June 1, 2026

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

Not Dead Yet Comments Re: Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements

Not Dead Yet, a grassroots disability rights organization that opposes assisted suicide and euthanasia, appreciates the opportunity to respond to the Centers for Medicare and Medicaid Services (CMS)' request for information on assisted suicide in the hospice care context as part of its proposed rule for the Medicare program.[1] Not Dead Yet supports CMS' intent to improve transparency and institute data guardrails for hospice care. This will help in the gathering of important data on U.S. patients as the population ages, potentially increasing the demand for hospice options. Not Dead Yet's comments, since we are not hospice care providers, primarily introduce additional issues related to assisted suicide and palliative care.

We recommend replacing references to "medical aid in dying" (MAID) with references to "physician-assisted suicide" or "assisted suicide."

The term "MAID" conflicts with existing statutory references to the practice. The Assisted Suicide Funding Restriction Act of 1997 (ASFR) refers to it as "assisted suicide, euthanasia, or mercy killing," as does Section 1553 of the Affordable Care Act.[2] Moreover, the term "MAID" reflects the views of assisted suicide proponents instead of the views of the public. Compassion and Choices, a prominent U.S.-based proponent organization, uses "medical aid in dying," as do many other proponent organizations.[3] The views of proponent organizations are not definitive nor normative. Using a term like MAiD is therefore more likely to confuse rather than elucidate in CMS' regulations. We recommend instead that CMS use the terminology already present in the Affordable Care Act and ASFR.

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[1] Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements, 91 Fed. Reg. 17338, 17338 (to be codified at 42 C.F.R. Pt. 418).
[2] 42 U.S. Code § 18113 (2024); Assisted Suicide Funding Restriction Act of 1997, 42 U.S. Code § 14401 *et. seq.* (2024).
[3] *See* Compassion and Choices, *Medical aid in dying is NOT suicide, assisted suicide or euthanasia,* https://compassionandchoices.org/resource/not-assisted-suicide/ (last accessed May 4, 2026); Patient Choices Vermont, *Guide to Medical Aid in Dying and End-of-Life Decision Making Empower Yourself to Make Thoughtful Choices*, https://www.patientchoices.org/guide-to-medical-aid-in-dying-and-end-of-life-decision-making.html (last visited May 4, 2026).

We recommend that HHS and CMS institute reporting requirements when assisted suicide drugs are prescribed to patients residing in hospice when doing so is not inconsistent with the state's assisted suicide law.

The RFI requests information from hospice providers on their use of assisted suicide or MAiD, including its relationship to the palliative care hospices provide.[4] The RFI also requests information on "any additional oversight mechanisms" that should be in place to safeguard federal funds.[5] We therefore recommend that CMS create standards that require hospice facilities to disclose to CMS and/or HHS how many patients elected to use MAiD and the entity's specific policies and practices concerning its use. Data collection should comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, the Patient Protection and Affordable Care Act, the laws governing Medicare and Medicaid, their regulations, and any applicable requirements in state law.

We recommend this in part due to the relative paucity of any data on assisted suicide. Many enacted or proposed assisted suicide laws contain no reporting requirements whatsoever,[6] while others contain only minimal, opaque requirements.[7] The existence of a reporting requirement does not necessarily mean that the agency reported to can act upon it. For example, in Oregon, the Oregon Health Authority receives limited reports from physicians who have prescribed lethal drugs, but they do not investigate whether physicians have complied with the requirements of the state's assisted suicide law.[8] Indeed, according to the National Council on Disability - an independent federal advisory agency - both reporting requirements and oversight requirements have decreased as more assisted suicide bills have been introduced, with the earliest bills containing the highest number.[9]

This has rendered the decision-making process in assisted suicide almost completely opaque. Indeed, it would be impossible for CMS to determine from existing data whether Medicare funds were impermissibly used to fund assisted suicide in hospice care. Reporting requirements from CMS would provide it with the basic information necessary to determine compliance with the ASFR.

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[4] 91 Fed. Reg. at 17363 ("In other words, do hospices generally continue to provide clinical care while a patient seeks qualification for MAID … Is there confusion amongst hospices regarding visits or other comfort measures … Do hospices have written policies …").

[5] 91. Fed. Reg. at 17363 ("As such, we are also requesting 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").

[6] *See, e.g.,* N.Y. State Assemb. A.136, 2025-2026 Regular Sess., §§2899 *et. seq.* (2026); H.B. 7760, R.I. Gen. Assemb., Jan. Sess. §§ 23-4.15 *et. seq* (2026).

[7] Nat'l Council on Disability, The Dangers of Assisted Suicide Laws: Part of the Bioethics and Disability Report Series 37-38 (Oct. 9, 2019), *available at* https://www.ncd.gov/report/the-danger-of-assisted-suicide-laws/.

[8] *Id.* at 34.

[9] *Id.* at 34-35.

We recommend that CMS include in its reporting requirements a provision requesting information on the hospice provider's written or oral policies concerning the chain of custody for controlled lethal medications used to cause death.

CMS' RFI expresses an interest in "what hospices do with any unused lethal medications prescribed for MAID."[10] Not Dead Yet is also interested in this topic because state assisted suicide laws are often notably opaque. For example, New York's assisted suicide law, the Medical Aid in Dying Act, only states that a person who has custody or control of any unused medications must deliver them "to the nearest qualified facility … or shall dispose of it by lawful means in accordance with regulations" made by a lawful agency or party (such as a state Commissioner).[11] There are no provisions indicating how the state would address a situation in which unused medications were retained or improperly disposed of.[12] Rhode Island's proposed bill, H.7760, merely states that the state will adopt rules and regulations on this topic.[13]

CMS does not regulate state assisted suicide laws. However, having access to policies of hospice providers on this topic, whether formal or informal, could help CMS determine whether federal funds were or could be impermissibly used to pay for medications, personnel, or procedures used in assisted suicide.

We recommend that CMS additionally request information from hospice providers on whether any clinical care or palliative care is deprioritized or not recommended by hospice providers after assisted suicide has been requested by a patient.

CMS requests information on whether there is "confusion" among hospices as to what services may be provided when assisted suicide is offered, including on the day of death.[14] CMS additionally asks whether "hospices generally continue to provide clinical care while a patient seeks qualification for MAiD."[15] We appreciate CMS' interest in this question and recommend that CMS expand it to cover situations in which patients who request assisted suicide are steered away from services, not recommended services, or offered different services than patients who did not request it.

We have heard concerning reports that assisted suicide has been treated as an "alternative" to appropriate care. We are concerned that hospice providers may similarly offer, in practice, a different or lesser standard of care to patients who request assisted suicide but have already met

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[10] 91 Fed. Reg. at 17363.
[11] *See* N.Y. State Assemb. A.136 §2899-O (2026).
[12] *Id.*
[13] H.B. 7760, § 23-4.15-11 (2026).
[14] 91 Fed. Reg at 17363.
[15] *Id.*

the coverage standards for hospice care. Our central concern is that Medicare patients who qualify for palliative care, hospice care, or long-term care should receive those services without barriers or arbitrary limits imposed by providers. CMS should request information that will allow it to determine if its regulatory standards for hospice care have been violated.

Not Dead Yet and the undersigned thank CMS for its concern for patients and for its interest in the possible intersection of assisted suicide laws with hospice care. For more information on Not Dead Yet and its position on assisted suicide and euthanasia, please contact Ian McIntosh, our Executive Director, at imcintosh@notdeadyet.org and Kelly Israel, our Interim Deputy Director, at kisrael@notdeadyet.org.

Sincerely,

Not Dead Yet
Access Ready
American Association of People with Disabilities
American Association on Health and Disability
Autistic Self Advocacy Network
Autistic Women and Nonbinary Network
Deaf Equality
Disability Rights Education and Defense Fund
National Organization of Nurses with Disabilities
New Disabled South
Speak Foundation
TASH
United Spinal