Hospice & Palliative Care Network
OF MARYLAND

February 19, 2026

The Honorable Heather Bagnall, Chair
The Honorable Bonnie Cullison, Vice Chair
Maryland House Office Building
6 Bladen Street
Annapolis, MD 21401

RE: **Support for HB1151/SB611 – Maryland Department of Health – Study on Maryland Medicaid Assistance Program Reimbursement of Hospice Room and Board Services**

Dear Chair Bagnall, Vice Chair Cullinson, 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 HB1151/SB611**. 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 (HB1151/SB611)

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.

HB1151/SB611 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 HB1151/SB611**, and we respectfully request a favorable report.

Sincerely,

Peggy Shimoda

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