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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1851–P,
P.O. Box 8010
Baltimore, MD 21244–1850

Re: Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements; RIN 0938–AV78

To Whom It May Concern:

On behalf of the United States Conference of Catholic Bishops ("USCCB"), we respectfully submit these comments regarding the proposed rule "Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements" (the "Proposed Rule") from the U.S. Department of Health & Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS). Specifically, we write in response to the Proposed Rule's Request for Information regarding "Medical Aid in Dying (MAID)" in Section III.E.3 (the "RFI").

We appreciate CMS's solicitation of information to ensure that federal funds are not used for assisted suicide, and offer these comments to help CMS discern how best to do so.

I. What the Catholic Churches teaches about palliative care and assisted suicide

The Catholic Church condemns euthanasia as a grave sin:

> Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick, or dying persons. It is morally unacceptable…Thus an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator.[1]

This does not preclude appropriate palliative care, which the Church regards as an affirmative good:

[1] Catechism of the Catholic Church (CCC) 2277.

> The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable Palliative care is a special form of disinterested charity. As such it should be encouraged.[2]

The Holy See's Dicastery for the Doctrine of the Faith addressed the intersection of palliative care and assisted suicide six years ago:

> [P]alliative medicine constitutes a precious and crucial instrument in the care of patients during the most painful, agonizing, chronic and terminal stages of illness. *Palliative care* is an authentic expression of the human and Christian activity of providing care, the tangible symbol of the compassionate "remaining" at the side of the suffering person. Its goal is "to alleviate suffering in the final stages of illness and at the same time to ensure the patient appropriate human accompaniment" improving quality of life and overall well-being as much as possible and in a dignified manner. Experience teaches us that the employment of palliative care reduces considerably the number of persons who request euthanasia…
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> It should be recognized, however, that the definition of palliative care has in recent years taken on a sometimes equivocal connotation. In some countries, national laws regulating palliative care…as well as the laws on the "end of life"…provide, along with palliative treatments, something called Medical Assistance to the Dying (MAiD) that can include the possibility of requesting euthanasia and assisted suicide. Such legal provisions are a cause of grave cultural confusion: by including under palliative care the provision of integrated medical assistance for a voluntary death, they imply that it would be morally lawful to request euthanasia or assisted suicide.
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> In addition, palliative interventions to reduce the suffering of gravely or terminally ill patients in these regulatory contexts can involve the administration of medications that intend to hasten death, as well as the suspension or interruption of hydration and nutrition even when death is not imminent. In fact, such practices are equivalent to a direct action or omission to bring about death and are therefore unlawful. The growing diffusion of such legislation and of scientific guidelines of national and international professional

[2] CCC 2279.

societies, constitutes a socially irresponsible threat to many people, including a growing number of vulnerable persons who needed only to be better cared for and comforted but are instead being led to choose euthanasia and suicide.[3]

II. Concerns with premises in the RFI

a. Use of the term "MAID"

The RFI adopts the term "MAID," an acronym for "medical aid in dying," to refer to assisted suicide. Though popular among its proponents, this euphemistic term is foreign to federal law. Indeed, in terms of statutes, it appears to be foreign in origin.[4] CMS's deviation from the language of the statute in question – the Assisted Suicide Funding Restriction Act of 1997 (ASFRA) – in favor of the preferred messaging of advocates for assisted suicide could be misunderstood as endorsement of their policy preferences.

The term "MAID" also obscures the truth of the matter. While "assisted suicide" is an accurate description – someone assists another person's suicide by providing the means for it – "medical aid in dying" could refer to any form of appropriate medical support for a dying patient. CMS's use of the term thus impedes communication with the regulated community and affected individuals. Pope Leo has warned that "authentic dialogue" can only occur when we use language that "express[es] distinct and clear realities unequivocally."[5]

b. Discrepancy between the statute and regulation

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[3]Congregation for the Doctrine of the Faith, *Letter Samaritanus bonus on the Care of Persons in the Critical and Terminal Phases of Life* (July 14, 2020), https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20200714_samaritanus-bonus_en.html.

[4] It seems to have first been adopted in Quebec's 2014 assisted suicide law, and then in Canada's nationwide law of 2016, albeit both referred to "Assistance" rather than "Aid." *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, S.C. 2016, C 14 (Can.). See also Christy Laverty, "Language Matters: Why we use the term 'Medical assistance in dying,'" Dying with Dignity Canada, Jan. 21, 2022, at https://www.dyingwithdignity.ca/blog/language-matters/.

[5] Pope Leo XIV, *Address to Members of the Diplomatic Corps Accredited to the Holy See* (Jan. 9, 2026), https://www.vatican.va/content/leo-xiv/en/speeches/2026/january/documents/20260109-corpo-diplomatico.html ("Today, the meaning of words is ever more fluid, and the concepts they represent are increasingly ambiguous. Language is no longer the preferred means by which human beings come to know and encounter one another. Moreover, in the contortions of semantic ambiguity, language is becoming more and more a weapon with which to deceive, or to strike and offend opponents. We need words once again to express distinct and clear realities unequivocally. Only in this way can authentic dialogue resume without misunderstandings.").

The RFI accurately restates a key substantive provision of ASFRA and the corresponding provision of its implementing regulation. However, it fails to note a significant discrepancy between the two.

ASFRA permits federal funding for "the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not *also* furnished for the purpose of causing, *or the purpose of assisting in causing*, death, for any reason."[6] The regulatory provision intended to clarify this part of the statute permits funding for "the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for *the specific purpose* of causing death."[7]

The regulation omits the statute's prohibition on services with "the purpose of assisting in causing" death and that such prohibition applies even when causing or assisting in causing death is "also" a purpose alongside pain alleviation. Instead, the regulation adds that services are only subject to ASFRA's funding restriction if their purpose in causing death is "specific." By omitting the word "also" and the "assisting in causing" phrase, the regulation would seem to permit funding for things that the statute prohibits: services that have a purpose of hastening or facilitating death, or that are complementary to a service that causes death. The addition of "specific," meanwhile, has no basis in the statute and creates ambiguity, especially in combination with the noted omissions. For instance, one might understand a service with "the specific purpose" of causing death to be one whose *sole* purpose is to cause death, which would narrow ASFRA's restriction considerably, possibly even allowing reimbursement of services with a purpose of causing death (rather than facilitating it) if that is not their exclusive purpose.

In both the proposed and final rules in 1999 that established this regulation, the preamble restates ASFRA's restrictions accurately, but the regulatory text deviates from the preamble, without explanation.[8] In furtherance of the inquiries and purposes of its RFI, CMS should consider ways to assess the impact of the ambiguity created by this regulation, as discussed further below.

c. State law limitations on eligibility for assisted suicide

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[6] 42 U.S.C. 14402(b)(4) (emphasis added).
[7] 42 CFR 411.15(q) (emphasis added).
[8] 64 FR 39608, 39625 (Jul. 22, 1999); 64 FR 59380, 59410 (Nov. 2, 1999).

The RFI emphasizes that, under the laws of states that have legalized assisted suicide, "strict criteria require a prognosis of 6 months or less to live." This is misleading.

First, such prognoses are of course fallible – the Oregon Health Authority's 2025 report on its "Death with Dignity Act" program stated that 6% of patients who committed suicide with drugs dispensed under the law had outlived their prognoses.[9]

Second, in Montana, there is no requirement that the patient receive a prognosis of six months or less to live. Montana's assisted suicide regime was created not by statute but by the Montana Supreme Court's decision in *Baxter v. State*, which held that "a terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply."[10] The court relied on policy aims it found to be evident in the Montana legislature's passage of a statute shielding physicians from liability for withdrawing or withholding life-sustaining treatment from a terminally ill patient who requests it. While the court did not explicitly import that statute's definition of "terminal condition," it is defined as "an incurable or irreversible condition that, *without the administration of life-sustaining treatment*, will, in the opinion of the attending physician or attending advanced practice registered nurse, result in death within a *relatively short time*" (emphasis added).[11]

Third, as the Montana statute suggests, there is a crucial ambiguity in some state assisted suicide laws regarding whether the six-month prognosis is based on the patient continuing or discontinuing treatment for the condition. Where statutes receive the latter construction, the statutes are vastly more permissive than the RFI's description of them would lead the average reader to believe. Countless treatable or manageable illnesses and conditions can be reasonably expected to cause death within six months if untreated, such as type 1 diabetes, which 1.8 million adults in the United States have,[12] or anorexia.[13]

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[9] Oregon Health Authority, Public Health Division, Center for Health Statistics, Oregon Death with Dignity Act: 2025 Data Summary (Apr. 1, 2026), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year28.pdf.
[10] *Baxter v. State*, 2009 MT 449, 354 Mont. 234, 251.
[11] MCA § 50-9-102(16).
[12] Centers for Disease Control and Prevention, National Diabetes Statistics Report (Jan. 21, 2026), https://www.cdc.gov/diabetes/php/data-research/index.html (accessed June 1, 2026).
[13] Katie Engelhart, "Should Patients Be Allowed to Die From Anorexia?," The New York Times Magazine, Jan. 3, 2024; Matt Vallière, "Assisted suicide was offered to my friend Jane Allen. She had an eating disorder," The Denver Post, Oct. 2, 2025.

III. Maintenance or revocation of hospice elections upon choosing assisted suicide

The RFI seeks information on whether covered hospices permit patients who have chosen assisted suicide to maintain their hospice elections, or whether hospices encourage such patients to revoke their elections. We understand this question to be operative because a hospice election – which allows Medicare to fund the patient's treatment – can function as a legal obstacle to the provision of assisted suicide. It is cleaner, legally speaking, for a hospice if a patient is off Medicaid when assisted suicide services are provided.

It is a measure of assisted suicide's corrosive nature that a hospice would encourage patients to limit their access to life-affirming palliative care so that the hospice can reduce its exposure under ASFRA. The USCCB's Ethical and Religious Directives, which provide authoritative guidance on how Catholic healthcare providers should address certain moral issues, state that "[d]ying patients who request euthanasia should instead be given loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death."[14] CMS should reject any suggestion that revocation of hospice elections presents an elegant solution to how hospices can comply with ASFRA while operating under states' assisted suicide regimes. Instead, CMS should explore ways to facilitate coverage of the spiritual and psychological support that an appropriately holistic palliative care regimen can give to patients and their families.

IV. Mechanisms to safeguard the use of federal funds

The RFI requests "information on any additional CMS oversight mechanisms that should be in place to safeguard the use of Federal funds for the provision of MAID items and services." There are several steps for CMS to consider.

a. Protection of conscience rights

The RFI observes in a footnote that two federal statutes protect rights of conscience in the context of assisted suicide – Section 1553 of the Affordable Care Act, and 42 U.S.C. 14406. These statutes prohibit entities receiving certain federal funding from discriminating on the basis of a conscientious refusal to participate in assisted suicide, or from interpreting certain provisions of federal law to require the administration of assisted suicide, respectively. They accordingly bear consideration in CMS's examination of safeguarding use of federal funds.

[14] USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, 7th ed., dir. 59 (2025).

We have previously urged HHS to exercise its judicially recognized rulemaking authority over these two statutes before.[15] This should include requiring assurances and certifications of compliance with these statutes by covered entities, as in section 88.4 of the 2019 Conscience Rule, and establishing compliance requirements comparable to those applicable to other civil rights laws, as in section 88.6 of the 2019 Conscience Rule. It should also include definitions of terms in those statutes for clarity and broad protection of conscience rights, as in section 88.2 of the 2019 Conscience Rule.

b. Protection against disability discrimination

The Proposed Rule notes in passing that hospices it covers must comply with Section 504 of the Rehabilitation Act, which prohibits recipients of federal financial assistance from discriminating on the basis of disability.[16]

As with the applicable conscience statutes, we have also previously urged HHS to clarify how Section 504 applies in the context of assisted suicide.[17] The threats that suicide, and assisted suicide in particular, pose to persons with disabilities are well documented.[18] Recent alarming reports from Canada and the Netherlands heighten the need for the Department to proactively address this issue domestically.[19]

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[15] USCCB, Comment on Safeguarding the Rights of Conscience as Protected by Federal Statutes, HHS-OCR-2023-0001-0847 (Mar. 1, 2023), https://www.regulations.gov/comment/HHS-OCR-2023-0001-0847.
[16] 91 FR at 17339.
[17] USCCB, Comment on Discrimination on the Basis of Disability in Health and Human Service Programs or Activities, HHS-OCR-2023-0013-0783 (Nov. 13, 2023), https://www.regulations.gov/comment/HHS-OCR-2023-0013-0783.
[18] *See, e.g.*, National Council on Disability, *The Danger of Assisted Suicide Laws: Part of the Bioethics and Disability Series*, 2019.
[19] Benjamin Lopez Steven, "Number of Assisted Deaths Jumped More than 30 Per Cent in 2022, Report Says," CBC News (Oct. 27, 2023), https://www.cbc.ca/news/politics/maid-canada-report-2022-1.7009704 ("[T]he number of medically assisted deaths in 2022 was more than 30 per cent higher than the year prior. Medically assisted deaths constituted 4.1 per cent of all deaths in Canada last year"); Tristin Hopper, "Disability Rights Groups Fight Against Euthanasia," Nat'l Post (Jan. 5, 2023), https://nationalpost.com/opinion/disability-rights-groups-euthanasia ("50 Canadian disability and anti-poverty non-profits co-signed a letter to Minister of Justice David Lametti urging him to dial back Canada's MAID regime lest it continue 'euthanizing people with disabilities who are not terminally ill.'"); Maria Cheng, "Some Dutch People Seeking Euthanasia Cite Autism or Intellectual Disabilities, Researchers Say," Associated Press (June 28, 2023), https://apnews.com/article/euthanasia-autism-intellectual-disabilities-netherlands-b5c4906d0305dd97e16da363575c03ae ("Several people with autism and intellectual disabilities have been legally euthanized in the Netherlands in recent years because they said they could not lead normal lives").

c. Measuring assisted suicide and ensuring program integrity

In part because of the gap identified above with CMS's regulation implementing ASFRA, and in part because CMS cannot reasonably presume that assisted suicide never occurs in Medicare-funded hospices even when illegal under state law, HHS should consider expanding its inquiry from the RFI to include how hospice interacts with requests for facilitation of death in all states, such as by administering excessive morphine or sedation or by facilitating voluntary stopping of eating and drinking.

In the interests of both legal and fiscal integrity, HHS may also wish to consider developing oversight mechanisms to ensure that providers are following the statute and not, looking only to the regulation, unlawfully using Medicare funds for drugs or services to assist in causing death, such as in the aforementioned ways.

The findings of such an appropriately broader inquiry and the information gathered through such an oversight mechanism may also support the need to conform the regulatory text with the statute, and thereby also help ensure providers' and the governments' compliance with the actual statute.

V. Conclusion

We are grateful that the RFI reaffirms CMS's commitment to ensuring that federal funds are not used for assisted suicide. Especially given the troubling discrepancy between ASFRA and its implementing regulation, we encourage CMS to seek information on whether the ambiguity created by that discrepancy has led to violations of the statute. CMS, and HHS more broadly, should seek to ensure that end-of-life care respects the fundamental, God-given dignity of every human person.

Respectfully submitted,

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