. The adjustments to these services shall meet the needs of members and maintain budget neutrality by not requiring any additional expenditure of general fund beyond the current projected appropriation for such nursing services.

2. The department shall have authority to implement these changes to be effective July 1, 2019. The department shall also have authority to promulgate any emergency regulations required to implement these necessary changes within 280 days or less from the enactment dated of this act. The department shall submit a report and estimates of any projected cost savings to the Chairmen of the House Appropriations and Senate Finance Committees 30 days prior to implementation of such changes.

3. The department shall work with stakeholders to review changes to services covered, provider qualifications, rates and rate methodologies for private duty nursing services, and make recommendations to the Chairmen of the House Appropriations and Senate Finance Committees by December 15, 2018.

UUU. Effective July 1, 2018, the Department of Medical Assistance Services shall explore private sector technology based platforms and service delivery options to allow qualified, licensed providers to deliver the Consumer-Directed Agency with Choice model in the Commonwealth of Virginia. The department shall work with stakeholders to examine this model of care and assess the changes that would be required including the services covered, provider qualifications, medical necessity criteria, reimbursement methodologies and rates to implement the model. The department shall submit a report on its findings to the Chairmen of the House Appropriations and Senate Finance Committees by December 1, 2018.

VVV. Effective July 1, 2019, the department shall amend the State Plan for Medical Assistance to clarify payment rules for new nursing homes or renovations that qualify for mid-year rate adjustments, to include the following:

1. For any facility whose Fair Rental Value report has less than 12 months of experience, the department shall develop an occupancy schedule that represents average statewide occupancy by month of operation for use in calculating the per diem rate in lieu of a minimum occupancy requirement or actual occupancy.

2. Any new beds or renovations placed in service between the reporting year and the rate year shall be treated as a mid-year rate adjustment. No new rate will be made after April 30. Rate updates that fall between May 1 and June 30 shall be effective July 1 of the same year.

3. The department shall annualize real estate taxes, property taxes and property insurance costs that do not represent a full year's cost.

4. Costs shall be based on currently available documentation at the time but are subject to audit. The department may use any reasonable method to estimate costs for which there is inadequate documentation. Any adjustments based on subsequent documentation or audit for a current rate year shall be applied beginning with the next rate year.

5. The department shall have 15 days from the date of the provider's submission to determine if the filing is complete for purposes of setting a rate for a new or renovated facility. The facility shall have 15 days from the date the filing is deemed incomplete to submit the required information. The deadline for setting the rate shall be extended for 30 days after the filing is deemed complete.

6. Providers may propose a phased renovation subject to approval by the department. The phased renovation may include reductions to available beds. Any modifications to the proposed renovation are also subject to approval by the department.

7. The department shall have the authority to implement these reimbursement changes

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **Transmittal # 18-19**

TO: DC Medicaid Hospice and Nursing Home Providers

FROM: Claudia Schlosberg, J.D.
Senior Deputy Director and State Medicaid Director

DATE: May 4, 2018

SUBJECT: **Interim Process for Hospice Billing & Reimbursement for Beneficiaries Residing in Nursing Homes**

Purpose

This transmittal provides notice and interim guidance to hospice and nursing home providers on the process for billing and reimbursement of Room & Board services under the new nursing home reimbursement methodology. Further, this document also serves as notice to retract Transmittal # 18-02: *Revised Hospice Policy and Procedure -New Prior Authorization Process for Nursing Facility Room and Board - issued on January 31, 2018.*

Background

The Department of Health Care Finance (DHCF) implemented a new Nursing Home reimbursement methodology pursuant to an approved State Plan Amendment (SPA) approved on March 19, 2018 by the Centers for Medicare and Medicaid Services (CMS) to be effective for services provided on or after February 1, 2018. Under the new methodology, DHCF shall reimburse in-District nursing homes through a prospective payment system (PPS) using the Resource Utilization Group (RUG-IV) Grouper 48 classification system.

On January 31, 2018; DHCF issued Transmittal #18-02, requiring nursing home providers to bill for room and board (Revenue Code 0659) and Hospice provider's bill for routine services (Revenue Code 0651) to maintain the integrity of the individualized based facility rate using the RUG-IV code. However, after further review, DHCF has determined that that the revised billing process conflicts with federal rules for hospice reimbursement. The Federal rule stipulates that a Medicaid beneficiary residing in a nursing home that elect's the hospice benefit is considered a "hospice patient". Consequently, the room and board reimbursement must be made to the hospice provider, who in turn is required to pass-thru the payment to the nursing home.

Guidance

Until DHCF can formally operationalize changes in MMIS to allow Hospice providers to submit claims in accordance with federal law and the new Nursing Home methodology, please follow the interim process below for billing Hospice room & board:

Interim Billing Procedures – Hospice Claims

Pending completion of the revision discussed above, the hospice and nursing home providers should submit their claims for room & board services provided effective for dates of service beginning February 1, 2018.

- The hospice providers will submit PA request to Qualis for inpatient hospice, revenue code 0659 for dates of service on or after February 1, 2018.
- The nursing home will bill/submit claims with revenue code 0659 (no PA required), and the claim will suspend.
- Hospice providers will bill claims with revenue code 0659, and the claim will suspend.
- Claims processor at Conduent will process claim for hospice provider and manually price hospice claims using the calculated allowed amount from the nursing home claims (RUGS/HIPPS Code).
- Claims processor will deny nursing home claim after hospice claims is approved.

Prior Authorization (PA)

- Nursing homes will be required to obtain PAs for special needs "add-on" payments (including behavioral health, bariatric and ventilator residents). New PA numbers will be required for ongoing vent patients.
- Note that for patients with multiple PA-related conditions, a single PA covering the full set of conditions is required – Multiple overlapping PAs cannot be used for the same patient
- PAs may be granted for up to 90 days

DHCF will continue to communicate information about the new payment methodology on the agency's website: https://dhcf.dc.gov/page/2018-dhcf-medicaid-updates-01

If you have any questions, please contact Andrea Clark, Reimbursement Analyst, Office of Rates, Reimbursement and Financial Analysis, at (202) 724-4096 or email andrea.clark@dc.gov

cc: Medical Society of the District of Columbia
DC Hospital Association
DC Primary Care Association
DC Health Care Association
DC Home Care Association
DC Behavioral Health Association
DC Coalition of Disability Service Providers

Hospice & Palliative Care Network
OF MARYLAND

October 23, 2023

Joshua Sharfstein, MD
Chair
Jonathan Kromm, PhD, MSHP
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Sharfstein and Executive Director Kromm,

As the Health Services Cost Review Commission (HSCRC) prepares for negotiations with CMMI on the next phase of the TCOC Model, the Hospice & Palliative Care Network of Maryland (HPCNM) respectfully requests that the HSCRC include as part of its negotiations a request to waive the federal rule regarding the method for paying room and board when hospice services are provided in a nursing home.

Background

The Social Security Act (SSA) of 1982 outlines Medicare and Medicaid hospice benefits. When a dually eligible nursing home resident elects the Medicare hospice benefit, the resident is also required to elect the Medicaid hospice benefit. The hospice provider then becomes the only provider authorized to bill for services, including the daily rate for room and board services provided by the nursing home.[1] Sections 1902(a)(13)(B) of the SSA states that Medicaid programs must pay *at least* 95% of the nursing home room and board for a hospice patient receiving services in a nursing home. Maryland Medicaid reimburses at the 95% level.[2] Consequently, since the hospice provider becomes the only provider authorized to bill for services, the hospice provider receives the room and board payment from the State and then must pay it to the nursing home.[3]

[1] Medicare Benefit Policy Manual (cms.gov)
[2] Maryland's regulation is at 10.09.35.08(E) and tracks the federal requirements. http://www.dsd.state.md.us/comar/comarhtml/10/10.09.35.08.htm
[3] "The State Medicaid Agency pays the hospice the daily amount allowed by the State for room and board while the patient is receiving hospice care, and the hospice pays the facility." Section 20.3 of the Manual.

Issue

The federal rule places hospices in the middle and requires them to be a "payor" of services to the nursing home, resulting in additional staff time and resources – expenses that would be better allocated to patient care. Because of payment delays to the hospice provider, the hospice provider either: 1) waits until payment is received to make payment to the nursing facility, causing friction between care partners; or 2) pays prior to receiving payment causing cash flow issues for the hospice provider. Because the rate paid is only 95%, there is also the concern that this rule creates a disincentive for nursing facilities to enroll or encourage enrollment in hospice. As such, many hospice providers pay the nursing facility at a rate of 100%, which becomes a financial burden to the hospice provider.

Potential Solution

Because the issue is grounded within the federal law, Maryland is unable to make a regulatory or legislative change. However, under Maryland's unique TCOC Model, there is an opportunity to request a waiver or exemption from CMMI to allow the nursing facility to directly bill for services, thereby eliminating the hospice provider as the "middleman." Typically, in seeking a waiver or exemption under Maryland's TCOC contract, the State reviews whether the request increases quality and/or saves money. The goal of this proposal satisfies both because the goal is to increase hospice participation and lower costs (costs associated with the administrative burden caused by the federal rule) for both the hospice provider and the nursing home.

On behalf of the HPCNM, we welcome the opportunity to work with the HSCRC and other stakeholders to further discuss the benefits associated with requesting this waiver as part of the renegotiations of the TCOC Model.

Sincerely,

Heather Guerieri, RN, MSN, CHPN
President

Peggy Funk, CAE
Executive Director

cc: Monica Escalante, HPCNM Legislative Cochair
Carlos Graveran, HPCNM Legislative Cochair

July 10, 2025

Good evening, Jeanne-Marie,

I hope this message finds you well. I wanted to share a recent example that illustrates the strength of collaboration among hospices on Maryland's Eastern Shore and underscores the importance of maintaining the Certificate of Need (CON) structure in our region.

On Tuesday, Coastal Hospice received a referral for a patient residing in Pocomoke City, in the southernmost part of Worcester County. The patient currently lives with their daughter in Pocomoke but also spends time with their son on the family farm in Denton, located in Caroline County. The family specifically requested hospice services that would allow the patient to continue this pattern of living between the two homes, a reflection of both personal preference and the importance of family support in end-of-life care.

To honor this request, Coastal Hospice reached out to Compass Regional Hospice to explore a collaborative care plan. While we initially considered establishing a travel contract to alternate services every two weeks, both organizations agreed that such an arrangement could be overly complex for the patient and care teams, especially as the patient continues to decline.

Instead, in the spirit of cooperation and with the agreement of Heather at Compass Regional, Coastal Hospice will continue to care for the patient, even when they are at the Denton residence. We are fortunate to have a Coastal Hospice RN who lives in the Denton area and can serve as the patient's primary nurse. Given the patient's limited ability to travel in the coming weeks, this solution offers continuity of care, simplifies logistics for the family, and most importantly, respects the patient's wishes.

This case is a powerful example of how hospices on the Eastern Shore work together to prioritize patient choice and high-quality care over territorial boundaries. Maintaining the current CON structure allows this kind of flexibility and collaboration to thrive. It ensures that hospices remain accountable, community-focused, and responsive to unique and complex patient needs across county lines.

We hope this story reinforces the value of preserving the CON process in our region. It is not only a safeguard for quality and accountability, but a critical tool for protecting patient choice and fostering the kind of collaboration that improves end-of-life care for all Marylanders.

Thank you for your ongoing leadership and support.

Warm regards,

Ann Lovely, RN, BSN, CHPN

President & CEO

Coastal Hospice, Inc

alovely@coastalhospice.org

(410) 742-8732 x655

MHA Comments from Meeting 4 on 8/18/25

Hello Jeanne-Marie and thank you for allowing MHA to participate in your workgroup. Below are my summarized notes based on the comments we received from the hospital field on the 2 advance questions you shared.

Question 1: How can hospice work more effectively with acute and subacute providers to ensure patients receive the right care at the right time?

To ensure patients receive the right care at the right time, hospice must work more seamlessly with acute and subacute providers. The field recommends a multi-pronged strategy focused on integration, communication, and education.

1. Embed Hospice Liaisons in Care Settings
Hospice and palliative care liaisons—such as nurses or social workers—should be physically present in hospitals, rehab centers, and skilled nursing facilities. Their proactive involvement enables earlier identification of eligible patients, facilitates anticipatory care planning, and reduces unnecessary hospitalizations and length of stay.

2. Standardize Shared Decision-Making Across Transitions
Using shared documentation tools and clinical triggers (like frequent hospitalizations or poor prognosis) can prompt timely hospice consultations. This ensures care goals follow the patient across settings and transitions are smoother.

3. Invest in Cross-Training and Education
Acute care teams need ongoing education about hospice eligibility and benefits to dispel myths and improve referrals. Likewise, hospice staff should understand the workflows and pressures in acute settings to foster empathy and collaboration.

4. Strengthen Communication and Interoperability
Improved EHR integration and real-time communication between providers are essential. This reduces referral delays and ensures continuity in documenting patient preferences and advance care planning.

5. Address Systemic Barriers to Access
Standardizing hospice qualification criteria across providers can reduce confusion. Expanding residential hospice capacity and identifying alternate placement options are critical to avoiding prolonged hospital stays. Smaller hospitals need on-site hospice representatives to support accurate evaluations, especially when chart reviews fall short.

6. Accelerate Referral Turnaround and Normalize Goals-of-Care Conversations
A 24–48 hour referral-to-transfer goal should be the standard. Embedding hospice teams into daily workflows—like rounds and discharge planning—helps normalize goals-of-care discussions. These conversations should begin early in the admission and be revisited regularly.

7. Improve Flexibility and Community Coordination
Greater flexibility in interpreting General Inpatient (GIP) criteria and timely updates to MOLST forms by skilled nursing facilities can bridge care gaps. Finally, addressing community placement and capacity challenges ensures patients can access hospice when coverage is available.

This integrated approach fosters timely, patient-centered care and strengthens the continuum between curative and comfort-focused treatment.

Question 2: What can be done to improve the timeliness of hospice referrals from acute and subacute settings?

Timely hospice referrals are essential to ensuring patients receive compassionate, appropriate care when they need it most. Yet delays persist—often due to uncertainty, lack of awareness, or fragmented systems. The field recommends a set of targeted strategies to address these barriers and streamline the referral process.

1. Use Prognostic Tools to Trigger Early Identification
Incorporating validated tools like the Surprise Question, Palliative Performance Scale, and disease-specific decline indicators into discharge planning can help clinicians recognize hospice-eligible patients earlier. Automating alerts when thresholds are met ensures these patients don't slip through the cracks.

2. Build Awareness Among Providers and Families
Misconceptions about hospice—such as the belief that it signals "giving up"—can delay referrals. Awareness campaigns aimed at physicians, discharge planners, and families can reframe hospice as a proactive, quality-of-life-enhancing option. Education should emphasize that hospice often improves comfort, dignity, and even survival.

3. Align Incentives with Early Referrals
Hospitals and skilled nursing facilities should adopt metrics that reward timely hospice referrals as a marker of high-quality care. This alignment can shift organizational culture toward earlier engagement.

4. Pilot Co-Management Models
Innovative models where palliative and hospice teams co-manage patients before formal eligibility can ease transitions. These partnerships allow for earlier symptom management and smoother handoffs when hospice enrollment becomes appropriate.

5. Improve Access to Shared Platforms and On-Site Evaluators
Ensuring all providers and nurse evaluators have access to common e-discharge platforms like Careport and Wellsky can reduce delays. Smaller hospitals especially benefit from on-site hospice evaluators who can make timely, accurate assessments—something chart reviews alone often miss.

6. Embed Hospice Teams in Early Care Planning
Hospice and palliative care teams should be integrated into early workflows—participating in rounds, discharge planning, and consults. This normalizes goals-of-care conversations and makes hospice a natural next step rather than a last-minute decision.

7. Strengthen Real-Time Communication Across Settings
Hospitals, SNFs, and hospice providers must improve real-time communication to avoid bottlenecks. Streamlined consult processes and shared documentation can make transitions faster and more seamless.

By combining clinical tools, education, system integration, and cultural shifts, we can make hospice referrals timely, thoughtful, and patient-centered—ensuring individuals receive the right care at the right moment.