114TH CONGRESS
1ST SESSION

S. _____

To amend title XVIII of the Social Security Act to provide for advanced illness care coordination services for Medicare beneficiaries, and for other purposes.

IN THE SENATE OF THE UNITED STATES

_____

_____ introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to provide for advanced illness care coordination services for Medicare beneficiaries, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Care Planning Act of 2015''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The population of the United States is estimated to age rapidly, with the number of people over the age of 65 set to double to more than 72,000,000, or 1 in 5 Americans, over the next two decades.

(2) Americans today are living longer and healthier lives than ever before in the history of the United States yet are also facing increased incidence of multiple serious conditions as aging progresses.

(3) Americans with advanced illness face a complicated and fragmented system of care delivery that puts them at risk for repeat hospitalizations, adverse drug reactions, and conflicting medical advice that may be overwhelming to individuals and families.

(4) The progression of advanced illness leads to the need for increasingly intensive decision support, health care services, and support from caregivers.

(5) The complexity of care needed by individuals with advanced illness may result in uncoordi-

nated care, adverse health outcomes, frustration, wasted time, and undue emotional burdens on individuals and their caregivers.

(6) Numerous private sector leaders, including hospitals, health systems, home health agencies, hospice programs, long-term care providers, employers, and other entities, have put in place innovative solutions to provide more comprehensive and coordinated care for Americans living with advanced illness.

(7) Hospice programs, as one of the longest standing Medicare care coordination benefits that offer a comprehensive set of services via an interdisciplinary team working to provide person- and family-centered care to the frailest and most vulnerable individuals in our communities, can serve as a model for advanced illness care delivery.

(8) Palliative care programs that serve patients beginning at diagnosis with advanced illness and provide care designed to reduce the symptom burden of illness can serve as a model for interdisciplinary team care planning based on the individual's goals of care.

(9) The Government of the United States, as the Nation's largest purchaser of health care services, must learn from these innovators and encour-

age health care providers to furnish more supportive and comprehensive advanced illness care to improve the efficacy and quality of health care delivered for generations of Americans to come.

(10) Health care providers who serve individuals with advanced illness face complicated care systems and legal concerns that may result in over- or under-treatment of individuals with advanced illness.

(11) Individuals have the well-established right to accept or reject medical treatment that is offered, as well as the well-established right to document their preferences for how treatment decisions should be made if, at some point in the future, they lose the ability to make health care decisions.

(12) Too often, individuals with advanced illness do not understand the conditions they are facing or their treatment options, and they do not receive the information or support they need to evaluate treatment options in light of their personal goals and values and to document treatment plans in a manner that allows providers and facilities to follow their plans.

(13) Providing quality services and planning support to individuals with advanced illness will protect and preserve their dignity.

SEC. 3. IMPROVEMENT OF ADVANCED ILLNESS PLANNING AND COORDINATION.

(a) MEDICARE COVERAGE OF PLANNING SERVICES.—

(1) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (EE), by striking ''and'' at the end;

(B) in subparagraph (FF), by inserting ''and'' at the end; and

(C) by inserting after subparagraph (FF) the following new paragraph:

''(GG) planning services (as defined in subsection (iii));''.

(2) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Planning Services

''(iii)(1)(A) The term 'planning services' means a voluntary decisionmaking process that includes the elements described in paragraph (2) and is furnished to a planning services eligible individual by an applicable provider through an interdisciplinary team.

''(B)(i) Except as provided in clause (ii), planning services may only be furnished to a planning services eligible individual under this title once in each 12-month period.

''(ii) The Secretary shall establish appropriate exceptions to the frequency limitation under clause (i), such as when there is a change in the individual's medical condition.

''(2)(A) The elements described in this paragraph are the following:

''(i) One or more face-to-face encounters between one or more members of the interdisciplinary team and the individual and, at the individual's discretion, caregivers, or, for an individual who lacks decisionmaking capacity under State law, the individual's legally authorized representative.

''(ii) The provision of information about the typical trajectory of illnesses or conditions that affect the individual, including foreseeable care decisions that may need to be made at a future time when the individual is likely to be unable to make decisions due to temporary or permanent cognitive incapacity.

''(iii) Assisting the individual in defining and articulating goals of care, values, and preferences.

''(iv) Providing the individual with and discussing information about the benefits and burdens of relevant ranges of treatment options available to the individual, including disease modifying or potentially curative treatment, palliative care, which may be provided alone or in conjunction with disease modifying treatment, and, when the individual may be currently eligible or may become eligible for hospice care due to disease progression.

''(v) Assisting the individual in evaluating treatment options and approaches to care to identify those that most closely align with the individual's goals of care, values, and preferences.

''(vi) Preparing, and sharing with relevant providers, documentation—

''(I) that states the individual's goals of care, preferences, and values, preferred decisionmaking strategies, and a plan of care that is concrete and actionable; and

''(II) that is in State or locally recognized forms that are used for the purpose of assuring that providers can follow the plan across care settings, such as advance directives or portable treatment orders.

''(vii) Referrals to providers, including medical and social service providers, who deliver care consistent with the plan.

''(viii) Providing culturally and educationally appropriate training for the individual and caregivers to support their ability to carry out the plan.

''(B) Even when the individual's decisional capacity is impaired and another person or entity, such as an appointed agent, proxy, or surrogate, is exercising legal authority under State law governing decisionmaking on behalf of incapacitated individuals, the interdisciplinary team shall make a reasonable attempt to include the individual in the planning process.

''(3) For purposes of this subsection, the term 'planning services eligible individual' means an individual that meets at least one of the following criteria:

''(A) The individual is diagnosed with metastatic or locally advanced cancer.

''(B) The individual is diagnosed with Alzheimer's disease or another progressive dementia.

''(C) The individual is diagnosed with late-stage neuromuscular.

''(D) The individual is diagnosed with late-stage diabetes.

''(E) The individual is diagnosed with late-stage kidney, liver, heart, gastrointestinal, cerebrovascular, or lung disease.

''(F) The individual needs assistance with two or more activities of daily living (defined as bathing, dressing, eating, getting out of bed or a chair, mobility, and toileting) not associated with an acute or post-operative conditions that are caused by one or more serious or life threatening illnesses or frailty.

''(G) The individual meets other criteria determined appropriate by the Secretary, including criteria that are designed to identify individuals with a need for planning services due to a serious or life threatening illness or risk of decline in cognitive function over time.

''(4) For purposes of this subsection, the term 'applicable provider' means a hospice program (as defined in section 1861(dd)(2)) or other provider of services (as defined in section 1861(u)) or supplier (as defined in section 1861(d)) that—

''(A) furnishes planning services through an interdisciplinary team; and

''(B) meets such other requirements the Secretary may determine to be appropriate.

''(5)(A) For purposes of this subsection, the term 'interdisciplinary team' means a group that—

''(i) includes the personnel described in subsection (dd)(2)(B)(i);

''(ii) may include a chaplain, minister, or personal religious or spiritual advisor;

''(iii) may include other direct care personnel; and

''(iv) meets requirements that may be established by the Secretary.

''(B) An applicable provider furnishing planning services to a planning services eligible individual shall offer to the individual (or the individual's legally authorized representative when the individual has been found to lack decisional capacity) the opportunity to select either a chaplain affiliated with the provider, a minister, or personal religious or spiritual advisor who can help to represent the individual's goals, values, and preferences to serve as a core team member at the individual's (or legally authorized representative's) request.

''(C) The requirements established by the Secretary under subparagraph (A)(ii) shall include a requirement that interdisciplinary team members (except for the chosen chaplain, minister, or personal religious or spiritual advisor) have training and experience in delivering person-

directed planning services and in team-based delivery of services for individuals with dementing illness and individuals with a serious or life threatening illness.''.

(3) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(GG),'' after ''(2)(FF) (including administration of the health risk assessment),''.

(4) FREQUENCY LIMITATION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (O), by striking ''and'' at the end;

(ii) in subparagraph (P) by striking the semicolon at the end and inserting '', and''; and

(iii) by adding at the end the following new subparagraph:

''(Q) in the case of planning services (as defined in section 1861(iii)(1)), which are furnished more frequently than is covered under subparagraph (B) of such section;''; and

(B) in paragraph (7), by striking ''or (P)'' and inserting ''(P), or (Q)''.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2017.

(b) ADVANCED ILLNESS CARE COORDINATION SERVICES PROJECT.—Section 1115A(b)(2) of title XI of the Social Security Act (42 U.S.C. 1315a(b)(2)) is amended—

(1) in subparagraph (A), by adding at the end the following new sentence: ''The models selected under this subparagraph shall include the model described in subparagraph (D) and such model shall be implemented by not later than December 31, 2017.''; and

(2) by adding at the end the following new subparagraph:

''(D) ADVANCED ILLNESS CARE COORDINATION SERVICES MODEL.—

''(i) MODEL.—

''(I) IN GENERAL.—The model described in this subparagraph is a model under which payments are made to applicable providers that furnish advanced illness care coordination services to eligible individuals.

''(II) REQUIREMENT.—At least one applicable provider selected for

participation under the model shall be a hospice program (as defined in section 1861(dd)(2)).

''(ii) APPLICABLE PROVIDER.—In this subparagraph, the term 'applicable provider' has the meaning given such term in section 1861(iii)(4).

''(iii) ADVANCED ILLNESS CARE COORDINATION SERVICES.—In this subparagraph, the term 'advanced illness care coordination services' means the following services:

''(I) Planning services (as defined in section 1861(iii)).

''(II) A multi-dimensional assessment of the individual's strengths and limitations.

''(III) An assessment of the individual's formal and informal supports, including caregivers.

''(IV) Comprehensive medication review and management (including, if appropriate, counseling and self-management support).

"(V) In-home supportive services for the eligible individual and caregivers consistent with the care plan.

"(VI) 24-hour access to emergency support in person or via telephone or telemedicine with the individual's medical record and care plan available to the responder.

"(VII) Coordination across health care and social service systems, including involvement of the interdisciplinary team to evaluate quality and address concerns over time.

"(VIII) Such other services as specified by the Secretary.

"(iv) ELIGIBLE INDIVIDUAL.—In this subparagraph, the term 'eligible individual' means an individual who—

"(I) is entitled to, or enrolled for, benefits under part A of title XVIII and enrolled under part B of such title, but not enrolled under part C of such title; and

"(II) has the need for assistance with two or more activities of daily

living (defined as bathing, dressing, eating, getting out of bed or a chair, mobility, and toileting) that is not associated with an acute or post-operative condition that is caused by one or more serious or life threatening conditions or frailty.''.

SEC. 4. QUALITY MEASUREMENT DEVELOPMENT.

(a) IN GENERAL.—Section 931(c)(2) of the Public Health Service Act (42 U.S.C. 299b–31(c)(2)) is amended—

(1) by redesignating subparagraphs (I) and (J) as subparagraphs (L) and (M), respectively; and

(2) by inserting after subparagraph (H) the following new subparagraphs:

''(I) the process of eliciting and documenting patient (and, where relevant and appropriate, caregiver) goals, preferences, and values from the patient or from a legally authorized representative, including the articulation of goals that accurately reflect how the patient wants to live;

''(J) the effectiveness, patient-centeredness (and, where relevant, caregiver-centeredness), and accuracy of care plans, including docu-

mentation of individual goals, preferences, and values;

''(K) agreement and consistency among—

''(i) the patient's goals, values, and preferences;

''(ii) any documented care plan;

''(iii) the treatment delivered; and

''(iv) outcomes of treatment;''.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Health and Human Services to carry out the amendments made by this section, $5,000,000 for fiscal year 2016. Amounts appropriated under the preceding sentence shall remain available until expended.

SEC. 5. INCLUSION OF ADVANCE CARE PLANNING MATERIALS IN THE MEDICARE & YOU HANDBOOK.

(a) IN GENERAL.—Section 1804(a) of the Social Security Act (42 U.S.C. 1395b–2(a)) is amended—

(1) in paragraph (2), by striking ''and'' at the end;

(2) in paragraph (3), by striking the period at the end and inserting a semicolon; and

(3) by inserting after paragraph (3) the following new paragraphs:

''(4) information on—

''(A) care planning;

''(B) how individual goals, values, and preferences should be considered in framing a care plan; and

''(C) a range of approaches for treating advanced illness, including disease modifying options, palliative care that supports individuals from the onset of advanced illness and can be provided at the same time as all other care types, and hospice care; and

''(5) information on documentation options for care planning or advance care planning, including advance directives and portable treatment orders.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to notices distributed on or after January 1, 2017.

SEC. 6. IMPROVEMENT OF POLICIES RELATED TO THE USE AND PORTABILITY OF ADVANCE DIRECTIVES.

(a) MEDICARE.—

(1) IN GENERAL.—Section 1866(f) of the Social Security Act (42 U.S.C. 1395cc(f)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (A)(i), by striking ''State law'' and all that follows through ''medical care'' and inserting ''relevant

State and Federal law (whether statutory or as recognized by the courts) to make decisions concerning medical care'';

(ii) by striking subparagraph (B);

(iii) by redesignating subparagraphs (C), (D), and (E) as subparagraphs (G), (H), and (I), respectively;

(iv) by inserting after subparagraph (A) the following new subparagraphs:

''(B) to request and document in a prominent part of the individual's current medical record the content of (or a copy of) an advance directive or portable treatment order;

''(C) to provide each individual with the opportunity to discuss the information provided pursuant to subparagraph (A) with an appropriately trained employee or volunteer of the provider or organization;

''(D) in the case of an individual with decisional capacity under State law, to follow the individual's current treatment instructions, as expressed in writing or through verbal or non-verbal communications;

''(E) in the case of an individual who lacks decisional capacity—

''(i) to ensure that treatment decisions are made in accordance with current preferences, values, and goals of the individual, when possible to ascertain and follow, and in accordance with current advance directives and portable treatment orders that are valid under State law where the care is delivered, and instructions provided by legally authorized representatives in accordance with State and Federal law; and

''(ii) in the absence of a current advance directive or portable treatment order that is valid under State law where the care is delivered, to deliver treatment based on credible evidence of the individual's treatment preferences, goals, and values, such as a current advance directive or portable treatment order executed in another State;

''(F) that specify conditions or circumstances under which an advance directive, portable treatment order, or treatment directions from an individual or legally authorized representative would not be followed;'';

(v) in subparagraph (H), as redesignated by subparagraph (C), by striking ''State law'' and all that follows through

''respecting'' and inserting ''this section and relevant State and Federal law respecting'';

(vi) in subparagraph (I), as redesignated by subparagraph (C), by inserting ''and portable treatment orders'' before the period at the end;

(vii) in the flush matter at the end, by striking ''(C)'' and inserting ''(G)''; and

(viii) by adding at the end the following new sentence: ''Nothing in subparagraph (D) or (E) shall be construed to apply to a request or directive ordering a sterilization or ordering withdrawal of treatment from a pregnant woman if continued treatment can reasonably be expected to bring her child to live birth.'';

(B) by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively;

(C) by inserting after paragraph (2) the following new paragraph:

''(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter

of conscience cannot implement an advance directive or portable treatment order.'';

(D) in paragraph (4), as redesignated by paragraph (2)—

(i) by striking ''a written'' and inserting ''an'';

(ii) by striking ''State law'' and inserting ''State or Federal law''; and

(iii) by striking ''of the State'';

(E) by redesignating paragraph (5), as redesignated by paragraph (2), as paragraph (6);

(F) by inserting after paragraph (4) the following new paragraph:

''(5) In this subsection, the term 'portable treatment order' means a treatment order designed to document a clinical process that includes shared, informed medical decisionmaking, that reflects the individual's goals of care and values, and that is designed to apply across care settings, including the home.''; and

(G) by inserting after paragraph (6), as redesignated by paragraph (6), the following new paragraph:

''(7) Nothing in this subsection shall permit the Secretary to seek civil penalties, including exclusion from participation in the program under this title or the program

under title XIX, against an provider or organization if the provider or organization—

''(A) used reasonable efforts to deliver care that is consistent with an individual's goals, preferences, and values when addressing decisionmaking for an individual who lacks decisional capacity; or

''(B) exercised its right of conscience in accordance with paragraph (3).''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to provider agreements and contracts entered into, renewed, or extended under title XVIII of the Social Security Act on or after such date as the Secretary of Health and Human Services specifies, but in no case may such date be later than 1 year after the date of the enactment of this Act.

(3) RULE OF CONSTRUCTION.—Nothing in the provisions of, or the amendments made by, this subsection shall be construed to require a provider of services or an organization to act in a manner contrary to its religious or moral convictions.

(b) CLARIFICATION WITH RESPECT TO ADVANCE DIRECTIVES.—Paragraph (2) of section 7 of the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. 14406) is amended to read as follows:

''(2) to apply to, or to affect, any requirement with respect to a portion of an advance directive, physician treatment order, or request from an individual or their legally authorized representative, that directs the purposeful causing of, or the purposeful assisting in causing, the death of an individual, such as by assisted suicide, euthanasia, or mercy killing.''.

SEC. 7. ADDITIONAL REQUIREMENTS FOR FACILITIES.

(a) REQUIREMENTS.—

(1) IN GENERAL.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) in subparagraph (V), by striking ''and'' at the end;

(B) in subparagraph (W), as added by section 3005(1)(C) of the Patient Protection and Affordable Care Act (Public Law 111–148), by redesignating such subparagraph as subparagraph (X), moving such subparagraph to follow subparagraph (V), moving such subparagraph 2 ems to the left, and striking the period at the end and inserting a comma;

(C) in subparagraph (W), as added by section 6406(b)(3) of the Patient Protection and Affordable Care Act (Public Law 111–148), by

redesignating such subparagraph as subparagraph (Y), moving such subparagraph to follow subparagraph (X), as added by subparagraph (B), moving such subparagraph 2 ems to the left, and striking the period at the end and inserting ", and"; and

(D) by inserting after subparagraph (Y) the following new subparagraph:

"(Z) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to assure that documented care plans include any advance directives or portable treatment orders made while the individual received care by the provider and that such plan is sent to the individual's primary care provider upon discharge and any facility to which the individual is transferred.".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to agreements entered into or renewed on or after January 1, 2017.

(b) HHS STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on the extent to which hospitals, skilled nursing facilities, hospice programs, home health agencies, and applicable providers of planning services under section 1861(iii) of

the Social Security Act, as added by section 3(a), work with individuals to—

(A) engage in a care planning process;

(B) thoroughly and completely document the care planning process in the medical record;

(C) complete documents necessary to support the treatment and care plan, such as portable treatment orders and advance directives;

(D) provide services and support that is free from discrimination based on advanced age, disability status, or advanced illness; and

(E) provide documentation necessary to carry out the treatment plan to—

(i) subsequent providers or facilities; and

(ii) the individual, their legally authorized representatives, and, where appropriate and relevant, their caregiver.

(2) REPORT.—Not later than January 1, 2020, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under paragraph (1) together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

SEC. 8. GRANTS FOR INCREASING PUBLIC AWARENESS OF ADVANCE CARE PLANNING AND ADVANCED ILLNESS CARE.

(a) MATERIAL AND RESOURCES DEVELOPMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') is authorized to award grants to entities described in subsection (d) to develop online training modules, decision support tools, and instructional materials for individuals, caregivers, and health care providers that include—

(A) for healthy individuals, the importance of—

(i) identifying an individual who will make treatment decisions in the event of future cognitive incapacity;

(ii) discussing values and goals relevant to catastrophic injury or illness; and

(iii) completing an advance directive that—

(I) appoints a surrogate; and

(II) documents goals and values and other information that should be considered in making treatment decisions;

(B) for individuals with advanced illness, the importance of—

(i) articulating goals of care;

(ii) understanding prognosis and typical disease trajectory;

(iii) evaluating treatment options in light of goals of care;

(iv) developing a treatment plan; and

(v) documenting the treatment plan on advance directives, portable treatment orders, and other documentation forms used in the locality where the plan is to be executed;

(C) the role and effective use of State and other advance directive forms and portable treatment orders; and

(D) the range of services for individuals facing advanced illness, including planning services, palliative care, and hospice care.

(2) PERIOD.—Any grant awarded under paragraph (1) shall be for a period of 3 years.

(b) ESTABLISHMENT AND MAINTENANCE OF WEB- AND TELEPHONE-BASED RESOURCES.—

(1) IN GENERAL.—The Secretary is authorized to award grants to entities described in subsection

(d) to establish and maintain a website and telephone hotline to disseminate resources developed under subsection (a) and materials designed by the Department of Health and Human Services Center for Faith-Based and Neighborhood Partnerships for faith communities.

(2) PERIOD.—Any grant awarded under paragraph (1) shall be for a period of 5 years.

(3) ABILITY TO SUSTAIN ACTIVITIES.—The Secretary shall take into account the ability of an entity to sustain the activities described in paragraph (1) beyond the 5-year grant period in determining whether to award a grant under paragraph (1) to the entity.

(c) NATIONAL PUBLIC EDUCATION CAMPAIGN.—

(1) IN GENERAL.—The Secretary is authorized to award grants to entities described in subsection (d) to conduct a national public education campaign to raise public awareness of advance care planning and advanced illness care, including the availability of the resources created under subsections (a) and (b).

(2) PERIOD.—Any grant awarded under paragraph (1) shall be for a period of 5 years.

(d) ELIGIBLE ENTITIES.—Entities described in this subsection are public or private entities (including States or political subdivisions of a State, faith-based organizations, and religious educational institutions), or a consortium of any such entities.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to the Secretary—

(A) for purposes of making grants under subsection (a), $5,000,000 for fiscal year 2017, to remain available until expended;

(B) for purposes of making grants under subsection (b), $5,000,000 for fiscal year 2017, to remain available until expended; and

(C) for purposes of making grants under subsection (c), $5,000,000 for fiscal year 2017 to remain available until expended.

(2) LIMITATION.—None of the funds appropriated under paragraph (1) shall be used to—

(A) develop a model advance directive;

(B) develop or employ a dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual's disability); or

(C) make a grant to a private entity that advocates, promotes, or facilitates any item or procedure for which funding is unavailable under the Assisted Suicide Funding Restriction Act of 1997 (Public Law 105–12).

SEC. 9. RULE OF CONSTRUCTION.

Nothing in the provisions of, or the amendments made by, this Act shall be construed to limit the restrictions of, or to authorize the use of Federal funds for any service, material, or activity pertaining to an item or service or procedure for which funds are unavailable under, the Assisted Suicide Funding Restriction Act of 1997 (Public Law 105–12).