ETHICS AND PUBLIC POLICY CENTER

June 1, 2026

Via Federal eRulemaking Portal

Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements, File Code CMS-1851-P

Dear Secretary Kennedy:

We are scholars at the Ethics and Public Policy Center (EPPC). Eric Kniffin is an EPPC Fellow, member of EPPC's Administrative State Accountability Project (ASAP), and a former attorney in the U.S. Department of Justice's (DOJ) Civil Rights Division. Rachel Morrison is an EPPC Fellow, Director of ASAP, and a former attorney with the Equal Employment Opportunity Commission. Alexander Raikin is a Visiting Fellow in the Bioethics, Technology and Human Flourishing Program and has written extensively on assisted suicide. Aaron Kheriaty is a Fellow and Director of the Bioethics, Technology, and Human Flourishing Program at EPPC, and a licensed psychiatrist. Jamie Bryan Hall is Director of Data Analysis and a Fellow in the Life and Family Initiative at EPPC.

We write to offer public comment in response to the Centers for Medicare and Medicaid Services (CMS) proposed rule, "Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements," file code CMS-1851-P ("Proposed Rule").[1] This rule would update regulations related to hospice and includes requests for information. Our comments focus on the request for information on "the overlap between hospice and medical aid in dying (MAID)."[2]

The Proposed Rule reiterates that "no Medicare funds, including hospice payments, may be used to facilitate MAID, including physician consultation services, prescribing or dispensing of medications used for the purpose of causing death, or assistance with the ingestion of such medications."[3] However, since several states allow "MAID" for patients who are terminally ill, CMS is interested in learning more about "any issues that may arise when a Medicare hospice patient requests MAID" and requests information on "any additional CMS oversight mechanisms

[1] 91 Fed. Reg. 17338 (April 6, 2026), https://www.federalregister.gov/d/2026-06604.

[2] *Id.* at 17338.

[3] *Id.* at 17363.

1730 M Street N.W., Suite 910, Washington, D.C. 20036
tel. 202-682-1200 fax 202-408-0632
www.eppc.org

that should be in place to safeguard the use of Federal funds for the provision of MAID items and services."[4] Specifically, the Proposed Rule asks:

- What information do hospice providers give to these patients and how often is there overlap when a patient pursues MAID? In other words, do hospices generally continue to provide clinical care while a patient seeks qualification for MAID and do patients generally remain on service until death?

- Conversely, do hospices encourage patients to revoke their election if they choose to utilize MAID?

- Is there confusion amongst hospices regarding visits or other comfort measures that can be provided during this process, especially on the day of death?

- Do hospices have written policies regarding caring for patients using MAID? We are especially interested in understanding what hospices do with any unused lethal medications prescribed for MAID.[5]

We applaud CMS for seeking to better understand how "MAID" occurs in hospice and ways it can provide better oversight to ensure federal funds are not misused for "MAID." Below, we explain why EPPC is categorically opposed to assisted suicide, why assisted suicide is distinguishable from efforts to alleviate a terminal patient's pain, and why CMS should reject the suicide industry's preferred euphemism "MAID" and stick to the accurate term Congress chose: assisted suicide. Next, we summarize statutory restrictions on federal funding of assisted suicide and provide real-world evidence that suggests ongoing and potentially intentional violations of these restrictions. Finally, we recommend multiple ways CMS can provide oversight and safeguard the use of federal funds and point out that these recommendations align with Trump Administration priorities to combat billing fraud and enforce congressional limits on use of federal funds.

I. We thank CMS for drawing attention to assisted suicide, which is contrary to human dignity and the common good.

Before turning to the specific questions posed by CMS in the Proposed Rule, we take this opportunity to thank CMS and the Trump Administration for calling attention to this important issue. Each of us EPPC scholars and EPPC as an institution is categorically opposed to assisted suicide because it is contrary to human dignity and the common good.

Suicide is an uncomfortable word, but we urge CMS to use "assisted suicide" instead of "medical aid in dying" or "MAID" in its final rule. MAID is a euphemism developed by assisted suicide advocates who learned that accurate terminology hurts their cause. Congress has repeatedly used "assisted suicide" in federal law. CMS should follow Congress' lead and use plain language that lets the American public know what is at stake.

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[4] *Id.*

[5] *Id.*

A. EPPC is categorically opposed to assisted suicide.

As EPPC scholars, we work in different projects, but the mission we hold in common is our dedication to applying a full and true account of the human person to contemporary questions of politics, law, and culture, in pursuit of America's civic and cultural renewal. In our work, we draw upon what the Jewish and Christian traditions teach us about the human person, sources that have always been and remain a major part of the American project.

As relevant here, EPPC is categorically and unequivocally opposed to assisted suicide, because it is contrary to human dignity and contrary to the common good. EPPC has identified physician-assisted suicide as the "next critical battle for human dignity" and is committed to equipping lawmakers, policymakers, and the public to resist its expansion.[6] EPPC President Ryan T. Anderson has identified assisted suicide as one of the most important cultural and civil rights issues of our time.[7] More than a decade ago, Anderson authored a report, "Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality," which concludes, "We should respond to suffering with true compassion and solidarity. Doctors should help their patients to die a dignified death of natural causes, not assist in killing. Physicians are always to care, never to kill."[8]

EPPC scholars have consistently argued that physician-assisted suicide is wrong for four interconnected reasons. First, it **endangers vulnerable people**, as the promised safeguards don't work. Advocates for assisted suicide promise the practice can be contained. But the evidence shows that the purported safeguards—waiting periods, second opinions, terminal prognosis requirements—erode rapidly after legalization.

EPPC Visiting Fellow in Bioethics Alexander Raikin has documented that Canada's so-called "medical assistance in dying" deaths increased thirteenfold between 2016 and 2022, from 1,018 to 13,241. Assisted suicide is now effectively tied for the fifth leading cause of death in Canada—a trajectory that advocates explicitly promised would never occur.[9] Raikin's landmark investigative report in *The New Atlantis*, relying on leaked documents, revealed that Ontario's euthanasia regulators tracked 428 cases of possible criminal violations in a single fiscal year and referred not one case to law enforcement.[10] Assisted suicide is sold as an exceptional last resort,

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[6] EPPC 2023 Annual Report at 10, https://media.eppc.org/2024/05/EPPC_2023_AnnualReport.pdf.

[7] Ryan Anderson, *On EPPC's 2023 And Running a Think Tank In the Battle of Ideas*, EPPC (May 31, 2024), https://eppc.org/publication/ryan-anderson-on-eppcs-2023-and-running-a-think-tank-in-the-battle-of-ideas/.

[8] Ryan T. Anderson, *Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality*, The Heritage Foundation (March 24, 2015), https://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak.

[9] Alexander Raikin, *From Exceptional to Routine: The Rise of Euthanasia in Canada*, Cardus (2024) https://www.cardus.ca/research/health/reports/from-exceptional-to-routine/.

[10] Alexander Raikin, *A Pattern of Noncompliance*, New Atlantis, Winter 2025, https://www.thenewatlantis.com/publications/compliance-problems-maid-canada-leaked-documents.

but quickly becomes a routine practice that disproportionally affects vulnerable people, those who deserve society's special solicitude.

Second, assisted suicide **corrupts the practice of medicine**. As Ryan T. Anderson has argued, allowing physicians to prescribe lethal drugs for the purpose of killing their patients "turns the tools of healing into lethal weapons" and fundamentally distorts the doctor-patient relationship.[11] This view is consistent with the American Medical Association's position, which has described physician-assisted suicide as "incompatible with a physician's role as healer."[12] EPPC Fellow Aaron Kheriaty, a licensed psychiatrist, has extended this argument through his broader scholarship on the ethics of medicine. Dr. Kheriaty has shown that legalizing and normalizing physician-assisted suicide not only undermines the physician's role as healer but also erodes conscience protections, as objecting physicians are pressured, disciplined, or even expelled from practice if they refuse to participate or refer for what is, by any honest description, the taking of a human life.[13]

Third, assisted suicide **discriminates against persons with disabilities**. A person who is eligible for assisted suicide is, by definition, terminally ill and therefore disabled within the meaning of federal anti-discrimination law. EPPC Fellow Eric Kniffin has argued that referring such a person to an assisted-suicide provider—rather than to psychiatric or psychological treatment—constitutes disability discrimination under Section 504 of the Rehabilitation Act.[14] A non-disabled person expressing suicidal ideation would receive suicide prevention services; a person with a terminal disability is instead offered a prescription for death. This double standard was the subject of a 2019 report by the bipartisan federal National Council on Disability, which found that assisted suicide laws are selectively applied "to people with disabilities based on the devaluation of their lives" and recommended that HHS take steps to stem discriminatory practices in this area.[15]

Fourth, assisted suicide **violates human dignity and equality**. Laws permitting assisted suicide single out a subgroup of people as legally eligible to be killed, in violation of the equal dignity that every human person possesses. Ryan T. Anderson has argued that assisted suicide legislation is, at its core, "about one thing: killing," and that no amount of procedural window-

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[11] Anderson, *supra* note 8.

[12] American Medical Association, *Opinion 5.7: Physician-Assisted Suicide*, Code of Medical Ethics, https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide (last visited June 1, 2026).

[13] Aaron Kheriaty, *First, Take No Stand: On Assisted Suicide, the Medical Profession Ducks Behind "Neutrality,"* The New Atlantis, Summer 2019, https://www.thenewatlantis.com/publications/first-take-no-stand; Letter from Aaron Kheriaty, M.D., to American Medical Association in Opposition to Physician-Assisted Suicide (Nov. 9, 2015), https://lozierinstitute.org/wp-content/uploads/2017/02/Kheriaty-AMA-letter-1.pdf.

[14] EPPC Scholar's Comment Regarding "Discrimination on the Basis of Disability in HHS Programs or Activities," RIN 0945-AA15, EPPC (Nov. 14, 2023), https://eppc.org/news/eppc-scholar-and-others-comment-on-hhs-proposed-rule-on-disability-rights/.

[15] National Council on Disability, Assisted Suicide Laws and Their Dangers to People with Disabilities (Oct. 9, 2019), https://web.archive.org/web/20200510182725/https://www.ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf.

dressing changes that basic reality.[16] EPPC Fellow Andrew T. Walker has further argued that assisted suicide is "the logical end-point to a global abortion culture" and represents "state-sponsored suicide" masquerading as compassion, transforming the state from a guardian of life into an arbiter of which lives are dispensable.[17]

EPPC's opposition to assisted suicide is rooted in the natural law, the history of medicine, disability rights, and the constitutional commitment to equal protection—grounds that unite a broad, bipartisan coalition that includes progressive disability advocates, civil libertarians, and traditional religious voices. EPPC comments on this Proposed Rule in that same spirit, urging CMS to use all available legal tools to help enforce Congress' clear instruction that federal taxpayer funds are never to be used to facilitate, subsidize, or normalize assisted suicide in any form.

B. The Proposed Rule properly distinguishes between assisted suicide and efforts to alleviate a terminal patient's pain.

We also support CMS's care in honoring The Assisted Suicide Funding Restriction Act of 1997's (ASFRA) careful distinction between health care services furnished "for the purpose of causing, or assisting to cause, the death of any individual" and services provided "for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death." 91 Fed. Reg. 17340. Congress explicitly prohibited federal funds from being used to provide or pay for any health care item or service "furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide." 42 U.S.C. § 14402(a)(1). Congress clarified that this restriction does not apply to "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." 42 U.S.C. § 14402(b)(4). We commend CMS for preserving and articulating this distinction.

Congress' distinction between an action whose *purpose* is to hasten death and an action whose *purpose* is to relieve suffering, even when the latter carries a foreseeable risk of an earlier death, is not a minor technical exemption. It encodes a fundamental moral distinction that has been recognized and refined across centuries of ethical thought.

The distinction traces most explicitly to the philosophical principle known as the *doctrine of double effect*, which holds that an action with both a good effect and a harmful side effect may be morally permissible when:

(1) the action itself is not intrinsically wrong;

(2) the harmful effect is not what is intended, but only foreseen and tolerated;

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[16] Ryan T. Anderson, *Maryland's End-of-Life Bill Is About One Thing: Killing*, Washington Post (Feb. 25, 2019), https://www.washingtonpost.com/opinions/2019/02/25/marylands-end-of-life-bill-is-about-one-thing-killing/.

[17] Andrew Walker, *The Suicidal Ends of Secular Compassion, Center for Baptist Leadership*, EPPC (Dec. 2, 2024), https://eppc.org/publication/the-suicidal-ends-of-secular-compassion/.

(3) the good effect is not achieved *by means of* the harmful effect; and

(4) there is a proportionate reason for permitting the foreseeable harm.[18]

In the clinical context, the paradigm case is precisely the one the regulation describes: the administration of opioids or sedatives to relieve the pain and distress of a dying patient, where escalating doses may incidentally shorten life, but where death is not the instrument or the goal of the treatment.[19]

While the principle of double effect has deep roots in the medieval natural law tradition—especially in the thought of Thomas Aquinas[20]—it has long since been adopted outside of Catholic theological circles and is now a standard framework in secular bioethics and mainstream medical ethics. The *Stanford Encyclopedia of Philosophy* describes the doctrine as among the most discussed principles in both normative ethical theory and applied ethics, invoked by philosophers working across utilitarian, Kantian, and virtue-ethics frameworks to explain widely shared moral intuitions about complicity and intention.[21] An article in the *Harvard Bioethics Journal* calls the management of end-of-life pain "the classic case for applying the rule of double effect in medicine," noting that the principle is regularly applied in palliative care consultations, hospital ethics committee reviews, and legal proceedings without reference to any religious tradition.[22] The palliative care medicine literature likewise routinely invokes double effect to justify the use of opioids in terminal patients, describing the primary aim—relief of pain or dyspnea—as proportionate to the unintended risk of decreased respiratory drive or earlier death.[23]

This intent-based distinction is also grounded in constitutional law. In *Washington v. Glucksberg*, 521 U.S. 702 (1997), a unanimous Supreme Court rejected the argument that there is a constitutional right to assisted suicide. Justice O'Connor noted in her concurring opinion that all parties agreed that prohibitions on assisted suicide do not prohibit patients "suffering from a terminal illness and … experiencing great pain [from] obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death." *Id*. at 736–37 (O'Connor, J., concurring). *See also Vacco v. Quill*, 521 U.S.

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[18] Daniel P. Sulmasy, *"Reinventing" the Rule of Double Effect*, in *The Oxford Handbook of Bioethics* 116 (Bonnie Steinbock ed., 2007), https://doi.org/10.1093/oxfordhb/9780199562411.003.0006.

[19] Mary Katherine Brueck & Daniel P. Sulmasy, *The Rule of Double Effect: A Tool for Moral Deliberation in Practice and Policy*, Harv. Bioethics, https://bioethics.hms.harvard.edu/journal/rule-double-effect.

[20] Alison McIntyre, *Doctrine of Double Effect*, Stanford Encyclopedia of Philosophy (Edward N. Zalta & Uri Nodelman eds., Summer 2023 ed.), https://plato.stanford.edu/archives/sum2023/entries/double-effect/ ("Thomas Aquinas is credited with introducing the principle of double effect in his discussion of the permissibility of self-defense in the *Summa Theologica* (II-II, Qu. 64, Art.7). Killing one's assailant is justified, he argues, provided one does not intend to kill him.).

[21] *Id*.

[22] Mary Katherine Brueck & Daniel Sulmasy, *The Rule of Double Effect*, HMS Bioethics J. (Jan. 1, 2020), https://bioethics.hms.harvard.edu/journal/rule-double-effect.

[23] Travis Rinderle & James Willett, *Bioethical Distinctions of End-of-Life Care Practices*, 24 J. Palliative Med. 1400 (2022), https://doi.org/10.1089/jpm.2021.0320.

793, 807 n.11 (a state "may prohibit assisting suicide while permitting … palliative care … which may have the foreseen but unintended 'double effect' of hastening the patient's death").

This same principle is articulated in the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs), the authoritative moral and ethical guidelines that govern the delivery of health care in Catholic institutions across the United States.[24] The ERDs are issued by the United States Conference of Catholic Bishops (USCCB) and are adopted as binding policy by Catholic hospitals, hospices, nursing homes, and other health care facilities operating under Catholic auspices—a network that comprises roughly one in six hospital beds in the country.[25] Directive 63 of the ERDs states: "Medicines directed toward alleviating or suppressing pain and other symptoms may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the dose is therapeutic and the intent is not to hasten death."[26] Honoring the principle of double effect thus also honors religious liberty.

As discussed further below, published statements by assisted-suicide clinicians and professional organizations suggest that some providers are actively seeking to obscure that boundary by billing assisted suicide-related consultations as ordinary palliative care or advance care planning, because no CPT code exists for assisted suicide. That is not a legitimate application of the double-effect carve-out. We encourage CMS to do everything in its power to stop efforts to undermine this important principle of medical ethics.

C. CMS should reject the suicide industry's preferred euphemism and stick to the term Congress chose: assisted suicide.

The Proposed Rule uses the term "medical aid in dying" (MAID) as a shorthand for the practice at issue: assisted suicide. We urge the Administration to discontinue this usage and to employ instead the better term "assisted suicide" in the final rule.

Words matter in law and in policy. Terminology is particularly critical when advocacy groups strategically deploy euphemisms to obscure what is actually happening. Good public policy is grounded in reality.

HHS has already demonstrated that it understands this dynamic. When EPPC scholars urged HHS to replace "gender-affirming care" with "sex-rejecting procedures,"[27] HHS recognized (including in other CMS proposed rules) that accepting an advocate-generated

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[24] U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (7th ed. 2025), https://www.usccb.org/resources/ERDs-7th-ed-Approved_2025-11-12.pdf.

[25] *See* U.S. Conference of Catholic Bishops, *Catholic Health Care, Social Services and Humanitarian Aid*, https://www.usccb.org/offices/public-affairs/catholic-health-care-social-services-and-humanitarian-aid.

[26] ERDs dir. 63 (7th ed. 2025).

[27] *See, e.g.*, EPPC Comment, EO 12866 Meeting, "Medicare and Medicaid Programs; Hospital Condition of Participation: Limiting Participation Based on the Performance of Sex Trait Modification Procedures on Children," RIN 0938-AV87, and "Medicaid Program; Prohibition on Federal Medicaid Funding for Sex Trait Modification Procedures Furnished to Children and Youth (CMS-2451)," RIN 0938-AV73 (Aug. 28, 2025), https://eppc.org/wp-content/uploads/2025/08/EPPC-Comment-for-EO-12866-Meeting-on-CMS-Proposed-Rules.pdf; Eric Kniffin, Mary Hasson, & Rachel N. Morrison, Terminology and Definition: Replacing "Gender-Affirming Care" with "Sex-Rejecting Procedures", EPPC (May 2, 2025), https://eppc.org/replacement-term-for-gac/.

euphemism amounts to conceding the normative debate before it begins.[28] The same principle applies here with equal force. Using "MAID" in federal regulation is not neutral. It adopts, at taxpayer expense, the messaging strategy of the organizations most aggressively working to expand a practice that Congress has consistently opposed. **EPPC therefore urges CMS to use "assisted suicide" throughout any final rule, guidance, or related materials addressing this subject.**

1. Federal law directly addresses "assisted suicide."

The most important reason why CMS should use "assisted suicide" and not "MAID" in the final rule is that only the former—and not the latter—appears in federal law. The Assisted Suicide Funding Restriction Act of 1997 (ASFRA) prohibits federal funds from being used to provide or pay for any "assisted suicide, euthanasia, or mercy killing." 42 U.S.C. § 14402(a)(1). Section 1553 of the Affordable Care Act likewise prohibits the federal government, any state government, and any health care provider that receives federal financial assistance from discriminating against an individual or health care entity for refusing to provide "assisted suicide, euthanasia, or mercy killing." 42 U.S.C. § 18113(a). CMS's own codified exclusion at 42 C.F.R. § 411.15(q) applies to "assisted suicide."

Using a new term would not merely be inconsistent; it risks confusion about the scope of the very prohibitions the Administration is now seeking to enforce. A regulation that uses "MAID" to describe what ASFRA calls "assisted suicide" may inadvertently suggest that "MAID" encompasses something different, or something broader, than what Congress addressed in ASFRA. CMS should avoid this confusion by using language that directly maps onto federal law.

2. MAID is a poll-tested euphemism intended to misdirect the public from the uncomfortable truth.

"*Medical assistance in dying*, or "MAID," is a poll- and focus group-tested euphemism developed through a campaign to replace accurate but politically damaging terms such as "assisted suicide" and "euthanasia" with language more congenial to public sentiment.[29] The word "suicide" is viewed as particularly harmful because it "evokes feelings of repugnance and immorality."[30]

The pro-assisted suicide movement's efforts to avoid "suicide" has much in common with the campaign to replace "abortion" with "choice" and the effort to rebrand the chemical and surgical alteration of children's bodies as "gender-affirming care." In each case, an emotionally

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[28] *See, e.g.*, Medicare and Medicaid Programs; Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children, 90 Fed. Reg. 59463 (Dec. 19, 2025); Medicaid Program: Prohibition on Federal Medicaid Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children, 90 Fed. Reg. 59441 (Dec. 19, 2025).

[29] *See* Compassion & Choices, *Medical Aid in Dying Is Not Suicide, Assisted Suicide or Euthanasia*, https://compassionandchoices.org/resource/not-assisted-suicide/ (last visited June 1, 2026).

[30] Am. Coll. of Legal Med., *ACLM Policy on Aid in Dying* (Oct. 6, 2008), https://compassionandchoices.org/wp-content/uploads/2024/04/american-college-of-legal-medicine-position-statement.pdf.

appealing euphemism is substituted for plainly descriptive language in order to make a controversial practice sound benign.

The term MAID first took hold in Canada, through a 2016 law that employs "medical aid in dying" as an umbrella term for both physician-assisted suicide and euthanasia.[31] From Canada, the terminology migrated south to the United States. Today, American advocacy groups that had once spoken of "death with dignity" or sought to normalize "physician-assisted suicide" now insist on "medical aid in dying," explicitly telling candidates, journalists, and medical associations to avoid the word "suicide."[32] A 2023 Death with Dignity retrospective candidly describes the move from "assisted suicide" to "death with dignity" and then "aid in dying" as a deliberate rebranding designed to "reposition" the issue after early political defeats.[33]

In short, MAID is not a medical term but a political euphemism created to distract people from what the practice actually entails: medical professionals using their professional credentials to help their patients commit suicide.

3. "Assisted suicide" is a more accurate term.

Even if the term "assisted suicide" had not been used by Congress, it would still be the right term for CMS to use. Government agencies, especially within public health, should avoid euphemisms that obscure meaning to the public.

"Aid in dying" is too vague to inform the public as to what the practice entails. As the Council on Ethical and Judicial Affairs for the American Medical Association concluded, "MAID is not a precise or accurate term because physicians provide compassionate aid to patients in the dying process in many ways, including palliative care, which includes comfort care and hospice."[34]

Medical professionals can do a lot more for the terminally ill than help them kill themselves. Vulnerable patients deserve to know that. Family members deserve to know that. And the public deserves to know that too.

As the AMA's Council on Ethical and Judicial Affairs found, the term 'physician-assisted suicide' describes the practice with the greatest precision. The AMA Council stressed

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[31] Dep't of Justice (Can.), *Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016)* (2016), https://www.justice.gc.ca/eng/rp-pr/other-autre/adra-amsr/p1.html.

[32] Death with Dignity, *Language Matters: The Evolution of How We Talk About Death with Dignity* (Oct. 2023), https://deathwithdignity.org/news/2023/10/language-matters-the-evolution/; see also Compassion & Choices, *Medical Aid in Dying Is Not Suicide, Assisted Suicide or Euthanasia* (Dec. 23, 2024), https://compassionandchoices.org/wp-content/uploads/2018/07/fact-sheet-not-suicide-12-23-24.pdf.

[33] Death with Dignity, *Language Matters: The Evolution of How We Talk About Death with Dignity* (Oct. 2023), https://deathwithdignity.org/news/2023/10/language-matters-the-evolution/; Stephanie O'Neill, *'Assisted Suicide' or 'Aid in Dying?' The Semantic Battle over SB 128*, LAist (June 4, 2015), https://laist.com/news/kpcc-archive/assisted-suicide-or-aid-in-dying-the-semantic-batt.

[34] Council on Ethical & Judicial Affs., Am. Med. Ass'n, Reconsidering the Terminology to Describe Physician-Assisted Suicide, CEJA Rep. 3-A-25 (Mar. 28, 2023), https://councilreports.ama-assn.org/councilreports/downloadreport?uri=%2Fcouncilreports%2FA_25_ceja_report_3.pdf.

that assisted suicide "intentionally causes the patient's death, making it ethically distinct from widely accepted standard forms of palliative care that accept but never intentionally hasten death." The AMA thus continues to use "physician-assisted suicide" as its official terminology in both its House of Delegates policies and Code opinions.

A more accurate term for the intentional self-ingestion of a lethal substance in general terms is suicide. This wording is neither provocative nor radical. CMS itself described assisted suicide as recently as January 2025 as "suicide accomplished with the aid of a physician."

II. Federal law supports CMS's requests for information about assisted suicide.

While seeking to curtail assisted suicide is the right thing to do, CMS's request for information to help it better enforce the Assisted Suicide Funding Restriction Act of 1997 is also well grounded in federal law. Federal restrictions on assisted suicide are clearly established and there are good reasons to believe that assisted suicide is practiced in a manner that violates the civil rights of disabled persons.

A. Federal restrictions on assisted suicide are clearly established.

For nearly three decades—before any American had died through a state-sanctioned assisted suicide program—federal law has been clear: no federal funds can be used either directly or indirectly in connection with assisted suicide. Even without ASFRA, CMS[35] and the Health Care Financing Administration[36] have determined that funding a patient's suicide is prohibited by § 1862(a)(1)(A) of the Social Security Act because suicide is neither an item nor a service "reasonable and necessary for the diagnosis or treatment of illness or injury." The Proposed Rule is therefore right to stress its "expectation that hospice providers and staff are adhering" to this aspect of "Federal law,"[37] especially as these restrictions are so clear and well-established.

ASFRA articulates five main restrictions on federal funds and programs within healthcare. These comprise:

1. Prohibiting federal funds to provide any health care item or service for assisted suicide. Congress intended for this prohibition to include every activity relevant to providing assisted suicide, including "the provision of any assistance to obtain the means of death … the aid of a person or institution (such as physician or hospital), or

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[35] CMS, Assisted Suicide Funding Restriction Act of 1997 (P.L. 105-12), MLN Matters No. SE20014 (Jan. 5, 2021), https://www.cms.gov/files/document/se20014.pdf.

[36] *See* H.R. Rep. No. 105-46 (1997) (on the Assisted Suicide Funding Restriction Act of 1997) ("The Health Care Financing Administration (HCFA) has taken the position that: [T]he Medicare statute limits Medicare coverage to items and services that 'are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.' Physician assisted suicide, even if allowed under State law, does not meet these statutory criteria. As such, the program is prohibited from making payment for it." (alteration in original) (citing Letter from Debbie Chang, Director, Office of Legislative & Intergovernmental Affairs, Health Care Financing Administration (May 1, 1996))).

[37] CMS, "Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements," 91 Fed. Reg. 17,338 (Apr. 6, 2026), https://www.federalregister.gov/d/2026-06604.

the means to finance such a practice." It also intended to include the service of a "prescription for medication" as well as the medication itself. (§ 14402(a)(1))

2. Prohibiting federal funds to pay for any health care item or service for assisted suicide. This would include direct payment programs like Medicaid. (§ 14402(a)(2))

3. Prohibiting federal funds to pay for any health benefit coverage related to assisted suicide. (§ 14402(a)(3)) For state Medicaid, which is subsidized by the federal government, the state program must use exclusively state or private funds for procuring assisted suicide.

4. Restricting any healthcare items and services furnished by a facility owned or operated by the federal government to be used for assisted suicide. Notably, this would involve any healthcare facility directly administered by the federal government, including for instance veterans' homes and the Public Health Service, which includes the Indian Health Service. (§ 14402(c)(1))

5. Restricting any federal employees from providing any services for assisted suicide during the normal course of their employment. (§ 14402(c)(2)) Federal employees are free to participate in assisted suicide, as long as it is not during their employment.

These restrictions on federal funds and programs are **widely known**.

At the federal level, CMS's Medicare Provider Reimbursement Manual states repeatedly in *red italic print* that "*Items and services under ASFRA 1997"* are "nonreimbursable" and requires that such costs be reported on a separate line.[38]

The same is true at the state level. Most states that legalized assisted suicide clearly instruct physicians and hospices on the limits of ASFRA, and that this prohibition includes every aspect of assisting a suicide. For example, **New Mexico's** guidance to healthcare clinicians and pharmacists emphasizes that from MAID assessments to the lethal prescription, "MAID Claims are *not* billed to Medicare, Managed Care Organizations, or commercial health plans."[39] **California** similarly advises assisted suicide clinicians that "Medicare does not provide coverage for aid-in-dying drugs or for medical services related to prescribing of these drugs."[40] **Oregon's** Medicaid program exclusively covers "death with dignity" through state funds "except for those facilities limited by [ASFRA]."[41] **Hawaii** likewise clarifies that "federal law prohibits all health insurers … from paying for medical aid-in-dying services or medications with funds from the

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[38] CMS, Provider Reimbursement Manual, pt. 2, ch. 43, CMS Pub. No. 15-2, Transmittal 5 (Feb. 25, 2022) https://www.cms.gov/files/document/r5p243i.pdf.

[39] N.M. Hum. Servs. Dep't, Med. Assistance Div., Enacting the End-of-Life Options Act, Medical Aid in Dying Billing and Guidance, Supp. No. 23-11, at 4 (Nov. 6, 2023), https://www.hsd.state.nm.us/wp-content/uploads/SUPPLEMENT-23-11-Medical-Aid-in-Dying-MAID-1.pdf.

[40] Cal. Dep't of Health Care Servs., End of Life Option Act Services, Medi-Cal Provider Manual pt. 2, at 9 (rev. Aug. 2020), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/3AB29106-6C52-405A-973F-62DF9FFEEDC0/eloa.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[41] Or. Admin. R. 410-142-0380 (2024), https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=234122.

federal government," and its "Hawaii Medicaid program will cover the medications of Medicaid recipient … under our Fee-For-Service program utilizing 100% State funds."[42]

Likewise, advocates for assisted suicide, like **Death with Dignity**, instruct the public that "Federal funding, including Medicaid and Medicare, cannot be used for services or medications received under these laws." [43] **Compassion & Choices** also states that "Medical aid in dying services are not reimbursable through Medicare or the federal component of Medicaid."[44] **The Academy of Aid-in-Dying Medicine**, "the leading national organization that advances, teaches, and supports clinicians" involved with assisted suicide, emphasized in 2020 in its official telehealth policy for assisted suicide that it has the "full understanding that Medicare does not participate in aid-in-dying evaluations, care, or billing."[45]

B. Federal civil rights laws prohibit implementing assisted suicide in a manner that discriminates against people with disabilities.

In 2023, HHS issued a proposed rule, "Discrimination on the Basis of Disability in Health and Human Service Programs or Activities," RIN 0945-AA15.[46] In response, EPPC scholar Eric Kniffin submitted a public comment that thanked HHS for its efforts to help clarify Section 504's prohibition on discrimination on the basis of disability in the healthcare context. Section III of Kniffin's comment urged HHS to do more to apply the same conviction and clarity to its efforts to protect persons with disabilities from assisted suicide.[47]

Though proponents of assisted suicide promise that "strict procedures" will be put in place to ensure that assisted suicide would only be available to a very small population of people, there is much evidence that this is not what happens in practice. [48] The procedures appear to be particularly vulnerable when it comes to patients with disabilities. This concern has been the subject of litigation alleging that assisted suicide in practice discriminates against disabled persons in violation of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and the equal protection and substantive due process clauses of the 14th Amendment of the U.S. Constitution. One disability rights advocacy group summarizes the argument:

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[42] Haw. Med. Serv. Ass'n, *Our Care, Our Choice Act*, HMSA Provider Resource Center, https://prc.hmsa.com/s/article/Our-Care-Our-Choice-Act-prc (last visited June 1, 2026).

[43] Death with Dignity, *Frequently Asked Questions* (last visited June 1, 2026), https://deathwithdignity.org/resources/faqs/.

[44] Written Evidence Submitted to the Health & Social Care Committee, Assisted Dying/Assisted Suicide Inquiry, at 2 (2023), https://committees.parliament.uk/publications/40744/documents/198495/default/.

[45] Am. Clinicians Acad. on Med. Aid in Dying, *Telemedicine Policy Statement* (Mar. 25, 2020), https://www.aadm.org/wp-content/uploads/2024/12/Telemedicine-Policy-Recommendations.pdf.

[46] 88 Fed. Reg. 63392 (Sept. 14, 2023).

[47] EPPC Scholar's Comment Regarding "Discrimination on the Basis of Disability in HHS Programs or Activities," RIN 0945-AA15, EPPC (Nov. 14, 2023), https://eppc.org/news/eppc-scholar-and-others-comment-on-hhs-proposed-rule-on-disability-rights/.

[48] *Id*. at 8 (citing 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).

> **In [states that have legalized assisted suicide], there is a two-tiered system of law and medicine**, where a medical professional would be subject to civil and professional liability if they did not provide non-disabled people or people with non-life-threatening disabilities suicide prevention, according to the standard of care, if those people expressed a desire to harm or kill themselves in a medical setting. If those same professionals actually helped the person kill themselves by providing the means, i.e., a prescription for a lethal dose of drugs, **that medical professional would also be criminally liable under manslaughter statutes for helping another person die by suicide.**
>
> People with life-threatening disabilities, however, are not afforded the same criminal, civil, and professional liability protections as everyone else where assisted suicide is on the books. **When they get suicide assistance on the basis of their disability, namely the condition that is given a 6-month or less prognosis, this is treating members of a protected class in a different way than everyone else, thereby violating the anti-discrimination law that protects the civil rights and inherent equal human dignity of people with disabilities.**[49]

Researchers have also compiled substantial evidence on how physician-assisted suicide is carried out in people with intellectual disabilities and/or autism spectrum disorders. One study of 39 Dutch case reports over a decade yielded the following chilling results:

> **Factors directly associated with intellectual disability and/or ASD were the sole cause of suffering described in 21% of cases and a major contributing factor in a further 42% of cases.** Reasons for the EAS request included social isolation and loneliness (77%), lack of resilience or coping strategies (56%), lack of flexibility (rigid thinking or difficulty adapting to change) (44%) and oversensitivity to stimuli (26%). In one-third of cases, physicians noted there was 'no prospect of improvement' as ASD and intellectual disability are not treatable.[50]

As these sources show, individuals with disabilities are often pressured and coerced into preemptively ending their lives to avoid the alleged "burden" (financial or otherwise) they pose on their family or society. Additionally, insurance companies will have perverse financial incentives to push assisted suicide as a cheaper alternative to continuing to cover, sometimes expensive, medical care. When physicians are involved in assisting a person's suicide, they violate their oath to "do no harm" and corrupt the medical profession from being focused on healing to that of killing. The more **individuals with disabilities are no longer part of society due to preemptive shortening of their lives, the less important folks will consider research and medical innovations to aid their quality of life.**

We urge CMS to take this evidence into account and consider whether hospices and other covered entities in jurisdictions that have legalized assisted suicide are taking adequate

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[49] End Assisted Suicide, https://endassistedsuicide.org/ (emphasis added).

[50] Irene Tuffrey-Wijne, et al, *Euthanasia and physician-assisted suicide in people with intellectual disabilities and/or autism spectrum disorders: investigation of 39 Dutch case reports* (2012-2021). BJPsych Open. 2023 May 23;9(3):e87. doi: 10.1192/bjo.2023.69 (emphasis added).

protections to ensure that the rights of Americans with disabilities are properly honored and protected.

III. There is evidence covered health care providers are violating federal restrictions on assisted suicide, and that some violations constitute fraud.

Despite Congress' clear prohibitions in ASFRA, there is considerable evidence that Federal funds are being used to pay for assisted suicide. The Proposed Rule provided several examples of prohibited acts—such as "playing a role in medical aid in dying," billing for "physician consultation services" related to assisted suicide, and "prescribing or dispensing of medications used for the purposes of causing death."[51] As shown below, there is substantial evidence that practitioners are billing the Federal government for such prohibited acts.

Federal law takes such infractions seriously. If a physician or hospice knowingly submits false claims to obtain payment for services not covered by Medicaid, such as assisted suicide, that constitutes fraud, leading to possible criminal and civil consequences.[52] As recent offenders have found, either from duping Medicaid to cover legally exempt medical procedures like cosmetic surgery[53] or non-covered hospice services,[54] "there are no awards or incentives for creativity when it comes to medical billing and tax fraud."[55]

A. There is evidence clinicians are violating ASFRA.

Recent claims by assisted suicide clinicians and their supporters indicate that federal funds have been regularly spent, and can be spent, on assisted suicide in hospices.

Consider the **American Clinicians Academy on Medical Aid in Dying ("ACAMAID"),** which runs one of the largest nationwide referral programs for assisted suicide.[56] In ACAMAID's trade journal on the practice of assisted suicide in the United States,

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[51] CMS, "Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements," 91 Fed. Reg. 17,338 (Apr. 6, 2026), https://www.federalregister.gov/d/2026-06604.

[52] These include 18 U.S.C. § 287 and the False Claims Act.

[53] Press Release, U.S. Att'y's Office for the Cent. Dist. of Cal., *Three Indicted in Insurance Fraud Scheme Involving More Than $50 Million Worth of Unneeded Medical Procedures* (July 16, 2014), https://www.justice.gov/usao-cdca/pr/three-indicted-insurance-fraud-scheme-involving-more-50-million-worth-unneeded-medical.

[54] Press Release, U.S. Att'y's Office for the Dist. of Utah, *Summit Hospice to Pay Over $1M to Settle False Claims Liability* (Mar. 3, 2023), https://www.justice.gov/usao-ut/pr/summit-hospice-pay-over-1m-settle-false-claims-liability.

[55] Press Release, U.S. Att'y's Office for the Cent. Dist. of Cal., *Coachella Valley Doctor Pleads Guilty in Multi-Million Dollar Scheme That Duped Insurance Companies Into Paying for Cosmetic Surgeries* (Mar. 18, 2016), https://www.justice.gov/usao-cdca/pr/coachella-valley-doctor-pleads-guilty-multi-million-dollar-scheme-duped-insurance.

[56] On November 24, 2025, the ACAMAID boasted that it had led to "1,458 referrals" for its physician-patient referral program "and a 100% success rate of connecting patients to aid-in-dying care." Posting to ACAMAID Google Group (Nov. 24, 2025), https://groups.google.com/g/acamaid/c/UOLX3daCGec/m/l0ZiycvpAgAJ.

[57]its "outside counsel" [58] claim there is "anecdotal evidence … [that] some hospice providers allow employed practitioners to prescribe and support ingestion with full hospice staff cooperation" while receiving per diem federal funds, only excluding federal funds for the purchase of the lethal medication itself.[59] Likewise, a "legal analysis" published by End of Life Washington, the leading pro-assisted suicide lobby in Washington State, claims that "MAID is permitted in federally supported facilities," including "hospices receiving federal funding."[60]

Both practices are prohibited by federal law as interpreted in the Proposed Rule, which states that "Federal funds cannot be used for prohibited activities, even in the context of a per diem payment. For example, hospices are prohibited from playing a role in [assisted suicide] where such practices have been legalized in the United States."[61]

Federal law is clear enough that assisted suicide advocates caution that hospices need to be secretive. ACAMAID's Director of Nursing Education, Thalia DeWolf, admitted as much in ACAMAID's trade journal:

> Several hospices in multiple states provide complete aid-in-dying services, including attending/prescribing clinicians and nurses who are fully involved in the assisted dying process. Unsurprisingly, these hospices are reluctant to publicly discuss how they do or do not bill Medicare for such services. **But in private conversations with the authors, they state that their aid-in-dying time so tightly overlaps with simultaneous palliative care of end-of-life symptoms that it is reasonable to bill Medicare for the entire days of attention.[62]**

This is a dubious practice that warrants immediate attention from CMS. Institutions that receive federal funds need to be open about how they receive federal funds. Nor is it appropriate to bill Medicare for assisted suicide related services based on the strategy that near-simultaneous palliative care is being provided—an assertion that is unlikely based on the healthcare services required for assisted suicide, as described above. The American Academy of Hospice and Palliative Medicine states that "the ending of suffering by ending life has been held as distinct from palliative care, which relieves suffering without intentionally hastening death."[63] Moreover,

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[57] *Journal of Aid-in-Dying Medicine*, Acad. of Aid-in-Dying Med., https://www.aadm.org/journal.

[58] Acad. of Aid-in-Dying Med., *Hospice Legal and Policy Frequently Asked Questions,* https://www.aadm.org/courses/general-hospice-legal-and-policy-faq (last visited June 1, 2026).

[59] *Journal of Aid-in-Dying Medicine*, Issue 1, at 13 (Dec. 2023), https://heyzine.com/flip-book/85e7517535.html#page/25.

[60] End of Life Washington, Legal Analysis By End of Life Washington on the Right of Residents of Long-Term Care Facilities to Ingest Prescribed Medical Aid in Dying Medications Without Interference by their Facilities, https://endoflifewa.org/wp-content/uploads/2026/03/Right-of-Residents-of-Long-Term-Care-Facilities-2.pdf (last updated Mar. 23, 2026).

[61] 91 Fed. Reg. at 17,340.

[62] Richard Width & Thalia DeWolf, *Hospice Policies on Medical Aid in Dying: Current Practices and Recent Progress*, 1 J. Aid-in-Dying Med. 40, 45 (Dec. 2023), https://heyzine.com/flip-book/85e7517535.html - page/55 (emphasis added).

[63] AAHPM, *Physician-Assisted Dying*, https://aahpm.org/advocacy/where-we-stand/pad/ (position statement approved in 2007 and has not been updated since).

there is a separate possible issue of double billing fraud: many state Medicaid services cover assisted suicide. To charge federal Medicaid for a prohibited service that state Medicaid has also covered would be an example of double billing.

The notion that hospice staff may be fully participating in a prohibited activity while receiving federal funding is concerning. It is even more concerning when this term is defined as all services related with assisted suicide. This is significant, as there is a considerable range of services or procedures that may be associated with assisted suicide. Although details vary from state to state, the services and materials required for administering a suicide by a physician or a nurse practitioner in the United States can be typically divided into the following categories:

1. At least two office visits, either virtually or in-person, for oral or written requests to the attending physician for suicide. The attending physician receives oral requests for suicide; a written request; and the attending physician prescribes the lethal prescription.

2. Office visit, either virtually or in-person, with a consulting physician to confirm the diagnosis and capacity of the request.

3. Consultation with a licensed psychiatrist, licensed psychologist, or social worker in cases of questions over capacity of patient.

4. Prescription of a lethal dose of prescription drugs, including preparing the medication by a pharmacist, the act of prescribing the medication, and the active mixing of the medication prior to its ingestion. The most common prescribed cocktail is DDMAPh (diazepam, digoxin, morphine sulfate, amitriptyline, and phenobarbital); DDHAPh (diazepam, digoxin, hydromorphone, amitriptyline, and phenobarbital); and DDMA (diazepam, digoxin, morphine sulfate, and amitriptyline).

There are no specific CPT codes consistently used for billing services associated with assisted suicide nationally used, since assisted suicide is not a recognized medical procedure at the federal level, California has instituted similar CPT codes for different services required for assisted suicide.[64]

The "outside counsel" for ACAMAID, in a legal memo published in ACAMAID's journal, claimed that the Assisted Suicide Funding Restriction Act, which explicitly prohibits directly or indirectly all federal funds for assisted suicide, does **not** prohibit any "consultation, consent form collection, capacity and prognostic assessments, family bereavement preparations, nursing evaluations, and prescribing of aid-in-dying medications."[65] In other words, the authors claim the Assisted Suicide Funding Restrictions Act only prevented federal funding of assisted suicide prescription, and not any other prerequisite act, including the act of prescribing the assisted suicide medication in the first place. We are aware of no state and no state medical body

[64] *See* Cal. Dep't of Health Care Servs., End of Life Option Act Services, Medi-Cal Provider Manual pt. 2, at 9 (rev. Aug. 2020), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/3AB29106-6C52-405A-973F-62DF9FFEEDC0/eloa.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[65] Kevin Malone & William Walters, *Assisted Suicide Funding Restriction Act: A Pathway to Compliance for Hospices*, 1 J. Aid-in-Dying Med. 40, 45 (Dec. 2023), https://heyzine.com/flip-book/85e7517535.html - page/25.

that supports this aggressive interpretation of federal law. This is plainly at odds with Congress' explicit intent, and with the past and current interpretations of ASFRA, including by ACAMAID just years prior.

Yet the ACAMAID now supports these conclusions, even as far as advising federally funded hospice workers there is no limit on their involvement in assisted suicide, including up to actively mixing the assisted suicide medication. It currently advises hospice physicians in its FAQ that "Nothing in Medicare hospice regulations or the Assisted Suicide Funding Restriction Act requires hospices to prohibit clinical staff from assisting in preparing the aid in dying medication for a participant who utilizes medical aid in dying" and that state law protects individuals who prepare the medication from civil or criminal liability.[66] This is incorrect. ASFRA is federal law, not state law, and state liability protections are irrelevant in this context.

Moreover, the ACAMAID's rationale for the permissibility of federal funding bankrolling assisted suicide relies strongly on the perception that the federal government does not adequately monitor whether hospices are billing the federal government for assisted suicide. In an ethics consultation run by the ACAMAID that encourages full participation of federally-funded hospices in assisted suicide, a key argument is that "There are no known instances of hospice programs having Federal funds withheld because they supported patients who chose medical aid in dying. Medicare, hospices, and other entities participating in aid in dying still are reimbursed through federal funding. Some hospices allow medical staff to serve as attending and consultant physicians and will allow staff to be present for the entire process."[67]

Some MAID advocates and commentators have suggested or implied that the fact that state laws legalizing "medical aid in dying" claim that this practice "is not suicide, assisted suicide, or euthanasia" might insulate the practice from federal restrictions in ASFRA. Though this is specious reasoning, CMS should be aware of this theory and take it into account as it makes inquiries related to the Proposed Rule and the concerns raised in this comment. CMS should make it clear that state-level word games cannot narrow the scope of Congress's prohibition in ASFRA.

The advice published on ACAMAID's publication and website is not theoretical. For instance, consider Eden Health, a hospice in Western Montana that is funded partly by the Department of Veterans Affairs and accepts Medicaid/Medicare. Although Eden Health states on its website that "Hospice care does not hasten or postpone death,"[68] its Hospice FAQ confirms that it recognizes MAID as a type of hospice care. [69] Pamela Brown, a registered nurse writing in the Journal of Aid-in-Dying Medicine, alleged that through her involvement in the ACAMAID, "I took the current policy [at Eden Health] and amended it to include support for physicians and nurses to mix aid-in-dying medications, and to remain by the bedside if the patient and family so

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[66] Acad. of Aid-in-Dying Med., *Hospice Legal and Policy Frequently Asked Questions*, https://www.aadm.org/courses/general-hospice-legal-and-policy-faq (last visited June 1, 2026).

[67] Aid in Dying Consultation Serv., Am. Clinicians Acad. on Med. Aid in Dying, *Navigating Conflict Between Professional Nursing Commitments to Patients and Institutional "Leave the Room" Policies* (Jan. 4, 2022), https://www.aadm.org/wp-content/uploads/2024/10/Ethics-Consultation-Leave-the-Room-Policies-1-4-22.pdf.

[68] Eden Health, https://www.eden-health.com/ (last visited June 1, 2026).

[69] Eden Health, *Frequently Asked Questions*, https://www.eden-health.com/faq/ (last visited June 1, 2026).

desired."[70] Eden's amended policies allow its doctors "to provide aid-in-dying care, which include[s] evaluations and, when appropriate, prescribing aid-in-dying medications."[71] Given Eden's funding model, these policies raise a serious, concrete risk of ASFRA violations. We encourage CMS to inquire into the billing and funding practices of hospices like Eden Health that help their patients commit suicide.

B. There is evidence Medicare billing is being redirected for assisted suicide.

The ACAMAID also hosts a public forum for assisted suicide clinicians that requires users to include their full names. This forum appears to document instances of Medicare fraud.

On August 13, 2020, a profile with the name of "Ryan Spielvogel" claimed a recurring strategy for how Medicaid funding can directly fund assisted suicide services, and although he recanted the strategy, it is a strategy that nonetheless continues to be shared within the forum. Ryan Spielvogel's profile also describes him as serving on the editorial board of ACAMAID's journal, and as the Medical Director for Sutter Health's End of Life Option Act Service, which states it "is involved in advocacy to expand access to medically assisted death in jurisdictions foreign and domestic."[72] Spielvogel alleges:

> In my system, Sutter Health in Northern California, we have been thinking about billing more acutely since the conference in February, although somewhat derailed by the subsequent viral apocalypse.
>
> We are very much aware that our hands are a little tied by the Assisted Suicide Funding Restriction Act of 1997, which is federal law that prohibits the use of federal money "for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing."
>
> On the face of it, this is quite problematic. It seems aimed at hamstringing any attempts for a medical practice to engage in MAID as few are able to write off all such visits, and requiring out-of-pocket payment greatly restricts accessing MAID to the "haves" and clearly increases income-based health disparities.
>
> Our solution moving forward is to couple our MAID visits with Advance Care Planning (ACP) visits. As you probably know, Medicare reimburses ACP through CPT codes 99497 (first 30 minutes), and 99498 (next 30 minutes). ACP visits must include and document a discussion of advanced directives and who was present for the visit, but may also include discussions of end-of-life decisions and treatment choices.

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[70] Kevin Malone & William Walters, *Assisted Suicide Funding Restriction Act: A Pathway to Compliance for Hospices*, 1 J. Aid-in-Dying Med. 40, 48 (Dec. 2023), https://heyzine.com/flip-book/85e7517535.html#page/58.

[71] *Id*.

[72] Acad. of Aid-in-Dying Med., *Ryan Spielvogel, MD, MS*, https://www.aadm.org/people/ryan-spielvogel-md-ms ("As Program Director for the Sutter Health Family Medicine Residency Program in Sacramento, Davis and Amador, Ryan has been a vocal supporter of incorporating training of medical aid in dying into residency and fellowship curricula and has published on the subject in peer-reviewed journals.").

> By reframing the visits as discussions of end of life care and treatment preferences, you can honestly discuss your patient's wishes as well as document a brief capacity evaluation and their reasoning for their choice as well as their other options and can even counsel them regarding MAID. As long as you also include the advanced directive discussion, this should all be billable under ACP. ACP codes can also be used once per day and while the patient is on hospice, so this same approach can be used for the second verbal request, home visits, and patients already on hospice.
>
> We will then also include a separate encounter which will be billed as a "no level of service" where we confirm that the patient is a "qualified individual" for MAID, confirm that they have received the required counseling, and document their first verbal request.
>
> While not as streamlined as it could be (without the federal restrictions), I feel like this is at least a way that we can all still get paid for the work we do while providing the care our patients need and do so in a way that respects the federal guidelines. This approach should also work for office-based visits, telehealth visits, and visits for patients on hospice.[73]

The following day, Spielvogel clarified that "I have read the law more carefully. While I am not an expert in compliance, nor a lawyer, I have reconsidered the billing practices that I posted in my previously [sic]. I no longer believe that would be a viable option and I'm not recommending that anybody else take that approach."

It is unclear whether Sutter Health ever implemented Spielvogel's suggestions "moving forward." However, since Spielvogel's post, multiple posters on the ACAMAID's forum have continued to recommend this exact strategy: to bill Medicaid for an explicitly non-covered service by submitting paperwork that represented it as a covered service.

On July 22, 2024, a profile named "David Hoffman", a bioethics professor at Columbia University that used his Columbia University email, posted in response to a request for billing help by stating: "42 U.S.C Ch. 138: ASSISTED SUICIDE FUNDING RESTRICTION prohibits use of federal funds to bring about a patient's death. But there is no restriction on discussing a patient's end of life options as part of an advance care planning consultation. These are reimbursable under Medicare using CPT code 99497 and 99498." A profile named "Catherine Sonquist Forest," whose profile caption describes herself as the medical director of Stanford Health Care, responded "This is exactly what I needed to advise."

More recently, on July 30, 2025, a profile named "Charles Blanke," which is the same name as an Oregon physician whose focus at a clinic in the Oregon Health & Science University is on "Medical Aid in Dying,"[74] complained that,

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[73] Copies of this forum post, and all other forum posts referenced in this comment, have been preserved and are in the possession of the undersigned scholars.

[74] Oregon Health & Science University, *Providers: Charles D. Blanke, M.D., FACP, FASCO*, https://www.ohsu.edu/providers/charles-d-blanke-md-facp-fasco ("Clinical focus: End-of-life care, Medical Aid in Dying (MAID)/Death with Dignity (DWD)").

> I have had a 25% clinic cancellation rate recently. Apparently, my university billing office is calling patients before they come and warning them the fee "won't be covered". It is also demanding they pay in advance.
>
> I realize much of the problem is the typical academic's lack of knowledge about billing, but I am wondering what has changed recently. I code the visits the same way I have done since 1997 and include the same elements.
>
> It is true I put "Death with Dignity" as the Chief Complaint (also not new). **I could put the underlying illness or "palliative care visit".** Wondering if anyone has insight or advice. Thanks. (emphasis added)

Another profile, claiming to be a physician named "Mark Apfel" responded, "Medicare ACP billing code is 99497 for the 1st 30 minutes and 99498 for each additional 30 minutes. Why not just Visit for Palliative Care as your chief complaint." It appears to be the same advice as another account named "Deb" too, who alleged that this was common practice at her workplace before she retired a year ago: "I also worked for a hospital system. We used the patient's terminal illness as the CC [ed. "chief complaint"]. It was also the primary diagnosis code Along with coding for "end of life planning "(I can't remember the code but it does exist and if I remember correctly it was a timed discussion similar to ICU care - different codes depending on how much time spent)."

ACAMAID's forum is rife with comments advising practitioners to bill for MAID discussions as routine advance care planning consultations. The forums have almost no critical or opposing commentary.

On April 8, 2026, a profile claiming to be "Jess Kaan", the Medical Director of End of Life Washington State,[75] stated "Yes, the same legal argument about ASFRA would apply to FQHCs. [ed: "federally qualified health centers"] I usually recommend that any time spend explicitly discussing MAiD during visits be noted (i.e. "X minutes spent discussing medical aid in dying, and this time was not included in the time that was billed") as an extra precaution **but providers can still bill for those visits since a discussion about MAID is also a goals of care and symptom management discussion (or should be)** [emphasis added]." In other words, it appears the Medical Director of End of Life Washington State is encouraging practitioners to seek federal funds for visits that discuss assisted suicide based on her claim that such discussions can be framed as a form of "advance care planning."

Using "advance care planning" ("ACP") billing codes for conversations about assisted suicide[76] is directly contrary to CMS guidance, which defines "advance care planning" as a

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[75] The public comment by "Jess Kaan" did not disclose that Jess Kaan serves as the Medical Director for End of Life Washington State.

[76] The CPT billing codes for advance care planning—codes 99497 and 99498—cannot plausibly cover conversation about assisted suicide. The Billing Code Description for each is as follows:

- **99497:** Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

discussion between a medical clinician and a patient for advanced directives, "to discuss the patient's health care wishes if they become *unable to make their own medical decisions* [italics added]."[77] No state permits advance directives for assisted suicide, as no state accepts applications for assisted suicide when patients are unable to make their own decisions. CMS guidance is also clear that advance care planning meetings must be documented and cannot be combined with other discussions: "Discuss ACP issues during the time you're billing for ACP services. Don't discuss any other active management of a patient's issues for the time reported when you bill ACP codes."[78]

C. There is evidence Federally Administered Facilities are violating ASFRA.

ASFRA explicitly precludes any employee of the Federal government from assisting in assisted suicide as part of their regular employment and bans participation of the health care facility owned or operated by the Federal government.[79] But some state governments have advised federally funded institutions that they can participate in assisted suicide.

- **California** has published billing instructions for assisted suicide procedures for Federally Qualified Health Centers, Rural Health Clinics, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics, the last of which is explicitly precluded as part of ASFRA.[80]

- **Washington** is the only state with "a policy that allows veterans to remain in government-run residences if they intend to ingest lethal medications"; other assisted suicide jurisdictions—including California, Oregon, Colorado, and Vermont—forbid this practice.[81]

We have also found that ACAMAID hosts contradictory advice as to whether federally-funded institutions can proactively counsel patients about assisted suicide. ACAMAID's hospice FAQ states, "There is nothing in federal law or in the statutory frameworks governing medical aid in dying (MAID) that prohibits bedside hospice staff from providing truthful, non-directive information ***when patients express interest*** in controlling when their life ends using indirect or

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- **99498:** Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

[77] CMS, MLN Fact Sheet, Advance Care Planning, MLN909289 (March 2026) at 2, https://www.cms.gov/files/document/mln-advanced-care-planning.pdf.

[78] *Id*. at 3.

[79] 42 U.S.C. § 14402(c)(1) and (2).

[80] Cal. Dep't of Health Care Servs., End of Life Option Act Services, Medi-Cal Provider Manual pt. 2 (rev. Nov. 2023), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/3AB29106-6C52-405A-973F-62DF9FFEEDC0/eloa.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[81] *Aid in Dying Not Always Option at Vet Homes*, Walla Walla Union-Bulletin (Feb. 18, 2018), https://www.union-bulletin.com/news/local/aid-in-dying-not-always-option-at-vet-homes/article_d2cec25a-1443-11e8-8a75-ab2bb3196c4f.html.

non-statutory language."[82] Yet ACAMAID's Director of Nursing Education claims that "A more careful reading of aid-in-dying laws reveals ***no language that prohibits … discussing medically assisted dying if the patient does not specifically bring it up***."[83] CMS should speak clearly to this matter and look into whether federally-funded employees are initiating conversations about assisted suicide and pressuring vulnerable patients into killing themselves.

IV. Recommendations to combat billing fraud and safeguard the use of federal funds:

A. Recommendations for Maintaining ASFRA Prohibitions for Assisted Suicide

Based on public statements, it appears that assisted suicide proponents have attempted to muddy the waters around the clear-cut prohibitions Congress created in the Assisted Suicide Funding Restriction Act. We urge CMS to take the following actions to combat this confusion.

1. **Conduct a thorough audit** of hospices to ensure they are following federal law, both ASFRA and the Social Security Act. This is especially important for all hospices that have ever indicated on line 72 of the CMS-1984-14 Hospice Cost Report that they have performed assisted suicide services on site.

2. **Remind federally-run institutions of their federal obligations** that assisted suicide is not an acceptable service in a federal building, as dictated by ASFRA.

3. **Review billing practices** for CPT codes 99497 and 99498 to ensure that public funds intended for advance care planning have not been rediverted for a non-covered service.

4. **Take enforcement actions** to ensure compliance.

5. **Issue new regulations** that explicitly bar federally funded employees from raising assisted suicide as an acceptable treatment option as part of their employment, similar to the prior prohibitions by the Department of Health and Human Services that courts upheld in *Rust v. Sullivan*, 500 U.S. 173 (1991). This is especially important given the possible practice of clinicians proactively counseling assisted suicide as a treatment option to patients who did not explicitly request it.

B. Investigation of "Quiet Euthanasia" Practices at Hospitals or Hospice Programs

Anecdotal reports from nurses and other hospital personnel suggest that a regime of "quiet euthanasia" exists in some hospitals and hospice programs, in contravention of the law and the requirements of sound medical ethics, including the principle of informed consent. At present, we do not have published research to verify these claims, but anecdotal evidence suggests that some patients receive escalating doses of morphine, well beyond what would be

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[82] Acad. of Aid-in-Dying Med., *Hospice Legal and Policy Frequently Asked Questions,* https://www.aadm.org/courses/general-hospice-legal-and-policy-faq (last visited June 1, 2026) (emphasis added).

[83] Kevin Malone & William Walters, *Assisted Suicide Funding Restriction Act: A Pathway to Compliance for Hospices*, 1 J. Aid-in-Dying Med. 40, 43 (Dec. 2023), https://heyzine.com/flip-book/85e7517535.html#page/52.

required for comfort care or adequate pain control, with the intention of hastening the patient's death. Anecdotal reports from healthcare practitioners suggest that this may be done with or without the explicit consent of the patient or, in the case of an incapacitated patient, a surrogate decision maker.

We propose that CMS **conduct the following preliminary study**, which would be associational and suggestive, but could indicate whether additional investigation is warranted. The study would investigate whether there is an above-expected statistical spike in deaths in the days/weeks immediately following an inpatient who runs out of paid Medicare days (and thus becomes a financial liability for the hospital). This study would of course be merely associational and preliminary; but if it did find a positive association, it would suggest that further investigation was warranted.

The next step would be for CMS to **conduct a retrospective case-by-case medical records study** of suspicious cases to examine morphine dosing changes, diagnoses, medical prognosis, etc. This follow-up study could potentially verify whether this practice of "occult" euthanasia was quietly occurring, and which facilities or hospice programs are most frequently implicated. Medicare claims data, linked to death certificate records, would be the ideal database to investigate, since most of the elderly patients potentially subjected to such practices will be on Medicare.

C. Recommendation for Annual Certification and Reporting Requirement

CMS should **establish an assurance of compliance requirement for annual certification**, under penalty of perjury, that federal funding was not used for prohibited purposes, including relevant information to specify how this was ensured. This new requirement would provide useful information for CMS to determine whether further rulemaking might be necessary in the future.

The certification mechanism could be a simple checkbox on a signed form for those who certify that they refuse to participate in assisted suicide or euthanasia or mercy killing and certify that they refuse to even refer a patient to another provider for such purposes.

The greater the provider's participation or willingness to participate in assisted suicide or euthanasia or mercy killing, the greater the degree of information that should be required to ensure that federal funding was not used for prohibited purposes.

Any provider of such services should be required to report both the number of patients to whom such services were provided and the revenue obtained from the provision of such services, the federal revenue obtained from the provision of all services to said patients, and the total revenue obtained from the provision of all services to said patients. Any provider of referrals for such services should also be required to report analogous corresponding data. Any provider of such services or referrals for such services should also be required to report the total number of patients (regardless of whether the patient was provided or referred for such services) for whom federal revenue was received and the total amount of federal revenue, as well as the overall total number of patients and total revenue. In combination with the earlier required data, this will enable CMS to calculate the provider's dependency on such services or referrals for such

services and the provider's dependency on federal revenue to sustain the provider's overall business. Critically, this will provide insight into whether federal revenue may be sustaining businesses that provide or refer for services that may not be paid directly with federal funds.

All providers of such services or referrals for such services should be required to explain how they ensure compliance with the prohibition on the use of federal funding for these services. A provider who ensures full physical and financial separation of these activities from those activities paid by federal funds would be viewed most favorably.

Recognizing that money is fungible, any provider without full physical and financial separation of activities related to assisted suicide or euthanasia or mercy killing from federally funded activities likely receives at least some subsidy for these activities. **CMS should consider requiring physical and financial separation of assisted suicide and Medicare-funded hospice.**[84]

CMS should also consider the extent to which Medicare-funded counseling is encouraging assisted suicide and **require that any counseling and referrals related to assisted suicide in Medicare-funded hospice be nondirective.**[85]

The proposed reporting requirements would allow CMS to ascertain the extent to which this is a cause for concern and whether additional rulemaking in this area is appropriate.

D. These recommendations align with Trump Administration priorities.

The above recommendations are consistent with efforts by the Trump Administration to combat billing fraud and enforce congressional limits on use of federal funds. Since day one, the Trump Administration sought to eliminate the pervasive waste, fraud, and abuse of taxpayer dollars.[86] The Administration, including CMS, has also taken bold actions to ensure that federal dollars do not fund other harmful, life-ending, and morally fraught medical interventions, such as sex-rejecting procedures and abortion.[87] We urge CMS to continue these efforts by likewise taking bold actions to ensure federal funds do not support assisted suicide.

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[84] *Cf.* HHS, Compliance with Statutory Program Integrity Requirements, 84 Fed. Reg. 7714 (Mar. 4, 2019), https://www.federalregister.gov/d/2019-03461 (requiring Title X projects to physically and financially separate their abortion services from federally funded family planning services).

[85] *Cf. id.* (imposing nondirective counseling and referral requirements for abortion in federally funded Title X projects).

[86] *See, e.g.*, *Establishing and Implementing the President's "Department of Government Efficiency"*, White House (Jan. 20, 2025), https://www.whitehouse.gov/presidential-actions/2025/01/establishing-and-implementing-the-presidents-department-of-government-efficiency/; *Establishing the Task Force to Eliminate Fraud*, White House (Mar. 16, 2026), https://www.whitehouse.gov/presidential-actions/2026/03/establishing-the-task-force-to-eliminate-fraud/; *Eliminating Waste, Fraud, and Abuse in Medicaid*, White House (June 6, 2025), https://www.whitehouse.gov/presidential-actions/2025/06/eliminating-waste-fraud-and-abuse-in-medicaid/; *Trump Administration's Full-Scale War on Fraud*, White House (May 26, 2026), https://www.whitehouse.gov/releases/2026/05/trump-administrations-full-scale-war-on-fraud/.

[87] *See, e.g.*, Exec. Order 14187, Protecting Children From Chemical and Surgical Mutilation, 90 Fed. Reg. 8771 (Jan. 28, 2025), https://www.federalregister.gov/d/2025-02194; Exec. Order 14187, Protecting Children From Chemical and Surgical Mutilation, 90 Fed. Reg. 8771 (Jan. 28, 2025), https://www.federalregister.gov/d/2025-

Conclusion

Thank you for the opportunity to provide public comment and your efforts to enforce federal limits related to assisted suicide.

Sincerely,

Eric Kniffin, J.D.
Fellow
Administrative State Accountability Project
Ethics & Public Policy Center

Rachel N. Morrison, J.D.
Fellow and Director
Administrative State Accountability Project
Ethics & Public Policy Center

Alexander Raikin
Visiting Fellow
Bioethics, Technology, and Human Flourishing Program
Ethics & Public Policy Center

Aaron Kheriaty, M.D.
Fellow and Director
Bioethics, Technology, and Human Flourishing Program
Ethics & Public Policy Center

Jamie Bryan Hall
Fellow and Director of Data Analysis
Life and Family Initiative
Ethics & Public Policy Center

02194; Exec. Order 14182, Enforcing the Hyde Amendment, 90 Fed. Reg. 8751 (Jan. 24, 2025), https://www.federalregister.gov/d/2025-02175; Medicare and Medicaid Programs; Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children, 90 Fed. Reg. 59463 (Dec. 19, 2025); Medicaid Program: Prohibition on Federal Medicaid Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children, 90 Fed. Reg. 59441 (Dec. 19, 2025).