LeadingAge Maryland - 2026 - SB 611 - medicaid - h
Uploaded by: Aaron Greenfield
Position: FAV

PO Box 34
Sykesville, MD 21784

TO: Senate Finance Committee

FROM: LeadingAge Maryland

SUBJECT: Senate Bill 611, Maryland Department of Health - Study on Maryland Medical Assistance Program Reimbursement of Hospice Room and Board Services

DATE: February 24, 2026

POSITION: Favorable

LeadingAge Maryland supports Senate Bill 611, Maryland Department of Health - Study on Maryland Medical Assistance Program Reimbursement of Hospice Room and Board Services.

LeadingAge Maryland is a community of more than 150 not-for-profit aging services organizations serving residents and clients through continuing care retirement communities, affordable senior housing, assisted living, nursing homes and home and community-based services. Members of LeadingAge Maryland provide health care, housing, and services to more than 20,000 older persons each year.

This legislation is a modest, cost-free, and evidence-based first step toward addressing a long-standing gap in Maryland's end-of-life care system.

<u>The Coverage Misalignment</u>

Under current Maryland policy, Medicaid covers room and board for end-of-life patients residing in Skilled Nursing Facilities (SNFs). However, Maryland does not reimburse room and board in licensed residential hospice houses—even though federal Medicaid law permits states to do so.

As a result, hospice houses must either absorb approximately $300 per day in room and board costs for Medicaid beneficiaries—an unsustainable financial burden—or transfer patients to hospitals, nursing facilities, or home once acute symptoms stabilize. These transfers disrupt the hospice interdisciplinary plan of care, increase the likelihood of emergency department visits and readmissions, and undermine the stability families seek during a profoundly vulnerable time.

Importantly, twenty-five states—including neighboring Virginia, West Virginia, and Pennsylvania—already reimburse hospice room and board under Medicaid. Maryland remains an outlier.

Why This Matters for Maryland

This reimbursement gap has real consequences for patients and the broader health care system. Maryland Medicaid accounts for approximately 59% of SNF revenue—higher than the national average—creating a strong financial incentive toward institutional placement. At the same time, Maryland ranks near the bottom nationally in hospice length of stay and has one of the lowest hospice election rates among Medicaid beneficiaries in the country.

Hospice has been shown to reduce hospital utilization significantly. Hospice patients experience a readmission rate of approximately 1.4%, compared to 19.2% in skilled nursing facilities, reflecting stronger symptom control and care coordination. Yet families frequently choose SNFs not because they are the most appropriate setting, but because Medicaid covers room and board there—while hospice residences must rely heavily on philanthropy to serve Medicaid patients.

Hospitals often report a shortage of residential hospice beds, but in reality, beds may be available. The barrier is financial, not physical capacity. The current structure effectively steers low-income Marylanders into costlier, higher-intensity institutional settings at the end of life—often contrary to patient and family preference.

Why a Study Is Necessary

While anecdotal evidence of these harms is abundant, Maryland lacks the comprehensive fiscal and clinical analysis necessary to determine whether reimbursing hospice room and board would improve outcomes, align incentives, or reduce costs elsewhere in the system.

In prior legislative sessions, fiscal questions regarding room and board reimbursement have been met with uncertainty due to the absence of formal data.

SB 611 directs the Division of Health Care Financing and Medicaid to analyze:

- Fiscal impact
- Care outcomes
- System alignment
- Potential implications for a future State Plan Amendment

Without a formal study, the General Assembly cannot make an informed, evidence-based decision.

Fiscal Neutrality

This legislation appropriates no new funds. It does not expand eligibility. It does not mandate reimbursement. It simply requires analysis.

Other states have completed similar feasibility studies at modest cost. Delaware, for example, conducted an analogous review in 2023 for less than $75,000. Any future policy change would require separate legislative action and full fiscal transparency.

This bill does not impact the current budget.

Alignment with Maryland Policy Goals

This proposal aligns with Maryland's broader health care priorities.

Maryland's Triple Option waiver emphasizes "right place, right time" care. Hospice houses are already recognized in COMAR as appropriate settings for managing terminal symptom crises. The Health Services Cost Review Commission's global hospital budget model further incentivizes reducing avoidable hospital utilization at the end of life.

Additionally, recent legislative debates have reflected bipartisan concern that low-income Marylanders lack access to the full continuum of palliative and hospice services. This study directly supports the goal of improving equity in end-of-life care

SB 611 does not change coverage policy today. It simply asks whether Maryland is already paying for end-of-life room and board—but in the wrong setting.

When Medicaid beneficiaries cannot afford to remain in hospice residences, they often return to high-cost, high-intensity institutional settings in their final days. This creates a two-tier system in which wealthier Marylanders can remain in hospice houses, while low-income Marylanders cannot.

This bill equips the General Assembly with the data needed to evaluate whether Maryland's current financing structure aligns with patient preference, quality of care, and fiscal responsibility.

For these reasons, we respectfully urge a favorable report on Senate Bill 611.

Bridging Life FAV SB 611 Maryland Department of He
Uploaded by: Carlos Graveran
Position: FAV

BRIDGINGLIFE
Compassionate care for life's transitions

Date: February 24, 2026
To: Chair Beidle and Members of the Senate Finance Committee
Re: Senate Bill 611 - Maryland Department of Health - Study on Maryland Medical Assistance Program Reimbursement of Hospice Room and Board Services
Position: Favorable
Submitted By: Carlos Graveran on behalf of Bridging Life Hospice and Palliative Care

Dear Chair Beidle and Members of the Senate Finance Committee:

Thank you for the opportunity to provide testimony *in support of* Senate Bill 611, which would direct the Maryland Department of Health to study the impact of requiring the Maryland Medical Assistance Program to provide reimbursement for room and board services provided by a hospice house.

Bridging Life Hospice and Palliative Care is dedicated to serving individuals with advanced, life-limiting illnesses and complex care needs by delivering interdisciplinary hospice and palliative services focused on comfort, dignity, and quality of life. We serve many Maryland Medicaid beneficiaries who would otherwise spend their final days in high-cost hospital settings rather than in environments best suited to address their holistic needs.

Current Maryland Medicaid hospice reimbursement structures are *multi-layered and administratively challenging*. Hospice services for terminally ill individuals are covered under Medicaid when a physician certifies a life expectancy of six months or less, but room and board payments are not included. Reimbursement for room and board for Medicaid beneficiaries residing in nursing homes involve pass-through arrangements that complicate cash flow and operational consistency for providers. These payment complexities can result in delayed or fragmented funding, creating barriers to smooth service delivery at a time when continuity is critical.

Hospice and palliative care are evidence-based interventions that reduce acute care utilization, improve patient and family satisfaction, and lower overall cost of care by shifting care away from expensive hospital settings to community-based and home-like environments. Hospice care prioritizes pain and symptom management, psychosocial and spiritual support, and care coordination for the most vulnerable populations. It is both humane and cost-effective—improving quality of life while reducing preventable hospitalizations.

The Maryland AHEAD Model, which becomes effective January 1, 2026, seeks to advance health equity and improve care delivery while controlling costs by emphasizing value-driven care across the continuum, not solely in hospital settings. Hospice and palliative care services are *intrinsically aligned* with these objectives:

BRIDGINGLIFE
Compassionate care for life's transitions

- Better Care: Hospice and palliative care promote whole-person, patient-centered approaches that uphold quality of life through coordinated pain, symptom, and psychosocial support.
- Cost Control: By supporting beneficiaries in appropriate settings such as hospice homes or community residences, these services help avoid costly acute care admissions and prolonged hospital stays at the end of life.
- Health Equity and Community-Centered Delivery: Hospice care models can be tailored to meet cultural, linguistic, and social needs, increasing accessibility and reducing disparities in end-of-life care.

This study represents a necessary and *pragmatic first step* toward a better understanding of how Medicaid reimbursement for room and board in hospice houses could:

1. Improve hospice length of stay and reduce unnecessary transitions back to acute care;
2. Reduce hospital deaths and enable patients to remain in hospice environments that better support quality of life; and
3. Quantify Medicaid savings per death due to expanded hospice utilization and inform future payment policy. (Maryland General Assembly)

Given the complexities of current payment processes and the overarching goals of the AHEAD Model, it is prudent to evaluate whether aligning room and board reimbursement under Medicaid with hospice service delivery can enhance care quality and financial sustainability.

For these reasons, Bridging Life Hospice and Palliative Care *strongly supports a favorable report* on SB 611. We urge the Committee to advance this bill so Maryland can take an evidence-based step toward maximizing the value of hospice and palliative care for Medicaid beneficiaries and the broader health system.

Thank you for your consideration.

Carlos Graveran
Assistant Vice President
BridgingLife Hospice and Palliative Care
Main: 410-871-8000 | Direct: 410-871-7650 | Fax: 410-871-7242
bridginglifecare.org

Maryland Catholic Conference_FAV_SB611.pdf
Uploaded by: Diane Arias
Position: FAV

MARYLAND CATHOLIC CONFERENCE

February 24, 2026

Senate Bill 611
Maryland Department of Health - Study on Maryland Medical Assistance Program Reimbursement of Hospice Room and Board Services
Senate Finance Committee

Position: Favorable

The Maryland Catholic Conference (MCC) is the public policy representative of the three (arch)dioceses serving Maryland, which together encompass over one million Marylanders. Statewide, their parishes, schools, hospitals, and numerous charities combine to form our state's second largest social service provider network, behind only our state government.

Senate Bill 611 requires the Division of Health Care Financing and Medicaid within the Maryland Department of Health to study the impact of requiring the Maryland Medical Assistance Program to provide reimbursement for room and board services provided by a hospice house; and requiring the Department to report its findings to the Senate Finance Committee and the House Health Committee by September 30, 2026.

At the heart of the Catholic Church's ministry to the sick, elderly, disabled, and underserved is Christ's call to care for those most in need of compassion and accompaniment. The Church teaches that every human life possesses inherent dignity, regardless of age or health status. True compassion means ensuring access to high-quality medical care, including effective pain management and comprehensive palliative and hospice services.

Currently, Medicaid fee-for-service reimburses hospice room and board at a per diem rate equal to 95% of the skilled nursing facility rate. However, not all patients have access to skilled nursing facilities, nor are those settings always appropriate for individuals who require intensive symptom management in a hospice house environment.[1] Hospice houses are specifically designed to provide comfort-focused, end-of-life care in a setting that prioritizes dignity, family presence, and specialized pain management. Without adequate reimbursement

[1] chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://health.maryland.gov/mmcp/provider/Documents/transmittals/PT25-26_Clarification_of_HC_Reimbursement_and_Payment_Responsibility_for_Hospice_R&B_Pass_Through.pdf

for room and board, access to these facilities can be limited—particularly for low-income patients who rely on Medicaid.

Studying and potentially expanding reimbursement for hospice room and board would promote more equitable access to this level of care. It would ensure that patients are not denied placement in hospice houses simply because of their insurance status or financial circumstances. Increased access would allow more individuals to receive expert pain and symptom management in an environment designed for end-of-life care, reducing unnecessary hospitalizations and supporting families during a profoundly vulnerable time.

The end of life can also be a time of reconciliation, healing, and spiritual preparation. A hospice setting that integrates medical, emotional, and spiritual support offers patients and families the opportunity to approach death with peace and dignity. In a society that often distances itself from the realities of death and dying, strengthening hospice access affirms that the elderly and seriously ill are not burdens, but persons worthy of love and care.

While the Church firmly opposes assisted suicide and any practice that undermines the sanctity of life, it strongly supports policies that expand access to compassionate, high-quality end-of-life care. By studying and addressing reimbursement for hospice room and board, Senate Bill 611 takes an important step toward ensuring that all Marylanders—regardless of income—can receive dignified, comfort-centered care at the end of life.

For these reasons, the Maryland Catholic Conference asks for a favorable report on **SB 611**.

Thank you for your consideration.

SB611_MHA_FAV

Uploaded by: Jake Whitaker

Position: FAV

Maryland
Hospital Association

Senate Bill 611 - Maryland Department of Health - Study on Maryland Medical Assistance Program Reimbursement of Hospice Room and Board Services

Position: *Support*
February 24, 2026
Senate Finance Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment in support of Senate Bill 611 with Sponsor amendments.

MHA supports SB 611 because it advances a more equitable and compassionate process for supporting end-of-life care by directing the Maryland Department of Health to study the impact of requiring Medicaid reimbursement for room and board in hospice houses. This is an important step forward in closing this parity gap.

Ensuring Marylanders have access to high-quality hospice care not only provides patients and families with dignity and comfort, but can also help hospitals decrease length of stay, avoid emergency department and hospital utilization, reduce the risk of readmission, and provide a more appropriate level of care in a therapeutic setting.

Additionally, the goal of the legislation aligns with the AHEAD Model. As Maryland transitions to this new payment model, it is important to evaluate the utilization of non-hospital care to ensure patients are receiving the right level of care in the right setting. For example, sometimes patients who would benefit from care in a hospice house are transferred to a skilled nursing facility instead solely because Medicaid will cover the expense of the skilled nursing facility bed but not the hospice bed. That skilled nursing facility bed is then no longer available for patient boarding in a hospital who needs that level of care.

We appreciate the Sponsor bringing this important and timely bill forward. This study will provide insight to ensure reimbursement is not serving as a barrier to patients receiving care in the most appropriate and cost-effective setting.

For these reasons, we request a favorable report on SB 611.

For more information, please contact:
Jane Krienke, Assistant Vice President, Government Affairs & Policy
Jkrienke@mhaonline.org

Written Testimony- Senate Final.pdf
Uploaded by: Molly Kirsch
Position: FAV

Senate Finance Committee
SB611
Position: Favorable

Dear Senator Beidle and Members of Finance Committee,

We are writing as a coalition of hospice providers—including Compass Regional Hospice, serving Queen Anne's, Kent, and Caroline counties; Coastal Hospice, serving the Lower Eastern Shore- Dorchester, Somerset, Wicomico, and Worcester counties; Talbot Hospice, serving Talbot County; Hospice of the Chesapeake, serving Anne Arundel, Prince George's, Charles, and Calvert counties; LifeBridge Health, serving Greater Baltimore region**,** including Carroll County, Baltimore County, Baltimore City, and Frederick County; Montgomery & Prince George's Hospice serving Montgomery County and Prince George's County; and Hospice and Palliative Care Network of Maryland, which supports hospice providers statewide—to express strong support for establishing Medicaid reimbursement for room and board in licensed residential hospice facilities. In our work serving patients and families at the end of life, we see daily how current policy unintentionally steers individuals into care settings that are often more costly and less aligned with their needs and wishes.

Currently, Medicaid reimburses room and board for end-of-life patients in skilled nursing facilities (SNFs), but not in residential hospice homes. This creates a financial incentive that pushes families toward institutional placements even when a hospice residence would provide more appropriate, compassionate, and patient-centered care. This limits patient choice, unintentionally.

The impact of this misalignment is measurable. Maryland Medicaid covers approximately 59% of SNF revenue, higher than the national average, further reinforcing institutional placement over hospice residence options. At the same time, Maryland ranks near the bottom nationally in hospice length of stay, limiting the benefits patients and families can receive from coordinated end-of-life care. Maryland also has one of the lowest rates in the country of Medicaid beneficiaries electing the hospice benefit, restricting access to hospice services for many individuals, particularly those in rural and historically underserved communities.

We also know that hospice care improves outcomes. Hospice programs experience a hospital readmission rate of just 1.4%, compared with 19.2% for patients in skilled nursing facilities, reflecting stronger symptom management and care coordination. Yet families often choose SNFs because Medicaid covers room and board there, while hospice residences must rely heavily on philanthropy to cover these costs. This makes hospice houses financially vulnerable and, in some cases, has led to closures despite clear community need.

Hospitals frequently report difficulty placing patients in residential hospice settings, but the barrier is often **not** bed availability—it is affordability for families facing end-of-life decisions under significant stress.

Allowing Medicaid reimbursement for room and board in residential hospice facilities would simply correct a payment structure that directs patients to the wrong care setting. This change would support longer and more appropriate hospice stays, reduce avoidable hospital readmissions, improve family satisfaction, and ultimately lower Medicaid spending by better matching care to patient needs. It would also align with statewide efforts to reduce unnecessary hospital utilization.

Importantly, Maryland would not be alone in making this change. Twenty-four other states have already implemented policies providing room and board payment structures for hospice house residential care, demonstrating that this approach is both feasible and effective.

In short, Medicaid is already paying for room and board at the end of life—just often in the wrong setting. Extending reimbursement to residential hospice facilities would improve quality of care, respect patient choice, strengthen community-based end-of-life services, and use public resources more wisely.

Thank you for your consideration and for your commitment to improving care for Maryland families at the end of life.

Hospice & Palliative Care Network
OF MARYLAND

Talbot Hospice

Est. 1980
Coastal Hospice

COMPASS
hospice | grief services | supportive care

Montgomery & Prince George's
Hospice

hospice of the chesapeake

LIFEBRIDGE HEALTH
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BRIDGINGLIFE
Compassionate care for life's transitions

HPCNM FAV SB611.pdf
Uploaded by: Peggy Shimoda
Position: FAV

Hospice & Palliative Care Network
OF MARYLAND

February 19, 2026

The Honorable Pamela G. Beidle, Chair
The Honorable Antonio Hayes, Vice Chair
Senate Finance Committee
Miller Senate Office Building
Annapolis, MD 21401

RE: **Support for SB611/HB1051 – Maryland Department of Health – Study on Maryland Medicaid Assistance Program Reimbursement of Hospice Room and Board Services**

Dear Chair Beidle, Vice Chair Hayes, and Members of the Committee:

On behalf of the Hospice & Palliative Care Network of Maryland (HPCNM), we respectfully submit this letter **in strong SUPPORT of SB611/HB1051**. We are grateful to the bill sponsors for initiating a thoughtful and data-driven examination of Medicaid reimbursement for hospice house room and board services in Maryland.

Why this study matters: hospice houses are not "hospital inpatient units"

Maryland hospice providers deliver end-of-life care across multiple settings. Two settings are commonly confused:

- **Hospital "inpatient hospice" / General Inpatient (GIP) units**: short-term, medically necessary inpatient hospice care when symptoms cannot be managed in another setting.
- **Residential hospice facilities ("hospice houses")**: home-like residential settings for patients whose needs can no longer be safely met at home, but who **do not** require hospital-level inpatient care.

This distinction matters for policy design. **Hospice houses are a lower-intensity, comfort-focused alternative to hospital stays and other institutional settings,** especially when family caregiving is unavailable or unsafe.

Capacity is limited—and measurable

Using the **Maryland Health Care Commission (MHCC) 2024 Hospice Survey Public Use Dataset**, Maryland reported **five residential hospice facilities ("hospice houses")** with a combined **52 residential hospice beds statewide**. By comparison, providers reported substantially more **licensed inpatient beds** across inpatient/GIP-capable facilities in hospitals or skilled nursing facilities (reported separately in the same dataset).

Bottom line: hospice house capacity exists, but it is limited—and a Medicaid room-and-board policy decision will have practical access implications.

Hospital avoidance offsets: hospice is consistently associated with lower acute care use

Peer-reviewed studies of Medicare beneficiaries repeatedly find that hospice enrollment is associated with **fewer hospitalizations, fewer ED visits, and lower overall spending**, particularly when hospice occurs earlier rather than in the last few days of life.

For Maryland, this is especially important in the context of statewide goals to reduce avoidable hospital utilization and improve care transitions. A hospice house room-and-board benefit can support:

- safer discharges and avoidance of "bounce-backs,"
- fewer crisis-driven ED visits when symptom burden escalates, and
- more goal-concordant care for patients and families.

What we urge MDH to include in the study (SB611/HB1051)

We respectfully recommend that MDH's study include:

1. **Clear definitions and eligibility** distinguishing hospice house residential care from inpatient/GIP care.
2. **Maryland access analysis** (geography, bed capacity, referral patterns, waitlists, and caregiver availability).
3. **Maryland-specific rate modeling** for hospice house room-and-board under Medicaid (including potential guardrails).

4. **Cost-offset analysis** that explicitly models:
    - avoided hospitalizations/ED visits and
    - avoided SNF/rehab days when a hospice house is the clinically appropriate setting.
5. **Quality and accountability measures**, including patient/family experience and timeliness of access.

Conclusion

Patients will still be able to choose whatever care setting they prefer. This legislation does not mandate hospice house placement. However, it ensures that Medicaid beneficiaries have a **meaningful choice** — a choice that currently does not exist for many low-income Marylanders.

Without reimbursement, the "choice" is theoretical. With reimbursement, it becomes real.

SB611/HB1051 is a prudent, data-driven step to evaluate how Maryland Medicaid can ensure equitable access to appropriate end-of-life care—while potentially reducing avoidable higher-cost utilization. HPCNM and our members stand ready to assist MDH and the General Assembly with data, clinical expertise, and implementation considerations.

For these reasons, **HPCNM SUPPORTS SB611/HB1051**, and we respectfully request a favorable report.

Sincerely,

Peggy Shimoda

Peggy Shimoda, CAE
Executive Director
Hospice & Palliative Care Network of Maryland

Testimony in Support of SB611 - Becky Miller Hospi
Uploaded by: Sandra Dillon
Position: FAV

hospice of the chesapeake

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hospicechesapeake.org

February 20, 2026

Testimony of Becky Miller, CEO, Hospice of the Chesapeake
In Support of Senate Bill 611
Senate Finance Committee

Chair Beidle and members of the Senate Finance Committee.

My name is Becky Miller, and I am the CEO of Hospice of the Chesapeake. We respectfully urge a favorable report on SB611.

Our organization is the largest independent not-for-profit provider in Maryland offering hospice and palliative care services in Anne Arundel, Calvert, Charles, and Prince George's counties. We serve many Maryland Medicaid beneficiaries who would otherwise spend their final days in high-cost hospital settings rather than in environments best suited to address their holistic needs.

One of the most significant barriers to expanding residential hospice access is the lack of Medicaid reimbursement for hospice residential room and board. While hospice services are covered, the residential room and board components are not reimbursed.

As a result, patients who qualify for hospice and do not have the resources to afford room and board fees at a facility are frequently left with no option but placement in rehabilitation facilities (this is paid by Medicaid) or simply cannot be discharged from hospitals. They are effectively "forced into rehab" because residential hospice is financially inaccessible. Due to a systemic lack of options and no hospice beds available reality becomes a cycle of continued failure bouncing between rehab and costly hospitals stay. We hope to break this cycle with a more appropriate and holistic way of approaching end-of-life care for Maryland Medicaid beneficiaries.

SB611's study represents a necessary and pragmatic first step toward understanding how Medicaid reimbursement for room and board in hospice houses could improve hospice length of stay, reduce unnecessary burdensome transitions back to acute care, decrease hospital deaths, and quantify potential Medicaid savings associated with expanded hospice utilization.

This bill does not mandate a policy change — it calls for data, clarity, and responsible analysis.

We urge a favorable report on SB611. Thank you for your consideration.

Becky Miller, CEO
Hospice of the Chesapeake

SB611 Amendment 723924 1 final.pdf
Uploaded by: Johnny Mautz
Position: FWA

SB0611/723924/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

18 FEB 26
15:00:07

BY: Senator Mautz
(To be offered in the Finance Committee)

AMENDMENTS TO SENATE BILL 611
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, strike beginning with "Division" in line 4 down through "Health" in line 5 and substitute "Maryland Health Care Commission and the Maryland Medical Assistance Program jointly".

AMENDMENT NO. 2

On page 1, strike beginning with "Division" in line 11 down through "Health" in line 12 and substitute "Maryland Health Care Commission and the Maryland Medical Assistance Program jointly"; in line 16, strike "quantify" and substitute "analyze"; in the same line, after "per" insert "enrollee"; in line 17, strike "as a result of the use of hospice care; and" and substitute "associated with hospice care utilization during the last 6 months of life compared with costs associated with other services provided to Program enrollees during the last 6 months of life, including the impact on:

(i) avoided inpatient hospital stays;

(ii) emergency department utilization; and

(iii) intensive treatments near the end of life;";

in line 18, after "(2)" insert "analyze the projected fiscal impact of the provision of reimbursement for hospice house room and board services, including any potential offsets or net savings;

(3)";

in line 20, strike "hospice" and substitute "hospital"; and in line 22, before "result" insert "improve early access to hospice services;

(iv)".

On page 2, in line 1, strike "(iv)" and substitute "(v)"; and in the same line, after "utilization" insert "; and

(4) include a comparison of other states that provide reimbursement for hospice house room and board service, including a comparison of:

(i) payment models;

(ii) utilization outcomes; and

(iii) cost impacts".

SB611 REPRINT - final.pdf
Uploaded by: Johnny Mautz
Position: FWA

SENATE BILL 611

J1, J3 6lr2924
CF 6lr2923

By: **Senator Mautz**
Introduced and read first time: February 5, 2026
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Maryland Department of Health – Study on Maryland Medical Assistance Program Reimbursement of Hospice Room and Board Services

FOR the purpose of requiring the ~~Division of Health Care Financing and Medicaid within the Maryland Department of Health~~ Maryland Health Care Commission and the Maryland Medical Assistance Program jointly to study the impact of requiring the Maryland Medical Assistance Program to provide reimbursement for room and board services provided by a hospice house; and generally relating to a study of reimbursement for hospice room and board services under the Maryland Medical Assistance Program.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(a) The ~~Division of Health Care Financing and Medicaid within the Maryland Department of Health~~ Maryland Health Care Commission and the Maryland Medical Assistance Program jointly shall study the impact of requiring the Maryland Medical Assistance Program to provide reimbursement for room and board services provided by a hospice house, as defined in COMAR 10.07.22.02.

(b) The study required under subsection (a) of this section shall:

(1) ~~quantify~~ analyze overall Maryland Medical Assistance Program savings per enrollee death ~~as a result of the use of hospice care; and~~ associated with hospice care utilization during the last 6 months of life compared with costs associated with other services provided to Program enrollees during the last 6 months of life, including the impact on:

(i) avoided inpatient hospital stays;

(ii) emergency department utilization; and

(iii) intensive treatments near the end of life;

(2) analyze the projected fiscal impact of the provision of reimbursement for hospice house room and board services, including any potential offsets or net savings;

(3) examine how the provision of reimbursement for room and board services would:

(i) affect ~~hospice~~ hospital readmission rates;

(ii) improve hospice length of stay;

(iii) improve early access to hospice services;

(iv)result in a reduction in deaths in hospitals; and

REPRINT OF SENATE BILL 611 as amended by SB0611/723924/1 02/18/26 at 2:59 PM

~~(iv)~~ (v) result in a reduction in emergency department utilization; and

(4) include a comparison of other states that provide reimbursement for hospice house room and board service, including a comparison of:

(i) payment models;

(ii) utilization outcomes; and

(iii) cost impacts.

(c) On or before September 30, 2026, the Maryland Department of Health shall report its findings to the Senate Finance Committee and the House Health Committee, in accordance with § 2–1257 of the State Government Article.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2026.

SB 611 - FIN- MDH -LOC.docx (1).pdf
Uploaded by: Meghan Lynch
Position: UNF

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

February 24, 2026

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: Senate Bill 611– Maryland Department of Health - Study on Maryland Medical Assistance Program Reimbursement of Hospice Room and Board Services - Letter of Concern

Dear Chair Beidle and Committee Members:

The Maryland Department of Health (the Department) respectfully submits this letter of concern for Senate Bill (SB) 611- Maryland Department of Health – Study on Maryland Medical Assistance Program Reimbursement of Hospice Room and Board Services.

The Department currently reimburses room and board when a hospice program participant resides in a nursing facility. Federal law prohibits Medicaid reimbursement for room and board outside of a facility setting, including for hospice services delivered in a community setting such as a hospice house (see e.g., 42 C.F.R. § 441.310(a)(2) and 42 C.F.R. § 441.360(b).

The Department advises that there is a fiscal impact of $52,000 total funds ($26.000 general funds, $26,000 federal funds) associated with completion of the study required by SB 611,which would be due on September 30, 2026. The Department notes that room and board services delivered by hospice houses are not eligible for federal matching dollars and would ultimately require 100% state general funds.

If you would like to discuss this further, please do not hesitate to contact Meghan Lynch, Director of Government Affairs at meghan.lynch@maryland.gov.

Sincerely,

Meena Seshamani, M.D., Ph.D.
Secretary of Health