June 24, 2025

The Honorable David Schweikert
Member of Congress
166 Cannon HOB
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Schweikert,

On behalf of the National Alliance for Care at Home, LeadingAge, and the National Partnership for Healthcare and Hospice Innovation (NPHI), we write to express our strong concern and opposition to H.R. 3467. This letter focuses on the provision that would require Medicare Advantage (MA) plans to administer the Medicare Hospice Benefit (MHB), also known colloquially as an "MA carve-in". While we have serious concerns about this provision, we would value a further conversation about the overall intent and structure of the legislation. We appreciate your goal of reforming MA, it is unclear how requiring MA plans to administer the MHB would achieve that goal. The MHB is a form of managed care for patients facing terminal illness -negating the need for an MA organization to administer Medicare Parts A and B services once treatment shifts from curative to palliative in nature. Putting aside your overall intent, requiring MA plans to administer the MHB would likely undermine the integrity, accessibility, and quality of hospice care for America's most vulnerable seniors. We urge you to remove this harmful provision from future iterations of this legislation and any other efforts to reform MA.

Hospice is unlike other Medicare services because it already functions as a form of managed care. Hospices are required to cover all items and services needed by patients to palliate and manage their terminal condition, with the goal of enabling patients to live as fully and comfortably as possible until the end of their life. It is delivered through a coordinated interdisciplinary team, including physicians, nurses, social workers, and spiritual counselors, who work together to develop and update a comprehensive plan of care.[1] The hospice medical director plays a critical role in determining a patient's terminal prognosis and guiding the care plan. Currently, MA beneficiaries who elect hospice have their hospice benefit administered by traditional FFS Medicare, while retaining their MA plan for any supplemental benefits not covered by FFS Medicare. In practice, this administrative process is a seamless experience without burdens for patients or providers. This intentional separation also preserves the integrity of hospice care for patients by ensuring direct payment from CMS to hospice providers without any unnecessary administrative layer, or even possible interference, from MA plans. The decision to forgo curative care and elect to solely receive palliative care and support through the MHB is an immensely personal choice for patients and their families and the current structure of how the benefit is administered supports that choice.

Established under the Balanced Budget Act of 1997, the Special Rule for Hospice ensures that when a Medicare Advantage enrollee elects to receive hospice care, administration of the benefit reverts to Original Medicare, while the MA plan remains responsible for supplemental services.[2] This framework safeguards patient choice, avoids restrictive networks and administrative barriers, and ensures uninterrupted access to care during the final and most vulnerable phase of life – we urge that Congress continue to protect this well-thought out structure that works for beneficiaries and for

[1] 42 U.S.C. § 1395x(dd)(2)(B); 42 C.F.R. § 418.56.

[2] 42 U.S.C. § 1395w–23; Balanced Budget Act of 1997, Public Law 105–33, section 4002.

hospice providers. We ask that the current framework be preserved, which Congress has consistently done since 1997[3], as it reflects longstanding bipartisan agreement that end-of-life care requires special protections grounded in patient autonomy and clinical expertise.

A persistent issue in the MA space is the use of utilization management and the impact on beneficiaries – one example of many is a recent report that highlights how MA plans limit access to post-acute care services such as skilled nursing and home health via prior authorization.[4] In contrast, MA enrollees who elect hospice currently retain the freedom to choose any Medicare-certified hospice provider, free from network limitations or prior authorization requirements. Imagine these issues but amplified given that the beneficiaries in question are at end of life. The access afforded by the current system is essential as more than half of hospice beneficiaries pass away within 14 days of election, making delays in care both harmful and unacceptable. Timely access to this critical benefit would be jeopardized by inserting additional administrative layers and processes on top of a benefit that is already a form of managed care.

Announced in 2019, CMS tested a hospice "carve-in" under the Value-Based Insurance Design (VBID) model. Data revealed challenges such as administrative burdens, difficulty creating networks, and delayed payments for claims.[5] Lower reimbursement rates raised concerns about the financial viability of hospices and decreased access to hospice care. The demonstration did not result in increased or earlier access to hospice or better care coordination. As a result of these challenges, the demonstration was terminated seven years earlier than originally planned.

At its core, hospice is a deeply personal choice for those with serious illnesses. We urge you to reconsider requiring MA plans to administer the Medicare hospice benefit and rather follow the evidence, historical Congressional intent, and desire of beneficiaries and those who care for them in keeping these programs separate. The MHB, as currently structured, delivers high-quality, cost-effective care, with high satisfaction among patients and families. It ensures that care at the end of life is delivered according to patient values and needs. It is the gold standard of care delivery for those with terminal illnesses who elect to pursue palliative as opposed to curative care. **The proposed carve-in seeks to solve a problem that does not exist, upending hospice as we know it, and subjecting dying patients to new administrative hurdles, reduced choice, and the risk of diminished care. The bottom line is that patients and well-meaning providers will suffer the consequences of this short-sighted proposal.**

While we stand ready to work with you to protect and strengthen the MHB for all who need it, the hospice provision included in this legislation should not move forward. We, the unified hospice provider community, cannot compromise on the dignity, comfort, and choice that has defined the last forty years of hospice care in the United States.

Sincerely,

The National Alliance for Care at Home
LeadingAge
National Partnership for Healthcare and Hospice Innovation (NPHI)

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[3] Medicare Modernization Act of 2003, Public Law 108–173; Affordable Care Act of 2010, Public Law 111–148.
[4] https://strengthenhealthcare.org/new-report-medicare-advantage-patients-face-longer-hospital-stays-reduced-access-to-follow-up-care/
[5] https://www.cms.gov/priorities/innovation/data-and-reports/2025/vbid-2020-2023-hospice-aag