

RYAN WHITE CARE ACT AMENDMENTS OF 2000

JULY 25, 2000.—Committed to the Committee of the Whole House on the State of
the Union and ordered to be printed

Mr. BLILEY, from the Committee on Commerce,
submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 4807]

[Including cost estimate of the Congressional Budget Office]

The Committee on Commerce, to whom was referred the bill (H.R. 4807) to amend the Public Health Service Act to revise and extend programs established under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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AMENDMENT

The amendment is as follows:
 Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Ryan White CARE Act Amendments of 2000”.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

TITLE I—EMERGENCY RELIEF FOR AREAS WITH SUBSTANTIAL NEED FOR SERVICES

Subtitle A—HIV Health Services Planning Councils

- Sec. 101. Membership of councils.
- Sec. 102. Duties of councils.
- Sec. 103. Open meetings; other additional provisions.

Subtitle B—Type and Distribution of Grants

- Sec. 111. Formula grants.
- Sec. 112. Supplemental grants.

Subtitle C—Other Provisions

- Sec. 121. Use of amounts.
- Sec. 122. Application.
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TITLE II—CARE GRANT PROGRAM

Subtitle A—General Grant Provisions

- Sec. 201. Priority for women, infants, and children.
- Sec. 202. Use of grants.
- Sec. 203. Grants to establish HIV care consortia.
- Sec. 204. Provision of treatments.
- Sec. 205. State application.
- Sec. 206. Distribution of funds.
- Sec. 207. Supplemental grants for certain States.

Subtitle B—Provisions Concerning Pregnancy and Perinatal Transmission of HIV

- Sec. 211. Repeals.
- Sec. 212. Grants.
- Sec. 213. Study by Institute of Medicine.

Subtitle C—Certain Partner Notification Programs

- Sec. 221. Grants for compliant partner notification programs.

TITLE III—EARLY INTERVENTION SERVICES

Subtitle A—Formula Grants for States

- Sec. 301. Repeal of program.

Subtitle B—Categorical Grants

- Sec. 311. Preferences in making grants.
- Sec. 312. Planning and development grants.
- Sec. 313. Authorization of appropriations.

Subtitle C—General Provisions

- Sec. 321. Provision of certain counseling services.
- Sec. 322. Additional required agreements.

TITLE IV—OTHER PROGRAMS AND ACTIVITIES

Subtitle A—Certain Programs for Research, Demonstrations, or Training

- Sec. 401. Grants for coordinated services and access to research for women, infants, children, and youth.
- Sec. 402. AIDS education and training centers.

Subtitle B—General Provisions in Title XXVI

- Sec. 411. Evaluations and reports.
- Sec. 412. Data collection through Centers for Disease Control and Prevention.
- Sec. 413. Coordination.
- Sec. 414. Plan regarding release of prisoners with HIV disease.
- Sec. 415. Audits.
- Sec. 416. Administrative simplification.
- Sec. 417. Authorization of appropriations for parts A and B.

TITLE V—GENERAL PROVISIONS

- Sec. 501. Studies by Institute of Medicine.
- Sec. 502. Development of rapid HIV test.

Sec. 601. Effective date.

TITLE I—EMERGENCY RELIEF FOR AREAS WITH SUBSTANTIAL NEED FOR SERVICES

Subtitle A—HIV Health Services Planning Councils

SEC. 101. MEMBERSHIP OF COUNCILS.

(a) **IN GENERAL.**—Section 2602(b) of the Public Health Service Act (42 U.S.C. 300ff–12(b)) is amended—

(1) in paragraph (1), by striking “demographics of the epidemic in the eligible area involved,” and inserting “demographics of the population of individuals with HIV disease in the eligible area involved,”; and

(2) in paragraph (2)—

(A) in subparagraph (G), by striking “or AIDS”;

(B) in subparagraph (K), by striking “and” at the end;

(C) in subparagraph (L), by striking the period and inserting the following: “, including but not limited to providers of HIV prevention services; and”;

(D) by adding at the end the following subparagraph:

“(M) representatives of individuals who formerly were Federal, State, or local prisoners, were released from the custody of the penal system during the preceding three years, and had HIV disease as of the date on which the individuals were so released.”.

(b) **CONFLICTS OF INTERESTS.**—Section 2602(b)(5) of the Public Health Service Act (42 U.S.C. 300ff–12(b)(5)) is amended by adding at the end the following subparagraph:

“(C) **COMPOSITION OF COUNCIL.**—The following applies regarding the membership of a planning council under paragraph (1):

“(i) Not less than 33 percent of the council shall be individuals who are receiving HIV-related services pursuant to a grant under section 2601(a), are not officers, employees, or consultants to any entity that receives amounts from such a grant, and do not represent any such entity, and reflect the demographics of the population of individuals with HIV disease as determined under paragraph (4)(A). For purposes of the preceding sentence, an individual shall be considered to be receiving such services if the individual is a parent of, or a caregiver for, a minor child who is receiving such services.

“(ii) With respect to membership on the planning council, clause (i) may not be construed as having any effect on entities that receive funds from grants under any of parts B through F but do not receive funds from grants under section 2601(a), on officers or employees of such entities, or on individuals who represent such entities.”.

SEC. 102. DUTIES OF COUNCILS.

(a) **IN GENERAL.**—Section 2602(b)(4) of the Public Health Service Act (42 U.S.C. 300ff–12(b)(4)) is amended—

(1) by redesignating subparagraphs (A) through (E) as subparagraphs (C) through (G), respectively;

(2) by inserting before subparagraph (C) (as so redesignated) the following subparagraphs:

“(A) determine the size and demographics of the population of individuals with HIV disease;

“(B) determine the needs of such population, with particular attention to—

“(i) individuals with HIV disease who are not receiving HIV-related services; and

“(ii) disparities in access and services among affected subpopulations and historically underserved communities;”;

(3) in subparagraph (C) (as so redesignated), by striking clauses (i) through (iv) and inserting the following:

“(i) size and demographics of the population of individuals with HIV disease (as determined under subparagraph (A)) and the needs of such population (as determined under subparagraph (B));

“(ii) demonstrated (or probable) cost effectiveness and outcome effectiveness of proposed strategies and interventions, to the extent that data are reasonably available;

“(iii) priorities of the communities with HIV disease for whom the services are intended;

“(iv) availability of other governmental and nongovernmental resources to provide HIV-related services to individuals and families with HIV disease, including the State plan under title XIX of the Social Security Act (relating to the Medicaid program) and the program under title XXI of such Act (relating to the program for State children’s health insurance); and

“(v) capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities;”;

(4) in subparagraph (D) (as so redesignated), by amending the subparagraph to read as follows:

“(D) develop a comprehensive plan for the organization and delivery of health and support services described in section 2604 that—

“(i) includes a strategy for identifying individuals with HIV disease who are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds;

“(ii) includes a strategy to coordinate the provision of such services with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment services for such abuse; and

“(iii) is compatible with any State or local plan for the provision of services to individuals with HIV disease;”;

(5) in subparagraph (F) (as so redesignated), by striking “and” at the end;

(6) in subparagraph (G) (as so redesignated)—

(A) by striking “public meetings,” and inserting “public meetings (in accordance with paragraph (7)),”; and

(B) by striking the period and inserting “; and”; and

(7) by adding at the end the following subparagraph:

“(H) coordinate with Federal grantees that provide HIV-related services within the eligible area.”.

(b) **PROCESS FOR ESTABLISHING ALLOCATION PRIORITIES.**—Section 2602 of the Public Health Service Act (42 U.S.C. 300ff–12) is amended by adding at the end the following subsection:

“(d) **PROCESS FOR ESTABLISHING ALLOCATION PRIORITIES.**—Promptly after the date of the submission of the report required in section 501(b) of the Ryan White CARE Act Amendments of 2000 (relating to the relationship between epidemiological measures and health care for certain individuals with HIV disease), the Secretary, in consultation with entities that receive amounts from grants under section 2601(a) or 2611, shall develop epidemiologic measures—

(1) for establishing the number of individuals living with HIV disease who are not receiving HIV-related health services; and

(2) for carrying out the duties under subsection (b)(4) and section 2617(b).”.

(c) **TRAINING.**—Section 2602 of the Public Health Service Act (42 U.S.C. 300ff–12), as amended by subsection (b) of this section, is amended by adding at the end the following subsection:

“(e) **TRAINING GUIDANCE AND MATERIALS.**—The Secretary shall provide to each chief elected official receiving a grant under 2601(a) guidelines and materials for training members of the planning council under paragraph (1) regarding the duties of the council.”.

SEC. 103. OPEN MEETINGS; OTHER ADDITIONAL PROVISIONS.

Section 2602(b) of the Public Health Service Act (42 U.S.C. 300ff–12(b)) is amended—

(1) in paragraph (3), by striking subparagraph (C); and

(2) by adding at the end the following paragraph:

“(7) **PUBLIC DELIBERATIONS.**—With respect to a planning council under paragraph (1), the following applies:

“(A) The council may not be chaired solely by an employee of the grantee under section 2601(a).

“(B) In accordance with criteria established by the Secretary:

“(i) The meetings of the council shall be open to the public and shall be held only after adequate notice to the public.

“(ii) The records, reports, transcripts, minutes, agenda, or other documents which were made available to or prepared for or by the council shall be available for public inspection and copying at a single location.

“(iii) Detailed minutes of each meeting of the council shall be kept. The accuracy of all minutes shall be certified to by the chair of the council.

“(iv) This subparagraph does not apply to any disclosure of information of a personal nature that would constitute a clearly unwarranted invasion of personal privacy, including any disclosure of medical information or personnel matters.”.

Subtitle B—Type and Distribution of Grants

SEC. 111. FORMULA GRANTS.

(a) EXPEDITED DISTRIBUTION.—Section 2603(a)(2) of the Public Health Service Act (42 U.S.C. 300ff–13(a)(2)) is amended in the first sentence by striking “for each of the fiscal years 1996 through 2000” and inserting “for a fiscal year”.

(b) AMOUNT OF GRANT; ESTIMATE OF LIVING CASES.—

(1) IN GENERAL.—Section 2603(a)(3) of the Public Health Service Act (42 U.S.C. 300ff–13(a)(3)) is amended—

(A) in subparagraph (C)(i), by inserting before the semicolon the following: “, except that (subject to subparagraph (D)), for grants made pursuant to this paragraph for fiscal year 2005 and subsequent fiscal years, the cases counted for each 12-month period beginning on or after July 1, 2004, shall be cases of HIV disease (as reported to and confirmed by such Director) rather than cases of acquired immune deficiency syndrome”; and

(B) in subparagraph (C), in the matter after and below clause (ii)(X)—

(i) in the first sentence, by inserting before the period the following: “, and shall be reported to the congressional committees of jurisdiction”; and

(ii) by adding at the end the following sentence: “Updates shall as applicable take into account the counting of cases of HIV disease pursuant to clause (i).”

(2) DETERMINATION OF SECRETARY REGARDING DATA ON HIV CASES.—Section 2603(a)(3) of the Public Health Service Act (42 U.S.C. 300ff–13(a)(3)) is amended—

(A) by redesignating subparagraph (D) as subparagraph (E); and

(B) by inserting after subparagraph (C) the following subparagraph:

“(D) DETERMINATION OF SECRETARY REGARDING DATA ON HIV CASES.—

“(i) IN GENERAL.—Not later than July 1, 2004, the Secretary shall determine whether there is data on cases of HIV disease from all eligible areas (reported to and confirmed by the Director of the Centers for Disease Control and Prevention) sufficiently accurate and reliable for use for purposes of subparagraph (C)(i). In making such a determination, the Secretary shall take into consideration the findings of the study under section 501(b) of the Ryan White CARE Act Amendments of 2000 (relating to the relationship between epidemiological measures and health care for certain individuals with HIV disease), the fiscal impact of the use of such data, the impact of the use of such data on the organization and delivery of HIV-related services in eligible areas, and the fiscal impact of not using such data.

“(ii) EFFECT OF ADVERSE DETERMINATION.—If under clause (i) the Secretary determines that data on cases of HIV disease is not sufficiently accurate and reliable for use for purposes of subparagraph (C)(i), then notwithstanding such subparagraph, for any fiscal year prior to fiscal year 2007 the references in such subparagraph to cases of HIV disease do not have any legal effect.

“(iii) GRANTS AND TECHNICAL ASSISTANCE REGARDING COUNTING OF HIV CASES.—Of the amounts appropriated under section 2675 for a fiscal year, the Secretary shall reserve amounts to make grants and provide technical assistance to States and eligible areas with respect to obtaining data on cases of HIV disease to ensure that data on such cases is available from all States and eligible areas as soon as is practicable but not later than the beginning of fiscal year 2007.”.

(c) INCREASES IN GRANT.—Section 2603(a)(4) of the Public Health Service Act (42 U.S.C. 300ff–13(a)(4)) is amended to read as follows:

“(4) INCREASES IN GRANT.—

“(A) IN GENERAL.—For each fiscal year in a protection period for an eligible area, the Secretary shall increase the amount of the grant made pursuant to paragraph (2) for the area to ensure that—

“(i) for the first fiscal year in the protection period, the grant is not less than 98 percent of the amount of the grant made for the eligible area pursuant to such paragraph for the base year for the protection period;

“(ii) for any second fiscal year in such period, the grant is not less than 95.7 percent of the amount of such base year grant;

“(iii) for any third fiscal year in such period, the grant is not less than 91.1 percent of the amount of the base year grant;

“(iv) for any fourth fiscal year in such period, the grant is not less than 84.2 percent of the amount of the base year grant; and

“(v) for any fifth or subsequent fiscal year in such period, the grant is not less than 75 percent of the amount of the base year grant.

“(B) BASE YEAR; PROTECTION PERIOD.—With respect to grants made pursuant to paragraph (2) for an eligible area:

“(i) The base year for a protection period is the fiscal year preceding the trigger grant-reduction year.

“(ii) The first trigger grant-reduction year is the first fiscal year (after fiscal year 2000) for which the grant for the area is less than the grant for the area for the preceding fiscal year.

“(iii) A protection period begins with the trigger grant-reduction year and continues until the beginning of the first fiscal year for which the amount of the grant for the area equals or exceeds the amount of the grant for the base year for the period.

“(iv) Any subsequent trigger grant-reduction year is the first fiscal year, after the end of the preceding protection period, for which the amount of the grant is less than the amount of the grant for the preceding fiscal year.”.

SEC. 112. SUPPLEMENTAL GRANTS.

(a) IN GENERAL.—Section 2603(b)(2) of the Public Health Service Act (42 U.S.C. 300ff–13(b)(2)) is amended—

(1) in the heading for the paragraph, by striking “DEFINITION” and inserting “AMOUNT OF GRANT”;

(2) by redesignating subparagraphs (A) through (C) as subparagraphs (B) through (D), respectively;

(3) by inserting before subparagraph (B) (as so redesignated) the following subparagraph:

“(A) IN GENERAL.—The amount of each grant made for purposes of this subsection shall be determined by the Secretary based on a weighting of factors under paragraph (1), with severe need under subparagraph (B) of such paragraph counting one-third.”;

(4) in subparagraph (B) (as so redesignated)—

(A) in clause (ii), by striking “and” at the end;

(B) in clause (iii), by striking the period and inserting a semicolon; and

(C) by adding at the end the following clauses:

“(iv) the current prevalence of HIV disease;

“(v) an increasing need for HIV-related services, including relative rates of increase in the number of cases of HIV disease; and

“(vi) unmet need for such services, as determined under section 2602(b)(4).”;

(5) in subparagraph (C) (as so redesignated)—

(A) by striking “subparagraph (A)” each place such term appears and inserting “subparagraph (B)”;

(B) in the second sentence, by striking “2 years after the date of enactment of this paragraph” and inserting “18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000”; and

(C) by inserting after the second sentence the following sentence: “Such a mechanism shall be modified to reflect the findings of the study under section 501(b) of the Ryan White CARE Act Amendments of 2000 (relating to the relationship between epidemiological measures and health care for certain individuals with HIV disease).”; and

(6) in subparagraph (D) (as so redesignated), by striking “subparagraph (B)” and inserting “subparagraph (C)”.

(b) REQUIREMENTS FOR APPLICATION.—Section 2603(b)(1)(E) of the Public Health Service Act (42 U.S.C. 300ff–13(b)(1)(E)) is amended by inserting “youth,” after “children,”.

(c) CONFORMING AMENDMENT.—Section 2603(b) of the Public Health Service Act (42 U.S.C. 300ff–13(b)) is amended—

- (1) by striking paragraph (4); and
- (2) by redesignating paragraph (5) as paragraph (4).

Subtitle C—Other Provisions

SEC. 121. USE OF AMOUNTS.

(a) PRIMARY PURPOSES.—Section 2604(b)(1) of the Public Health Service Act (42 U.S.C. 300ff–14(b)(1)) is amended—

(1) in the matter preceding subparagraph (A), by striking “HIV-related—” and inserting “HIV-related services, as follows:”;

(2) in subparagraph (A)—

(A) by striking “outpatient” and all that follows through “substance abuse treatment and” and inserting the following: “Outpatient and ambulatory health services, including substance abuse treatment,”; and

(B) by striking “; and” and inserting a period;

(3) in subparagraph (B), by striking “(B) inpatient case management” and inserting “(C) Inpatient case management”;

(4) by inserting after subparagraph (A) the following subparagraph:

“(B) Outpatient and ambulatory support services (including case management), to the extent that such services facilitate, support, or sustain the delivery, or benefits of health services for individuals and families with HIV disease.”; and

(5) by adding at the end the following:

“(D) Outreach activities that are intended to identify individuals with HIV disease who are not receiving HIV-related services, and that are—

“(i) necessary to implement the strategy under section 2602(b)(4)(D), including activities facilitating the access of such individuals to HIV-related primary care services at entities described in paragraph (3);

“(ii) conducted in a manner consistent with the requirements under sections 2605(a)(3) and 2651(b)(2); and

“(iii) supplement, and do not supplant, such activities that are carried out with amounts appropriated under section 317.”.

(b) ADDITIONAL PURPOSES.—Section 2604(b) (42 U.S.C. 300ff–14(b)) of the Public Health Service Act is amended—

(1) by redesignating paragraph (3) as paragraph (4);

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

“(3) EARLY INTERVENTION SERVICES.—

“(A) IN GENERAL.—The purposes for which a grant under section 2601 may be used include providing to individuals with HIV disease early intervention services described in section 2651(b)(2) (including referrals under subparagraph (C) of such section), subject to subparagraph (B). The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV disease counseling and testing sites, health care points of entry specified by States or eligible areas, federally qualified health centers, and entities described in section 2652(a).

“(B) CONDITIONS.—With respect to an entity that proposes to provide early intervention services under subparagraph (A), such subparagraph applies only if the entity demonstrates to the satisfaction of the chief elected official for the eligible area involved that—

“(i) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and

“(ii) the entity will expend funds pursuant to such subparagraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved.”; and

(3) in paragraph (4) (as so redesignated), by inserting “youth,” after “children,” each place such term appears;

(c) QUALITY MANAGEMENT.—Section 2604 of the Public Health Service Act (42 U.S.C. 300ff–14) is amended—

(1) by redesignating subsections (c) through (f) as subsections (d) through (g), respectively; and

(2) by inserting after subsection (b) the following:

“(c) **QUALITY MANAGEMENT.**—

“(1) **REQUIREMENT.**—The chief elected official of an eligible area that receives a grant under this part shall provide for the establishment of a quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines.

“(2) **USE OF FUNDS.**—From amounts received under a grant awarded under this part for a fiscal year, the chief elected official of an eligible area may (in addition to amounts to which subsection (f)(1) applies) use for activities associated with the quality management program required in paragraph (1) not more than the lesser of—

“(A) 5 percent of amounts received under the grant; or

“(B) \$3,000,000.”.

SEC. 122. APPLICATION.

Section 2605(a) of the Public Health Service Act (42 U.S.C. 300ff-15(a)) is amended—

(1) by redesignating paragraphs (3) through (6) as paragraphs (4) through (7), respectively; and

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

“(3) that entities within the eligible area that receive funds under a grant under section 2601(a) will maintain relationships with appropriate entities in the area, including entities described in section 2604(b)(3);”.

SEC. 123. REVIEW OF ADMINISTRATIVE COSTS AND COMPENSATION.

Each chief elected official of an eligible area (as defined in section 2607 of the Public Health Service Act) shall ensure that, not later than one year after the date of the enactment of this Act, the planning council for the eligible area—

(1) conducts a review of the existing, available data on the extent to which entities in the area that receive amounts from a grant under section 2601(a) of the Public Health Service Act have from their overall budget expended amounts for administrative costs (including financial compensation and benefits), expressed as a proportion and indicating the growth in such expenditures, including a statement of the average amount expended for such costs per client served and the average amount expended for such costs per client served in providing HIV-related services; and

(2) makes a determination of whether the financial compensation of any officers or employees of such entities exceeds that of the chief elected official of the eligible area.

TITLE II—CARE GRANT PROGRAM

Subtitle A—General Grant Provisions

SEC. 201. PRIORITY FOR WOMEN, INFANTS, AND CHILDREN.

Section 2611(b) of the Public Health Service Act (42 U.S.C. 300ff-21(b)) is amended by inserting “youth,” after “children,” each place such term appears.

SEC. 202. USE OF GRANTS.

Section 2612 of the Public Health Service Act (42 U.S.C. 300ff-22) is amended—

(1) by striking “A State may use” and inserting “(a) **IN GENERAL.**—A State may use”; and

(2) by adding at the end the following subsections:

“(b) **SUPPORT SERVICES; OUTREACH.**—The purposes for which a grant under this part may be used include delivering or enhancing the following:

“(1) Support services under section 2611(a) (including case management) to the extent that such services facilitate, support, or sustain the delivery, or benefits of health services for individuals and families with HIV disease.

“(2) Outreach activities that are intended to identify individuals with HIV disease who are not receiving HIV-related services, and that are—

“(A) necessary to implement the strategy under section 2617(b)(4)(B);

“(B) conducted in a manner consistent with the requirement under section 2617(b)(6)(G); and

“(C) supplement, and do not supplant, such activities that are carried out with amounts appropriated under section 317.

“(c) EARLY INTERVENTION SERVICES.—

“(1) IN GENERAL.—The purposes for which a grant under this part may be used include providing to individuals with HIV disease early intervention services described in section 2651(b)(2) (including referrals under subparagraph (C) of such section), subject to paragraph (2). The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV disease counseling and testing sites, health care points of entry specified by States or eligible areas, federally qualified health centers, and entities described in section 2652(a).

“(2) CONDITIONS.—With respect to an entity that proposes to provide early intervention services under paragraph (1), such paragraph applies only if the entity demonstrates to the satisfaction of the State involved that—

“(A) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and

“(B) the entity will expend funds pursuant to such paragraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved.

“(d) QUALITY MANAGEMENT.—

“(1) REQUIREMENT.—Each State that receives a grant under this part shall provide for the establishment of a quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines.

“(2) USE OF FUNDS.—From amounts received under a grant awarded under this part for a fiscal year, the State may (in addition to amounts to which section 2618(c)(5) applies) use for activities associated with the quality management program required in paragraph (1) not more than the lesser of—

“(A) 5 percent of amounts received under the grant; or

“(B) \$3,000,000.”.

SEC. 203. GRANTS TO ESTABLISH HIV CARE CONSORTIA.

Section 2613 of the Public Health Service Act (42 U.S.C. 300ff-23) is amended—

(1) in subsection (b)(1)—

(A) in subparagraph (A), by inserting before the semicolon the following: “, particularly those experiencing disparities in access and services and those who reside in historically underserved communities”; and

(B) in subparagraph (B), by inserting after “by such consortium” the following: “is consistent with the comprehensive plan under 2617(b)(4) and”;

(2) in subsection (c)(1)—

(A) in subparagraph (D), by striking “and” after the semicolon at the end;

(B) in subparagraph (E), by striking the period and inserting “; and”;

(C) by adding at the end the following subparagraph:

“(F) demonstrates that adequate planning occurred to address disparities in access and services and historically underserved communities.”; and

(3) in subsection (c)(2)—

(A) in subparagraph (B), by striking “and” after the semicolon;

(B) in subparagraph (C), by striking the period and inserting “; and”;

(C) by inserting after subparagraph (C) the following subparagraph:

“(D) entities described in section 2602(b)(2).”.

SEC. 204. PROVISION OF TREATMENTS.

Section 2616 of the Public Health Service Act (42 U.S.C. 300ff-26) is amended by adding at the end the following subsection:

“(e) USE OF HEALTH INSURANCE AND PLANS.—In carrying out subsection (a), a State may expend a grant under this part to provide the therapeutics described in such subsection by paying on behalf of individuals with HIV disease the costs of purchasing or maintaining health insurance or plans whose coverage includes a full range of such therapeutics and appropriate primary care services.”.

SEC. 205. STATE APPLICATION.

(a) DETERMINATION OF SIZE AND NEEDS OF POPULATION; COMPREHENSIVE PLAN.—Section 2617(b) of the Public Health Service Act (42 U.S.C. 300ff-27(b)) is amended—

- (1) by redesignating paragraphs (2) through (4) as paragraphs (4) through (6), respectively;
- (2) by inserting after paragraph (1) the following paragraphs:
- “(2) a determination of the size and demographics of the population of individuals with HIV disease in the State;
- “(3) a determination of the needs of such population, with particular attention to—
- “(A) individuals with HIV disease who are not receiving HIV-related services; and
- “(B) disparities in access and services among affected subpopulations and historically underserved communities;” and
- (3) in paragraph (4) (as so redesignated)—
- “(A) by striking “comprehensive plan for the organization” and inserting “comprehensive plan that describes the organization”;
- “(B) by striking “, including—” and inserting “, and that—”;
- “(C) by redesignating subparagraphs (A) through (C) as subparagraphs (D) through (F), respectively;
- “(D) by inserting before subparagraph (C) the following subparagraphs:
- “(A) establishes priorities for the allocation of funds within the State based on—
- “(i) size and demographics of the population of individuals with HIV disease (as determined under paragraph (2)) and the needs of such population (as determined under paragraph (3));
- “(ii) availability of other governmental and nongovernmental resources to provide HIV-related services to individuals and families with HIV disease;
- “(iii) capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities and rural communities; and
- “(iv) the efficiency of the administrative mechanism of the State for rapidly allocating funds to the areas of greatest need within the State;
- “(B) includes a strategy for identifying individuals with HIV disease who are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds;
- “(C) includes a strategy to coordinate the provision of such services with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment services for such abuse;”;
- “(E) in subparagraph (D) (as redesignated by subparagraph (C) of this paragraph), by inserting “describes” before “the services and activities”;
- “(F) in subparagraph (E) (as so redesignated), by inserting “provides” before “a description”; and
- “(G) in subparagraph (F) (as so redesignated), by inserting “provides” before “a description”.
- (b) PUBLIC PARTICIPATION.—Section 2617(b) of the Public Health Service Act, as amended by subsection (a) of this section, is amended—
- (1) in paragraph (5), by striking “HIV” and inserting “HIV disease”; and
- (2) in paragraph (6), by amending subparagraph (A) to read as follows:
- “(A) the public health agency that is administering the grant for the State engages in a public advisory planning process, including public hearings, that includes the participants under paragraph (5), and entities described in section 2602(b)(2), in developing the comprehensive plan under paragraph (4) and commenting on the implementation of such plan;”.
- (c) HEALTH CARE RELATIONSHIPS.—Section 2617(b) of the Public Health Service Act, as amended by subsection (a) of this section, is amended in paragraph (6)—
- (1) in subparagraph (E), by striking “and” at the end;
- (2) in subparagraph (F), by striking the period and inserting “; and”; and
- (3) by adding at the end the following subparagraph:
- “(G) entities within areas in which activities under the grant are carried out will maintain relationships with appropriate entities in the area, including entities described in section 2612(c);”.

SEC. 206. DISTRIBUTION OF FUNDS.

- (a) MINIMUM ALLOTMENT.—Section 2618(b)(1)(A)(i) of the Public Health Service Act (42 U.S.C. 300ff-28(b)(1)(A)(i)) is amended—
- (1) in subclause (I), by striking “\$100,000” and inserting “\$200,000”; and

- (2) in subclause (II), by striking “\$250,000” and inserting “\$500,000”.
- (b) AMOUNT OF GRANT; ESTIMATE OF LIVING CASES.—Section 2618(b)(2) of the Public Health Service Act (42 U.S.C. 300ff–28(b)(2)) is amended—
- (1) in subparagraph (D)(i), by inserting before the semicolon the following: “, except that (subject to subparagraph (E)), for grants made pursuant to this paragraph for fiscal year 2005 and subsequent fiscal years, the cases counted for each 12-month period beginning on or after July 1, 2004, shall be cases of HIV disease (as reported to and confirmed by such Director) rather than cases of acquired immune deficiency syndrome”;
 - (2) by redesignating subparagraphs (E) through (H) as subparagraphs (F) through (I), respectively; and
 - (3) by inserting after subparagraph (D) the following subparagraph:

“(E) DETERMINATION OF SECRETARY REGARDING DATA ON HIV CASES.—If under 2603(a)(3)(D)(i) the Secretary determines that data on cases of HIV disease is not sufficiently accurate and reliable, then notwithstanding subparagraph (D) of this paragraph, for any fiscal year prior to fiscal year 2007 the references in such subparagraph to cases of HIV disease do not have any legal effect.”
- (c) INCREASES IN FORMULA AMOUNT.—Section 2618(b) of the Public Health Service Act (42 U.S.C. 300ff–28(b)) is amended—
- (1) in paragraph (1)(A)(ii), by inserting before the semicolon the following: “and then, as applicable, increased under paragraph (2)(H)”;
 - (2) in paragraph (2)—
 - (A) in subparagraph (A)(i), by striking “subparagraph (H)” and inserting “subparagraphs (H) and (I)”;
 - (B) in subparagraph (H) (as redesignated by subsection (b)(2) of this section), by amending the subparagraph to read as follows:

“(H) LIMITATION.—

“(i) IN GENERAL.—The Secretary shall ensure that the amount of a grant awarded to a State or territory under section 2611 for a fiscal year is not less than—

 - “(I) with respect to fiscal year 2001, 99 percent;
 - “(II) with respect to fiscal year 2002, 98 percent;
 - “(III) with respect to fiscal year 2003, 97 percent;
 - “(IV) with respect to fiscal year 2004, 96 percent; and
 - “(V) with respect to fiscal year 2005, 95 percent;

of the amount such State or territory received for fiscal year 2000 under such section. In administering this subparagraph, the Secretary shall, with respect to States or territories that will under such section receive grants in amounts that exceed the amounts that such States received under such section for fiscal year 2000, proportionally reduce such amounts to ensure compliance with this subparagraph. In making such reductions, the Secretary shall ensure that no such State receives less than that State received for fiscal year 2000.

“(ii) RATABLE REDUCTION.—If the amount appropriated under section 2677 for a fiscal year and available for grants under section 2611 is less than the amount appropriated and available under such section for fiscal year 2000, the limitation contained in clause (i) shall be reduced by a percentage equal to the percentage of the reduction in such amounts appropriated and available.”
- (d) TERRITORIES.—Section 2618(b)(1)(B) of the Public Health Service Act (42 U.S.C. 300ff–28(b)(1)(B)) is amended by inserting “the greater of \$50,000 or” after “shall be”.
- (e) SEPARATE TREATMENT DRUG GRANTS.—Section 2618(b)(2) of the Public Health Service Act, as amended by subsection (b)(3) of this section, is amended in subparagraph (I)—
- (1) by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively;
 - (2) by striking “(I) APPROPRIATIONS” and all that follows through “With respect to” and inserting the following:

“(I) APPROPRIATIONS FOR TREATMENT DRUG PROGRAM.—

“(i) FORMULA GRANTS.—With respect to”;
 - (3) in subclause (I) of clause (i) (as designated by paragraphs (1) and (2)), by striking “100 percent” and inserting “98 percent”; and
 - (4) by adding at the end the following clause:

“(ii) SUPPLEMENTAL TREATMENT DRUG GRANTS.—

“(I) IN GENERAL.—With respect to the fiscal year involved, if under section 2677 an appropriations Act provides an amount exclusively for carrying out section 2616, and such amount is not less than the amount so provided for the preceding fiscal year, the Sec-

retary shall reserve 2 percent of such amount for making grants to States whose population of individuals with HIV disease has, as determined by the Secretary, a need for quantities of therapeutics described in section 2616(a) greater than the quantities available pursuant to clause (i). Such a grant is available for purposes of obtaining such therapeutics. The Secretary shall carry out this clause as a program of discretionary grants, and not as a program of formula grants.

“(II) DISTRIBUTION OF GRANTS.—The Secretary shall disburse all amounts under grants under subclause (I) for a fiscal year not later than 240 days after the date on which the amount referred to in such subclause with respect to section 2616 becomes available.

“(III) REQUIREMENT OF MATCHING FUNDS.—A condition for receiving a grant under subclause (I) is that the State agree to make available (directly or through donations from public or private entities) non-Federal contributions toward the costs of obtaining the therapeutics involved in an amount that is not less than 25 percent of such costs (determined in the same manner as under 2617(d)(2)(A)).”

(f) TECHNICAL AMENDMENT.—Section 2618(b)(3)(B) of the Public Health Service Act (42 U.S.C. 300ff–28(b)(3)(B)) is amended by striking “and the Republic of the Marshall Islands” and inserting “the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau, and only for purposes of paragraph (1) the Commonwealth of Puerto Rico”.

SEC. 207. SUPPLEMENTAL GRANTS FOR CERTAIN STATES.

Subpart I of part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.) is amended—

(1) by striking section 2621; and

(2) by inserting after section 2620 the following section:

“SEC. 2621. SUPPLEMENTAL GRANTS.

“(a) IN GENERAL.—From amounts available pursuant to subsection (d) for a fiscal year, the Secretary shall make grants to States that meet the conditions to receive grants under section 2611, and that have one or more eligible communities, for the purpose of providing in such communities comprehensive services of the type described in section 2612(a) to supplement the development and care activities, primary care, and support services otherwise provided in such communities by the State under a grant under section 2611.

“(b) ELIGIBLE COMMUNITY.—For purposes of this section, the term ‘eligible community’ means a geographic area that—

“(1) is not within any eligible area as defined in section 2607; and

“(2) has a severe need for supplemental financial assistance to combat the HIV epidemic, according to criteria developed by the Secretary in consultation with the States, including evidence of underserved or rural areas or both.

“(c) APPLICATION.—A grant under subsection (a) may be made to a State if the State submits to the Secretary, as part of the State application submitted under section 2617, such information as required to apply for funds under this section as determined by the Secretary in consultation with the States.

“(d) FUNDING.—

“(1) IN GENERAL.—For the purpose of making grants under subsection (a) for a fiscal year, the Secretary shall reserve 50 percent of the amount specified in paragraph (2).

“(2) INCREASES IN PART B FUNDING.—

“(A) IN GENERAL.—For purposes of paragraph (1), the amount specified in this paragraph is the amount by which the amount appropriated under section 2677 for the fiscal year involved and available for carrying out part B is an increase over the amount so appropriated and available for the preceding fiscal year, subject to subparagraphs (B) and (C).

“(B) INITIAL ALLOCATION YEAR.—The allocation under paragraph (1) shall not be made until the first fiscal year for which the amount appropriated under section 2677 for the fiscal year involved and available for carrying out part B is an increase of not less than \$20,000,000 over the amount so appropriated and available for fiscal year 2000, subject to subparagraph (C).

“(C) EXCLUSION REGARDING SEPARATE TREATMENT DRUG GRANTS.—Each determination under subparagraph (A) or (B) of the amount appropriated under section 2677 for a fiscal year and available for carrying out part B shall be made without regard to any amount to which section 2618(b)(2)(D)(i) applies.”

Subtitle B—Provisions Concerning Pregnancy and Perinatal Transmission of HIV

SEC. 211. REPEALS.

Subpart II of part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-33 et seq.) is amended—

- (1) in section 2626, by striking each of subsections (d) through (f); and
- (2) by striking section 2627.

SEC. 212. GRANTS.

(a) IN GENERAL.—Section 2625(c) of the Public Health Service Act (42 U.S.C. 300ff-33) is amended—

- (1) in paragraph (1), by inserting at the end the following subparagraph:

“(F) Making available to pregnant women with HIV disease, and to the infants of women with such disease, treatment services for such disease in accordance with applicable recommendations of the Secretary.”;
- (2) by amending paragraph (2) to read as follows:

“(2) FUNDING.—

“(A) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there are authorized to be appropriated \$30,000,000 for each of the fiscal years 2001 through 2005. Amounts made available under section 2677 for carrying out this part are not available for carrying out this section unless otherwise authorized.

“(B) ALLOCATIONS FOR CERTAIN STATES.—

“(i) IN GENERAL.—Of the amounts appropriated under subparagraph (A) for a fiscal year in excess of \$10,000,000, the Secretary shall reserve the applicable percentage under clause (ii) for making grants under paragraph (1) to States that under law (including under regulations or the discretion of State officials) have—

“(I) a requirement that all newborn infants born in the State be tested for HIV disease; or

“(II) a requirement that newborn infants born in the State be tested for HIV disease in circumstances in which the attending obstetrician for the birth does not know the HIV status of the mother of the infant.

“(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable amount for a fiscal year is as follows:

“(I) For fiscal year 2001, 25 percent.

“(II) For fiscal year 2002, 50 percent.

“(III) For fiscal year 2003, 50 percent.

“(IV) For fiscal year 2004, 75 percent.

“(V) For fiscal year 2005, 75 percent.

“(C) CERTAIN PROVISIONS.—With respect to grants under paragraph (1) that are made with amounts reserved under subparagraph (B) of this paragraph:

“(i) Such a grant may not be made in an amount exceeding \$4,000,000.

“(ii) If pursuant to clause (i) or pursuant to an insufficient number of qualifying applications for such grants (or both), the full amount reserved under subparagraph (B) for a fiscal year is not obligated, the requirement under such subparagraph to reserve amounts ceases to apply.”; and

- (3) by adding at the end the following paragraph:

“(4) MAINTENANCE OF EFFORT.—A condition for the receipt of a grant under paragraph (1) is that the State involved agree that the grant will be used to supplement and not supplant other funds available to the State to carry out the purposes of the grant.”.

- (b) SPECIAL FUNDING RULE FOR FISCAL YEAR 2001.—

“(1) IN GENERAL.—If for fiscal year 2001 the amount appropriated under paragraph (2)(A) of section 2625(c) of the Public Health Service Act is less than \$14,000,000—

“(A) the Secretary of Health and Human Services shall, for the purpose of making grants under paragraph (1) of such section, reserve from the amount specified in paragraph (2) of this subsection an amount equal to the difference between \$14,000,000 and the amount appropriated under paragraph (2)(A) of such section for such fiscal year;

(B) the amount so reserved shall, for purposes of paragraph (2)(B)(i) of such section, be considered to have been appropriated under paragraph (2)(A) of such section; and

(C) the percentage specified in paragraph (2)(B)(ii)(I) of such section is deemed to be 50 percent.

(2) ALLOCATION FROM INCREASES IN FUNDING FOR PART B.—For purposes of paragraph (1), the amount specified in this paragraph is the amount by which the amount appropriated under section 2677 of the Public Health Service Act for fiscal year 2001 and available for grants under section 2611 of such Act is an increase over the amount so appropriated and available for fiscal year 2000.

SEC. 213. STUDY BY INSTITUTE OF MEDICINE.

Subpart II of part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–33 et seq.) is amended by adding at the end the following section:

“SEC. 2630. RECOMMENDATIONS FOR REDUCING INCIDENCE OF PERINATAL TRANSMISSION.

“(a) STUDY BY INSTITUTE OF MEDICINE.—

“(1) IN GENERAL.—The Secretary shall request the Institute of Medicine to enter into an agreement with the Secretary under which such Institute conducts a study to provide the following:

“(A) For the most recent fiscal year for which the information is available, a determination of the number of newborn infants with HIV born in the United States with respect to whom the attending obstetrician for the birth did not know the HIV status of the mother.

“(B) A determination for each State of any barriers, including legal barriers, that prevent or discourage an obstetrician from making it a routine practice to offer pregnant women an HIV test and a routine practice to test newborn infants for HIV disease in circumstances in which the obstetrician does not know the HIV status of the mother of the infant.

“(C) Recommendations for each State for reducing the incidence of cases of the perinatal transmission of HIV, including recommendations on removing the barriers identified under subparagraph (B).

If such Institute declines to conduct the study, the Secretary shall enter into an agreement with another appropriate public or nonprofit private entity to conduct the study.

“(2) REPORT.—The Secretary shall ensure that, not later than 18 months after the effective date of this section, the study required in paragraph (1) is completed and a report describing the findings made in the study is submitted to the appropriate committees of the Congress, the Secretary, and the chief public health official of each of the States.

“(b) PROGRESS TOWARD RECOMMENDATIONS.—Each State shall comply with the following (as applicable to the fiscal year involved):

“(1) For fiscal year 2004, the State shall submit to the Secretary a report describing the actions taken by the State toward meeting the recommendations specified for the State under subsection (a)(1)(C).

“(2) For fiscal year 2005 and each subsequent fiscal year—

“(A) the State shall make reasonable progress toward meeting such recommendations; or

“(B) if the State has not made such progress—

“(i) the State shall cooperate with the Director of the Centers for Disease Control and Prevention in carrying out activities toward meeting the recommendations; and

“(ii) the State shall submit to the Secretary a report containing a description of any barriers identified under subsection (a)(1)(B) that continue to exist in the State; as applicable, the factors underlying the continued existence of such barriers; and a description of how the State intends to reduce the incidence of cases of the perinatal transmission of HIV.

“(c) SUBMISSION OF REPORTS TO CONGRESS.—The Secretary shall submit to the appropriate committees of the Congress each report received by the Secretary under subsection (b)(2)(B)(ii).”.

Subtitle C—Certain Partner Notification Programs

SEC. 221. GRANTS FOR COMPLIANT PARTNER NOTIFICATION PROGRAMS.

Part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–21 et seq.) is amended by adding at the end the following subpart:

“Subpart III—Certain Partner Notification Programs

“SEC. 2631. GRANTS FOR PARTNER NOTIFICATION PROGRAMS.

“(a) IN GENERAL.—In the case of States whose laws or regulations are in accordance with subsection (b), the Secretary, subject to subsection (c)(2), may make grants to the States for carrying out programs to provide partner counseling and referral services.

“(b) DESCRIPTION OF COMPLIANT STATE PROGRAMS.—For purposes of subsection (a), the laws or regulations of a State are in accordance with this subsection if under such laws or regulations (including programs carried out pursuant to the discretion of State officials) the following policies are in effect:

“(1) The State requires that the public health officer of the State carry out a program of partner notification to inform partners of individuals with HIV disease that the partners may have been exposed to the disease.

“(2)(A) In the case of a health entity that provides for the performance on an individual of a test for HIV disease, or that treats the individual for the disease, the State requires, subject to subparagraph (B), that the entity confidentially report the positive test results to the State public health officer in a manner recommended and approved by the Director of the Centers for Disease Control and Prevention, together with such additional information as may be necessary for carrying out such program.

“(B) The State may provide that the requirement of subparagraph (A) does not apply to the testing of an individual for HIV disease if the individual underwent the testing through a program designed to perform the test and provide the results to the individual without the individual disclosing his or her identity to the program. This subparagraph may not be construed as affecting the requirement of subparagraph (A) with respect to a health entity that treats an individual for HIV disease.

“(3) The program under paragraph (1) is carried out in accordance with the following:

“(A) Partners are provided with an appropriate opportunity to learn that the partners have been exposed to HIV disease, subject to subparagraph (B).

“(B) The State does not inform partners of the identity of the infected individuals involved.

“(C) Counseling and testing for HIV disease are made available to the partners and to infected individuals, and such counseling includes information on modes of transmission for the disease, including information on pre-natal and perinatal transmission and preventing transmission.

“(D) Counseling of infected individuals and their partners includes the provision of information regarding therapeutic measures for preventing and treating the deterioration of the immune system and conditions arising from the disease, and the provision of other prevention-related information.

“(E) Referrals for appropriate services are provided to partners and infected individuals, including referrals for support services and legal aid.

“(F) Notifications under subparagraph (A) are provided in person, unless doing so is an unreasonable burden on the State.

“(G) There is no criminal or civil penalty on, or civil liability for, an infected individual if the individual chooses not to identify the partners of the individual, or the individual does not otherwise cooperate with such program.

“(H) The failure of the State to notify partners is not a basis for the civil liability of any health entity who under the program reported to the State the identity of the infected individual involved.

“(I) The State provides that the provisions of the program may not be construed as prohibiting the State from providing a notification under subparagraph (A) without the consent of the infected individual involved.

“(4) The State annually reports to the Director of the Centers for Disease Control and Prevention the number of individuals from whom the names of partners have been sought under the program under paragraph (1), the number of such individuals who provided the names of partners, and the number of partners so named who were notified under the program.

“(5) The State cooperates with such Director in carrying out a national program of partner notification, including the sharing of information between the public health officers of the States.

“(c) REPORTING SYSTEM FOR CASES OF HIV DISEASE.—

“(1) PREFERENCE IN MAKING GRANTS THROUGH FISCAL YEAR 2003.—In making grants under subsection (a) for each of the fiscal years 2001 through 2003, the

Secretary shall give preference to States whose reporting systems for cases of HIV disease produce data on such cases that is sufficiently accurate and reliable for use for purposes of section 2618(b)(2)(D)(i).

“(2) ELIGIBILITY CONDITION AFTER FISCAL YEAR 2003.—For fiscal year 2004 and subsequent fiscal years, a State may not receive a grant under subsection (a) unless the reporting system of the State for cases of HIV disease produces data on such cases that is sufficiently accurate and reliable for purposes of section 2618(b)(2)(D)(i).

“(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated \$30,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 through 2005.”.

TITLE III—EARLY INTERVENTION SERVICES

Subtitle A—Formula Grants for States

SEC. 301. REPEAL OF PROGRAM.

Subpart I of part C of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–41 et seq.) is repealed.

Subtitle B—Categorical Grants

SEC. 311. PREFERENCES IN MAKING GRANTS.

Section 2653 of the Public Health Service Act (42 U.S.C. 300ff–53) is amended by adding at the end the following subsection:

“(d) UNDERSERVED AND RURAL AREAS.—Of the applicants who qualify for preference under this section, the Secretary shall give preference to applicants that will expend the grant under section 2651 to provide early intervention under such section in rural areas or in areas that are underserved with respect to such services.”.

SEC. 312. PLANNING AND DEVELOPMENT GRANTS.

(a) IN GENERAL.—Section 2654(c)(1) of the Public Health Service Act (42 U.S.C. 300ff–54(c)(1)) is amended by striking “planning grants” and all that follows and inserting the following: “planning grants to public and nonprofit private entities for purposes of—

“(A) enabling such entities to provide HIV early intervention services; and

“(B) assisting the entities in expanding their capacity to provide HIV-related health services, including early intervention services, in low-income communities and affected subpopulations that are underserved with respect to such services (subject to the condition that a grant pursuant to this subparagraph may not be expended to purchase or improve land, or to purchase, construct, or permanently improve, other than minor remodeling, any building or other facility).”.

(b) AMOUNT; DURATION.—Section 2654(c) of the Public Health Service Act (42 U.S.C. 300ff–54(c)) is further amended—

(1) by redesignating paragraph (4) as paragraph (5); and

(2) by inserting after paragraph (3) the following:

“(4) AMOUNT AND DURATION OF GRANTS.—

“(A) EARLY INTERVENTION SERVICES.—A grant under paragraph (1)(A) may be made in an amount not to exceed \$50,000.

“(B) CAPACITY DEVELOPMENT.—

“(i) AMOUNT.—A grant under paragraph (1)(B) may be made in an amount not to exceed \$150,000.

“(ii) DURATION.—The total duration of a grant under paragraph (1)(B), including any renewal, may not exceed 3 years.”.

(c) INCREASE IN LIMITATION.—Section 2654(c)(5) of the Public Health Service Act (42 U.S.C. 300ff–54(c)(5)), as redesignated by subsection (b), is amended by striking “1 percent” and inserting “5 percent”.

SEC. 313. AUTHORIZATION OF APPROPRIATIONS.

Section 2655 of the Public Health Service Act (42 U.S.C. 300ff–55) is amended by striking “in each of” and all that follows and inserting “for each of the fiscal years 2001 through 2005.”.

Subtitle C—General Provisions

SEC. 321. PROVISION OF CERTAIN COUNSELING SERVICES.

Section 2662(c)(3) of the Public Health Service Act (42 U.S.C. 300ff-62(c)(3)) is amended—

- (1) in the matter preceding subparagraph (A), by striking “counseling on—” and inserting “counseling—”;
- (2) in each of subparagraphs (A), (B), and (D), by inserting “on” after the subparagraph designation; and
- (3) in subparagraph (C)—
 - (A) by striking “(C) the benefits” and inserting “(C)(i) that explains the benefits”; and
 - (B) by inserting after clause (i) (as designated by subparagraph (A) of this paragraph) the following clause:
 - “(ii) that emphasizes it is the duty of infected individuals to disclose their infected status to their sexual partners and their partners in the sharing of hypodermic needles; that provides advice to infected individuals on the manner in which such disclosures can be made; and that emphasizes that it is the continuing duty of the individuals to avoid any behaviors that will expose others to HIV;

SEC. 322. ADDITIONAL REQUIRED AGREEMENTS.

Section 2664(g) of the Public Health Service Act (42 U.S.C. 300ff-64(g)) is amended—

- (1) in paragraph (3)—
 - (A) by striking “7.5 percent” and inserting “10 percent”; and
 - (B) by striking “and” after the semicolon at the end;
- (2) in paragraph (4), by striking the period and inserting “; and”; and
- (3) by adding at the end the following paragraph:
 - “(5) the applicant will provide for the establishment of a quality management program to assess the extent to which medical services funded under this title that are provided to patients are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections and that improvements in the access to and quality of medical services are addressed.”.

TITLE IV—OTHER PROGRAMS AND ACTIVITIES

Subtitle A—Certain Programs for Research, Demonstrations, or Training

SEC. 401. GRANTS FOR COORDINATED SERVICES AND ACCESS TO RESEARCH FOR WOMEN, INFANTS, CHILDREN, AND YOUTH.

Section 2671 of the Public Health Service Act (42 U.S.C. 300ff-71) is amended—

- (1) in subsection (b)—
 - (A) in paragraph (1), by striking subparagraphs (C) and (D) and inserting the following:
 - “(C) The applicant will demonstrate linkages to research and how access to such research is being offered to patients.”; and
 - (B) by striking paragraphs (3) and (4);
 - (2) in subsection (g), by adding at the end the following: “In addition, the Secretary, in coordination with the Director of such Institutes, shall examine the distribution and availability of appropriate HIV-related research projects with respect to grantees under subsection (a) for purposes of enhancing and expanding HIV-related research, especially within communities that are underrepresented with respect to such projects.”;
 - (3) in subsection (f)—
 - (A) by striking the subsection heading and designation and inserting the following:
 - “(f) ADMINISTRATION.—
 - “(1) APPLICATION.—”; and
 - (B) by adding at the end the following paragraph:
 - “(2) QUALITY MANAGEMENT PROGRAM.—A grantee under this section shall implement a quality management program.”; and
 - (4) in subsection (j), by striking “1996 through 2000” and inserting “2001 through 2005”.

SEC. 402. AIDS EDUCATION AND TRAINING CENTERS.**(a) SCHOOLS; CENTERS.—**

(1) **IN GENERAL.**—Section 2692(a)(1) of the Public Health Service Act (42 U.S.C. 300ff–111(a)(1)) is amended—

(A) in subparagraph (A)—

(i) by striking “training” and inserting “to train”;

(ii) by striking “and including” and inserting “, including”; and

(iii) by inserting before the semicolon the following: “, and including (as applicable to the type of health professional involved), prenatal and other gynecological care for women with HIV disease”;

(B) in subparagraph (B), by striking “and” after the semicolon at the end;

(C) in subparagraph (C), by striking the period and inserting “; and”; and

(D) by adding at the end the following:

“(D) to develop protocols for the medical care of women with HIV disease, including prenatal and other gynecological care for such women.”.

(2) **DISSEMINATION OF TREATMENT GUIDELINES; MEDICAL CONSULTATION ACTIVITIES.**—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue and begin implementation of a strategy for the dissemination of HIV treatment information to health care providers and patients.

(b) DENTAL SCHOOLS.—Section 2692(b) of the Public Health Service Act (42 U.S.C. 300ff–111(b)) is amended—

(1) by amending paragraph (1) to read as follows:

“(1) IN GENERAL.—

“(A) **GRANTS.**—The Secretary may make grants to dental schools and programs described in subparagraph (B) to assist such schools and programs with respect to oral health care to patients with HIV disease.

“(B) **ELIGIBLE APPLICANTS.**—For purposes of this subsection, the dental schools and programs referred to in this subparagraph are dental schools and programs that were described in section 777(b)(4)(B) as such section was in effect on the day before the date of enactment of the Health Professions Education Partnerships Act of 1998 (Public Law 105–392) and in addition dental hygiene programs that are accredited by the Commission on Dental Accreditation.”;

(2) in paragraph (2), by striking “777(b)(4)(B)” and inserting “the section referred to in paragraph (1)(B)”; and

(3) by inserting after paragraph (4) the following paragraph:

“(5) **COMMUNITY-BASED CARE.**—The Secretary may make grants to dental schools and programs described in paragraph (1)(B) that partner with community-based dentists to provide oral health care to patients with HIV disease in unserved areas. Such partnerships shall permit the training of dental students and residents and the participation of community dentists as adjunct faculty.”.

(c) AUTHORIZATION OF APPROPRIATIONS.—

(1) **SCHOOLS; CENTERS.**—Section 2692(c)(1) of the Public Health Service Act (42 U.S.C. 300ff–111(c)(1)) is amended by striking “fiscal years 1996 through 2000” and inserting “fiscal years 2001 through 2005”.

(2) **DENTAL SCHOOLS.**—Section 2692(c)(2) of the Public Health Service Act (42 U.S.C. 300ff–111(c)(2)) is amended to read as follows:

“(2) DENTAL SCHOOLS.—

“(A) **IN GENERAL.**—For the purpose of grants under paragraphs (1) through (4) of subsection (b), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

“(B) **COMMUNITY-BASED CARE.**—For the purpose of grants under subsection (b)(5), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.”.

Subtitle B—General Provisions in Title XXVI**SEC. 411. EVALUATIONS AND REPORTS.**

Section 2674(c) of the Public Health Service Act (42 U.S.C. 300ff–74(c)) is amended by striking “1991 through 1995” and inserting “2001 through 2005”.

SEC. 412. DATA COLLECTION THROUGH CENTERS FOR DISEASE CONTROL AND PREVENTION.

Part D of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–71 et seq.) is amended—

(1) by redesignating section 2675 as section 2675A; and

(2) by inserting after section 2674 the following section:

“SEC. 2675. DATA COLLECTION.

“For the purpose of collecting and providing data for program planning and evaluation activities under this title, there are authorized to be appropriated to the Secretary (acting through the Director of the Centers for Disease Control and Prevention) such sums as may be necessary for each of the fiscal years 2001 through 2005. Such authorization of appropriations is in addition to other authorizations of appropriations that are available for such purpose.”.

SEC. 413. COORDINATION.

Section 2675A of the Public Health Service Act, as redesignated by section 412 of this Act, is amended—

(1) by amending subsection (a) to read as follows:

“(a) REQUIREMENT.—The Secretary shall ensure that the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Health Care Financing Administration coordinate the planning, funding, and implementation of Federal HIV programs to enhance the continuity of care and prevention services for individuals with HIV disease or those at risk of such disease. The Secretary shall consult with other Federal agencies, including the Department of Veterans Affairs, as needed and utilize planning information submitted to such agencies by the States and entities eligible for support.”;

(2) by redesignating subsections (b) and (c) as subsections (c) and (d), respectively;

(3) by inserting after subsection (b) the following subsection:

“(b) REPORT.—The Secretary shall biennially prepare and submit to the appropriate committees of the Congress a report concerning the coordination efforts at the Federal, State, and local levels described in this section, including a description of Federal barriers to HIV program integration and a strategy for eliminating such barriers and enhancing the continuity of care and prevention services for individuals with HIV disease or those at risk of such disease.”; and

(4) in each of subsections (c) and (d) (as redesignated by paragraph (2) of this section), by inserting “and prevention services” after “continuity of care” each place such term appears.

SEC. 414. PLAN REGARDING RELEASE OF PRISONERS WITH HIV DISEASE.

Section 2675A of the Public Health Service Act, as amended by section 413(2) of this Act, is amended by adding at the end the following subsection:

“(e) RECOMMENDATIONS REGARDING RELEASE OF PRISONERS.—After consultation with the Attorney General and the Director of the Bureau of Prisons, with States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary, consistent with the coordination required in subsection (a), shall develop a plan for the medical case management of and the provision of support services to individuals who were Federal or State prisoners and had HIV disease as of the date on which the individuals were released from the custody of the penal system. The Secretary shall submit the plan to the Congress not later than two years after the date of the enactment of the Ryan White CARE Act Amendments of 2000.”.

SEC. 415. AUDITS.

Part D of title XXVI of the Public Health Service Act, as amended by section 412 of this Act, is amended by inserting after section 2675A the following section:

“SEC. 2675B. AUDITS.

“For fiscal year 2002 and subsequent fiscal years, the Secretary may reduce the amounts of grants under this title to a State or political subdivision of a State for a fiscal year if, with respect to such grants for the second preceding fiscal year, the State or subdivision fails to prepare audits in accordance with the procedures of section 7502 of title 31, United States Code. The Secretary shall annually select representative samples of such audits, prepare summaries of the selected audits, and submit the summaries to the Congress.”.

SEC. 416. ADMINISTRATIVE SIMPLIFICATION.

Part D of title XXVI of the Public Health Service Act, as amended by section 415 of this Act, is amended by inserting after section 2675B the following section:

“SEC. 2675C. ADMINISTRATIVE SIMPLIFICATION REGARDING PARTS A AND B.

“(a) COORDINATED DISBURSEMENT.—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall develop a plan for coordinating the disbursement of appropriations for grants under part A with the disbursement of appropriations for grants under part B in order to assist grantees and other recipients of amounts

from such grants in complying with the requirements of such parts. The Secretary shall submit the plan to the Congress not later than 18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000. Not later than two years after the date on which the plan is so submitted, the Secretary shall complete the implementation of the plan, notwithstanding any provision of this title that is inconsistent with the plan.

“(b) BIENNIAL APPLICATIONS.—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall make a determination of whether the administration of parts A and B by the Secretary, and the efficiency of grantees under such parts in complying with the requirements of such parts, would be improved by requiring that applications for grants under such parts be submitted biennially rather than annually. The Secretary shall submit such determination to the Congress not later than two years after the date of the enactment of the Ryan White CARE Act Amendments of 2000.

“(c) APPLICATION SIMPLIFICATION.—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall develop a plan for simplifying the process for applications under parts A and B. The Secretary shall submit the plan to the Congress not later than 18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000. Not later than two years after the date on which the plan is so submitted, the Secretary shall complete the implementation of the plan, notwithstanding any provision of this title that is inconsistent with the plan.”.

SEC. 417. AUTHORIZATION OF APPROPRIATIONS FOR PARTS A AND B.

Section 2677 of the Public Health Service Act (42 U.S.C. 300ff-77) is amended to read as follows:

“SEC. 2677. AUTHORIZATION OF APPROPRIATIONS.

“(a) PART A.—For the purpose of carrying out part A, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

“(b) PART B.—For the purpose of carrying out part B, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.”.

TITLE V—GENERAL PROVISIONS

SEC. 501. STUDIES BY INSTITUTE OF MEDICINE.

(a) STATE SURVEILLANCE SYSTEMS ON PREVALENCE OF HIV.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall request the Institute of Medicine to enter into an agreement with the Secretary under which such Institute conducts a study to provide the following:

(1) A determination of whether the surveillance system of each of the States regarding the human immunodeficiency virus provides for the reporting of cases of infection with the virus in a manner that is sufficient to provide adequate and reliable information on the number of such cases and the demographic characteristics of such cases, both for the State in general and for specific geographic areas in the State.

(2) A determination of whether such information is sufficiently accurate for purposes of formula grants under parts A and B of title XXVI of the Public Health Service Act.

(3) With respect to any State whose surveillance system does not provide adequate and reliable information on cases of infection with the virus, recommendations regarding the manner in which the State can improve the system.

(b) RELATIONSHIP BETWEEN EPIDEMIOLOGICAL MEASURES AND HEALTH CARE FOR CERTAIN INDIVIDUALS WITH HIV DISEASE.—

(1) IN GENERAL.—The Secretary shall request the Institute of Medicine to enter into an agreement with the Secretary under which such Institute conducts a study concerning the appropriate epidemiological measures and their relationship to the financing and delivery of primary care and health-related support services for low-income, uninsured, and under-insured individuals with HIV disease.

(2) ISSUES TO BE CONSIDERED.—The Secretary shall ensure that the study under paragraph (1) considers the following:

(A) The availability and utility of health outcomes measures and data for HIV primary care and support services and the extent to which those measures and data could be used to measure the quality of such funded services.

(B) The effectiveness and efficiency of service delivery (including the quality of services, health outcomes, and resource use) within the context of a changing health care and therapeutic environment, as well as the changing epidemiology of the epidemic, including determining the actual costs, potential savings, and overall financial impact of modifying the program under title XIX of the Social Security Act to establish eligibility for medical assistance under such title on the basis of infection with the human immunodeficiency virus rather than providing such assistance only if the infection has progressed to acquired immune deficiency syndrome.

(C) Existing and needed epidemiological data and other analytic tools for resource planning and allocation decisions, specifically for estimating severity of need of a community and the relationship to the allocations process.

(D) Other factors determined to be relevant to assessing an individual's or community's ability to gain and sustain access to quality HIV services.

(c) OTHER ENTITIES.—If the Institute of Medicine declines to conduct a study under this section, the Secretary shall enter into an agreement with another appropriate public or nonprofit private entity to conduct the study.

(d) REPORT.—The Secretary shall ensure that—

(1) not later than three years after the date of the enactment of this Act, the study required in subsection (a) is completed and a report describing the findings made in the study is submitted to the appropriate committees of the Congress; and

(2) not later than two years after the date of the enactment of this Act, the study required in subsection (b) is completed and a report describing the findings made in the study is submitted to such committees.

SEC. 502. DEVELOPMENT OF RAPID HIV TEST.

(a) EXPANSION, INTENSIFICATION, AND COORDINATION OF RESEARCH AND OTHER ACTIVITIES.—

(1) IN GENERAL.—The Director of NIH shall expand, intensify, and coordinate research and other activities of the National Institutes of Health with respect to the development of reliable and affordable tests for HIV disease that can rapidly be administered and whose results can rapidly be obtained (in this section referred to a “rapid HIV test”).

(2) REPORT TO CONGRESS.—The Director of NIH shall periodically submit to the appropriate committees of Congress a report describing the research and other activities conducted or supported under paragraph (1).

(3) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

(b) PREMARKET REVIEW OF RAPID HIV TESTS.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention and the Commissioner of Food and Drugs, shall submit to the appropriate committees of the Congress a report describing the progress made towards, and barriers to, the premarket review and commercial distribution of rapid HIV tests. The report shall—

(A) assess the public health need for and public health benefits of rapid HIV tests, including the minimization of false positive results through the availability of multiple rapid HIV tests;

(B) make recommendations regarding the need for the expedited review of rapid HIV test applications submitted to the Center for Biologics Evaluation and Research and, if such recommendations are favorable, specify criteria and procedures for such expedited review; and

(C) specify whether the barriers to the premarket review of rapid HIV tests include the unnecessary application of requirements—

(i) necessary to ensure the efficacy of devices for donor screening to rapid HIV tests intended for use in other screening situations; or

(ii) for identifying antibodies to HIV subtypes of rare incidence in the United States to rapid HIV tests intended for use in screening situations other than donor screening.

(c) GUIDELINES OF CENTERS FOR DISEASE CONTROL AND PREVENTION.—Promptly after commercial distribution of a rapid HIV test begins, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish or update guidelines that include recommendations for States, hospitals, and other appropriate entities regarding the ready availability of such tests for adminis-

tration to pregnant women who are in labor or in the late stage of pregnancy and whose HIV status is not known to the attending obstetrician.

TITLE VI—EFFECTIVE DATE

SEC. 601. EFFECTIVE DATE.

This Act and the amendments made by this Act take effect October 1, 2000, or upon the date of the enactment of this Act, whichever occurs later.

PURPOSE AND SUMMARY

The Ryan White CARE Act Amendments of 2000 reauthorizes programs providing for the comprehensive health care of Americans suffering from HIV/AIDS and prevention programs to prevent the spread of HIV.

BACKGROUND AND NEED FOR LEGISLATION

Acquired Immunodeficiency Syndrome (AIDS) cases were first reported in the United States in 1981. In the two decades since, more than 700,000 persons in the United States have been diagnosed with AIDS. The General Accounting Office (GAO) recently estimated that by the end of 1998, 300,000 persons in the United States were living with AIDS, and that as many as hundreds of thousands of people in this country are infected with the human immunodeficiency virus (HIV), but have not yet progressed to AIDS.

Because persons with AIDS faced problems obtaining insurance coverage and access to primary care and support, the Congress responded in 1990 by passing the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (P.L. 101–381). The framework of that Act, as passed, continues in force today.

Title I of the Act provides relief to eligible metropolitan areas (EMAs) disproportionately impacted by AIDS. By fiscal year (FY) 1991, there were 16 EMAs receiving CARE Act Title I funding. Currently, as of FY2000, there are 51 EMAs. Title I relief is provided through formula and supplemental grants to be used for case management and comprehensive treatment services, among other things. Such grants are intended to supplement, not supplant, State funding, and have the express purpose of delivering or enhancing HIV-related outpatient and ambulatory health and support services. These services include case management, substance abuse and mental health treatment, comprehensive treatment services, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharges.

As originally enacted in 1990, a community was entitled to be an EMA if the area had more than 2,000 cases of AIDS, or if the cumulative per capita incidence of AIDS exceeded one quarter of one percent. Under the Ryan White CARE Act Amendments of 1996 (P.L. 104–186), this was changed so that areas could qualify for funding under Title I if the area has a population of 500,000 or more individuals, and the area has reported to the Director of the Centers for Disease Control and Prevention (CDC) a cumulative total of more than 2,000 cases of AIDS for the most recent five calendar years.

Title I funding is, generally, equally divided amongst formula and supplemental grants. Formula grants are distributed to EMAs

according to a complex distribution factor, taking into account the estimated living number of AIDS cases in the EMA. The estimated living number of AIDS cases in an EMA is determined by the number of AIDS cases reported to, and confirmed by, the CDC in the most recent ten year period, multiplied (on a yearly basis) by a percentage developed by the Secretary of the Department of Health and Human Services. Title I supplemental grants are awarded based upon severe need, though these grants have been awarded historically in a way which results in a doubling of the Title I formula amount.

One important exception must be noted. The 1990 CARE Act distributed formula funds based partially upon the historical number of AIDS cases the EMA had experienced, irrespective of whether the disease sufferers were still alive. The 1996 CARE Act Amendments altered this to allocate funds based upon living number of AIDS cases. Because the change from historic incidences of AIDS to estimated living AIDS cases per EMA could have caused significant disruptions in funding received by certain EMAs, the 1996 CARE Act Amendments contained a "hold harmless" clause. According to this provision, no EMA could lose more than five percent, over five years, from the EMA's FY1995 Title I formula grant. To fund the "hold harmless" provision, the amount of Title I supplemental grant funds available to all EMAs is reduced accordingly.

Title I grants are made to the chief elected official of the city or county in the EMA that administers the health agency providing services to the greatest number of persons with AIDS. This chief elected official must establish or designate an HIV health services planning council to establish priorities for care delivery according to Federal guidelines, in order to receive Title I funds. Members of the councils must reflect the demographics of the epidemic in the EMA, and it shall include representatives of health care providers; community-based organizations serving affected populations and AIDS service organizations; affected communities, including people with HIV disease or AIDS, and historically underserved groups and subpopulations; mental health and substance abuse providers, and others. The council may not be directly involved in the administration of any Title I grant.

Title II funds provide formula grants to states and territories for comprehensive care services including home and community-based health care and support services. States use such funds to provide services directly or through contracts with HIV care consortia. Title II grants are also used to provide health insurance coverage for low-income persons through Health Insurance Continuation Programs and drug treatments for individuals with HIV and AIDS who have limited or no coverage from private insurance or Medicaid through AIDS Drug Assistance Programs (ADAPs). Prior to FY1996, States determined the amount of their Title II funds they would dedicate to ADAPs. In FY1996, Congress began appropriating ADAP-targeted funds under Title II.

Grants are awarded to States based upon a weighted formula that accounts for two factors: (1) the estimated number of living AIDS cases in the State; and (2) the estimated number of living AIDS cases in the State who are not in a Title I EMA. States with more than 1% of the total AIDS cases reported nationally must

contribute State matching funds based on a formula, and grants may not be made to any State that does not make a good faith effort to notify a spouse of an HIV-infected patient that the spouse should seek testing.

Further, Title II provides up to \$10 million for States which certify that they have in effect regulations or measures to adopt CDC guidelines concerning HIV virus counseling and voluntary testing for pregnant women. Priority is given to States that have the greatest proportion of HIV seroprevalance among child bearing women, as determined by the CDC.

Early intervention services are provided for under Title III of the CARE Act. Under this, public and private nonprofit entities already providing primary care services to low-income and medically underserved populations compete for grants to provide HIV testing, risk reduction counseling, case management, outreach, medical evaluation, transmission prevention, oral health, nutritional and mental health services, and clinical care. Community health centers, homeless programs, local health departments, family planning programs, hemophilia diagnostic and treatment centers, as well as other nonprofit community-based programs all compete for Title III grants.

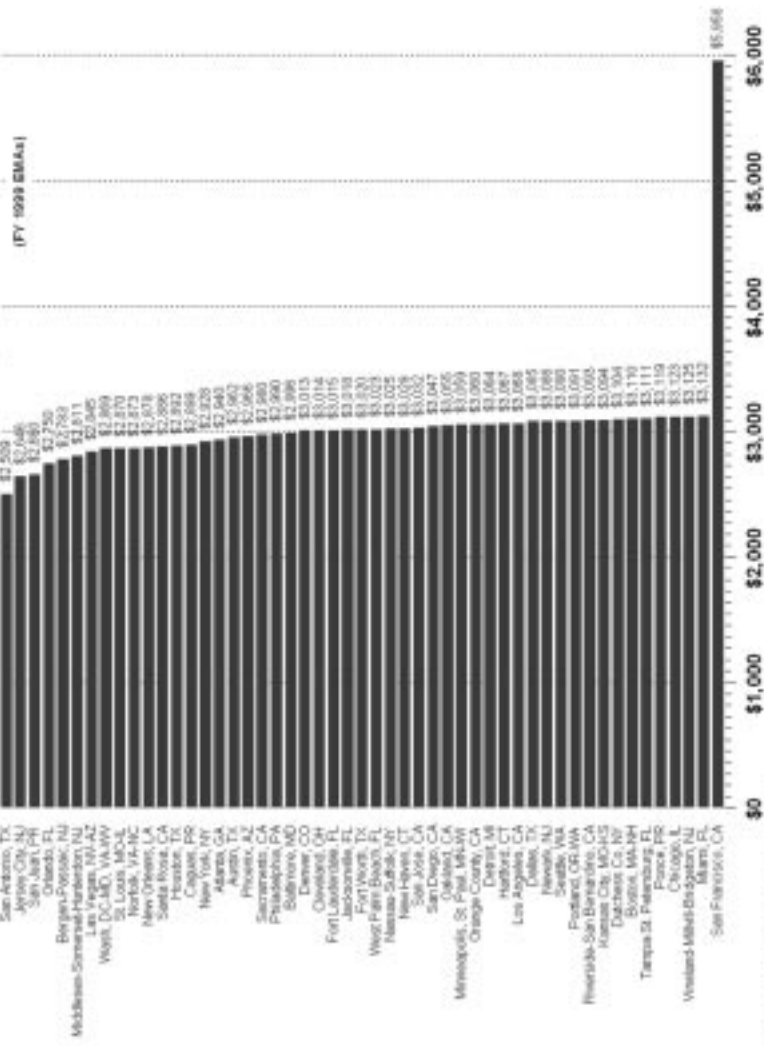
When enacted in 1990, Title IV authorized a number of different HIV-related programs, but the only one for which funds were appropriated was pediatric demonstration grants. In the 1996 CARE Act Amendments, this funded program was replaced with a program of grants for coordinated services and access to research for women, infants, children and youth. Such grants provide opportunities for women, infants, children and youth to be voluntary participants in research of potential clinical benefit to individuals with HIV and AIDS. Such individuals are provided access to health care on an outpatient basis, case management, referrals, transportation, child care, and other services which enable participation.

Other programs under the CARE Act which have been funded include special projects of national significance for the care and treatment of individuals with HIV/AIDS, AIDS Education and Training Centers program (AETC), and the AIDS Dental Reimbursement program.

Funding Fairness. The Committee has amended and enhanced the CARE Act to respond to significant changes in the HIV/AIDS epidemic. It is important to the Committee that no eligible metropolitan area lose its ability to provide services authorized under the CARE Act. At the same time, it is equally important to the Committee that no EMA receive significantly more Title I formula funding on a per case basis than other similarly-situated EMAs.

It is the Committee's intention that, over time, each EMA should receive Title I formula funds in proportion to its estimated number of living HIV cases. The GAO has reported, however, that presently one EMA, the San Francisco EMA, receives dramatically more Title I funding on a per case basis than any other EMA. For example, GAO reports that in FY 1999 San Francisco spent \$5,598 per AIDS case, while the other 50 EMAs spent between \$2,509 and \$3,132 per AIDS case. More specifically, GAO reported that the San Francisco EMA receives roughly 80% more per in Title I grant funds per AIDS case than other EMAs.

Nominal EMA Funding Amounts per AIDS Case



Source: House Committee on Health

A few have defended this disparity by stating that per patient cost is higher than other places because the costs of care in services in the Bay Area is so inflated. But even if CARE Act money were adjusted for funding the cost of providing medical care (it presently is not), San Francisco still receives far more than any other EMA per capita. The accompanying graph uses the Medicare hospital cost wage index cost adjuster on the per capita Title I formula and discretionary grant money used in chart 1. Even with these adjustments, it is clear that the San Francisco EMA still gets the most of all EMAs. With similar cost structures as San Francisco, Oakland and San Jose in the Bay Area join New York at the bottom of Title I funding.

The present disparity in funding results from the way EMAs were funded under Title I when the CARE Act was enacted in 1990. Originally, EMAs were funded based upon the cumulative number of AIDS cases the EMA experienced. In 1996, Title I formula funding was altered to compensate EMAs based upon the estimated number of living AIDS cases in the EMA, rather than the cumulative caseload of living and dead AIDS cases. So that certain EMAs would not find their Title I formula funding dramatically decreased, a hold harmless provision was included in the reauthorization limiting funding cuts to no more than five percent, over five years, from the 1995 Title I formula amount.

The GAO reports that presently only the San Francisco EMA benefits from this hold harmless provision, thus explaining the disparity in funding. During the July 11, 2000 hearing before the Subcommittee on Health and Environment, the GAO acknowledged that a reason for this is that San Francisco's basis of funding, due to the hold harmless, still compensates the EMA for individuals who have long ago died.

To ensure that per case funding is more equitable, H.R. 4807 reforms the hold harmless provision which limits funding reductions to EMAs. According to the provision in this bill, no EMA would experience a reduction greater than 25% of its base year formula allocation over the next five fiscal years. Such a regime would still leave the San Francisco EMA with more Title I formula funds on a per case basis than any other EMA, while still alleviating some of the unfair funding disparities.

As a way to protect State funding provided by Title II, the legislation contains a hold harmless provision which ensures that no State will see more than a one percent cut in Title II formula funds per fiscal year. This reflects a continuation of present law. It is important to note that no State has benefitted from this provision since its enactment.

The Committee intends that Title I supplemental awards are not intended to be allocated on the basis of formula grant allocations. Instead, such supplemental awards are to be directed to those eligible areas with "severe need," or the greatest or expanding public health challenges in confronting the epidemic. The Committee has included additional factors to be considered in the assessment of severe need, including the current prevalence of HIV/AIDS, and the degree of increasing and unmet needs for services. Additionally, the Committee believes that syphilis, hepatitis B and hepatitis C should be regarded as important co-morbidities to HIV/AIDS.

It is the Committee's strong view that HRSA's Bureau of HIV/AIDS should employ standard, quantitative measures to the maximum extent possible in lieu of narrative self-reporting when awarding supplemental awards. The Committee renews the Bureau's obligation to develop in a timely manner a mechanism for determining severe need upon the basis of national, quantitative incidence data. In this regard, the Committee recognizes that adequate and reliable data on HIV prevalence may not be uniformly available in all eligible areas on the date of enactment. The Committee also notes that "HIV disease" under the CARE Act encompasses both persons living with AIDS as well as persons diagnosed as HIV positive who have not developed AIDS.

Just as importantly, for the first time the CARE Act will recognize the need for Title II supplemental grants with the passage of H.R. 4807. These grants are intended for areas, other than EMAs, experiencing a severe need for supplemental financial assistance. Like with Title I supplemental awards, it is the Committee's intention that Title II supplemental awards should not be allocated in proportion to formula awards, but rather on the basis of demonstrated severe need.

The Committee intends that preference should be given to shift Title III grants to addressing the needs of rural areas and underserved areas. This preference is intended to further shift CARE Act programs towards eliminating disparities in access and services among affected subpopulations and historically underserved communities.

The Committee strongly supports the use of Title I funds to conduct outreach activities to identify individuals with HIV/AIDS who are not receiving services, and get them under medical care and treatment. President Reagan's HIV Commission concluded that "early diagnosis of HIV infection is essential" because HIV infection "can be treated more effectively when detected early." The Committee concurs with these findings and acknowledges that the medical breakthroughs which have been developed in the twelve years since the issuance of this report make early intervention even more important. This authorization reflects the Committee's intent to increase the coordination between HIV prevention and HIV care and treatment services in all CARE Act programs. The Committee expects such activities will be of particular importance when focusing on underserved populations, and of particular value in bringing into and retain in care those individuals who are knowledgeable of their status but are not receiving services.

HIV Reporting. According to CDC, in June 1999 there were an estimated 287,946 Americans living with AIDS. Currently, CDC is not able to determine how many Americans were living with HIV, because only 29 states report HIV cases. CDC expects all states to be reporting newly diagnosed HIV cases by 2003 and that an additional 1 to 3 years may be needed to get all HIV cases entered into such new reporting systems. It is difficult for regions without reliable HIV surveillance to adequately address the needs or understand the scope of the epidemic.

The identification of HIV reporting as a serious public health concern was identified by the first Presidential Commission on HIV, appointed by President Reagan, which issued the "Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic" on June 24, 1988. According to that report:

The term "AIDS" is obsolete. "HIV infection" more correctly defines the problem. The medical, public health, political, and community leadership must focus on the full course of HIV infection rather than concentrating on later stages of the disease (ARC and AIDS). Continual focus on AIDS rather than the entire spectrum of HIV disease has left our nation unable to deal adequately with the epidemic. Federal and state data collection efforts must now be focused on early HIV reports, while still collecting data on symptomatic disease.

Eleven and a half years later, the CDC has implemented proposals consistent with proposals made by President Reagan's Commission on the Human Immunodeficiency Virus Epidemic.

To address the challenge of insufficient value being derived from AIDS data alone, CDC joined the Council of State and Territorial Epidemiologists (CSTE) to recommend in December 1999 that all states and territories include name surveillance for HIV infection as an extension of their AIDS surveillance activities. On May 11, 2000,

Surgeon General Satcher testified before the Subcommittee on Health and Environment that he agreed with the CDC and CSTE recommendation. In light of the consensus that has finally emerged, the Committee believes all jurisdictions should shift the focus from AIDS to the full spectrum of HIV infection for improved prevention and care. Federal funding as well should be based upon the full extent of the disease rather than only on the late stages defined as AIDS. This will ensure more equitable funding and more timely and appropriate responses.

The consequences and human toll of dithering over HIV reporting over the last decade has been high, and not just in this country. The Committee believes that other public health institutions throughout the world have not yet adopted HIV reporting, and for this reason the Committee strongly recommends that the CDC should work in consultation with HRSA on all international HIV/AIDS initiatives to avoid repeating mistakes made in the past. The Committee is also concerned that, because public health institutions had no data to show the rate of growth of HIV cases among various American cultural and ethnic communities, communities of color are disproportionately affected and infected by the HIV epidemic.

HIV Case Classification. The Committee is aware of concerns that the heterosexual and NIR categories as currently defined may result in systematic underreporting of heterosexual cases of HIV, which could be detrimental to addressing the prevention needs of certain groups, particularly communities of color.

This classification system may have been satisfactory early in the epidemic, but the changing dynamics of the HIV/AIDS epidemic require a timely reassessment and refinement of current classification methods. The Committee applauds the CDC's recognition of State efforts to accomplish these goals, including Virginia's efforts to identify NIR cases with multiple sex partners. The CDC has indicated that it is also currently reassessing HIV/AIDS case classification methods to ensure the most adequate understanding of the disease and its modes of transmission and to properly allocate and target resources to those groups that are increasingly at risk of infection, such as African American females.

Based on this understanding, the Committee urges the Secretary to commit to an agenda of coordinated actions with the States and patient advocates, including the development and validation of rigorous sampling techniques, the promulgation of formal guidance to the States, the provision of technical assistance to State and local health authorities, and the expansion of the CDC's current pilot projects with interested States. Finally, the Committee applauds the CDC's commitment to hold a public meeting to obtain expert

opinion on this issue, and its current efforts to consult with the Committee prior to the meeting regarding its attendance.

Demographics and Needs of Populations with HIV Disease. The comprehensive service delivery plan is an effective way to demonstrate the organization and delivery of CARE Act services based upon the planning, priority setting, and funding allocation processes conducted by the planning council. The intent of the legislation is also to have the additional factors reflected in the plan. Those factors include disparities in access to medical and health-related support services by specific subpopulations; the needs of persons with HIV not in care; capacity development needs; and quality of HIV primary care and health-related supportive services. Both the planning process and the resulting plan should include the participation of, and address the needs of, populations and subpopulations living with HIV and AIDS.

The Committee requires that Planning Councils determine the size, demographics and needs of the population with HIV disease. The Committee recognizes that adequate and reliable data on HIV prevalence may not be uniformly available in all eligible areas on the date of enactment. Therefore, priorities for the allocation of funds and the comprehensive plan should reflect HIV prevalence to the extent that data are reasonably available. The Committee also notes that "HIV disease" under the CARE Act encompasses both persons living with AIDS as well as persons diagnosed as HIV positive who have not developed AIDS.

The reauthorization bill reflects the Committee position that priority setting and funding allocation decisions should be based on the size and demographic characteristics of the populations with HIV disease in the eligible area. Planning, priority setting, and funding allocation processes must take into account shifts in the local HIV/AIDS epidemic, existing health HIV-related disparities, and resulting negative health outcomes.

The Committee intends Planning Councils to develop a strategy to identify individuals with HIV disease who are not receiving services and to inform and enable such individuals to receive services under Title I. The Committee wants CARE Act providers to work actively to bring into and retain in care those individuals who are unaware of their HIV status and those who are knowledgeable of their status but are not receiving services. As part of this process, the Committee believes strongly in the importance of Planning Councils focusing on eliminating disparities in access and services among affected subpopulations and historically underserved communities. The Committee recognizes that the availability or lack of HIV prevalence data in particular EMAs will be reflected in the scope, goals, timetable and allocation of funds for implementation of the strategy.

The Committee also intends Planning Councils to develop a strategy to coordinate the provision of Title I services with HIV prevention services and substance abuse prevention and treatment services. The Committee has amended numerous aspects of CARE Act programs to enhance the coordination between HIV prevention and HIV care and treatment services. The Committee further requests that the Secretary work with title I grant recipients and providers to establish epidemiologic measures and tools for use by

EMAs in identifying the number of individuals with HIV infection, especially those who are not in care.

The Committee expects that the development of such measures will refine and expand the ability of EMAs and Planning Councils to identify and provide services to individuals with HIV disease who are not receiving services. The efforts on the part of EMAs and Planning Councils to accomplish these important tasks, however, should not be delayed until this process is complete. Instead, the Committee expects EMAs and Planning Councils to establish and implement strategies responsive to these urgent needs before the development of nationally uniform measures, to the extent that is practicable and to which necessary prevalence data is reasonably available.

Early Intervention Services. The Committee authorizes early intervention services as eligible services under certain circumstances in Titles I and II. The Committee intends to allow grantees to provide certain early intervention services, such as HIV counseling, testing, and referral services, to individuals at high risk for HIV infection in accordance with statewide planning and regional consortia planning activities. Additionally, the Committee intends that the types of organizations that may provide early intervention services are the same as those that provide other HIV-related services through Parts B or C of the Act, or are points of access into the health care system for individuals at high risk for HIV, as specified by States under guidance from HRSA's Bureau of HIV/AIDS.

The Committee recognizes that these organizations may include traditional community based organizations (CBOs) that act as points of entry and/or referral agencies into the health care system, especially for traditionally underserved and minority populations. This provision is solely for the purpose of expanding the scope of primary care services to include HIV testing, counseling, and referral. The Committee recognizes the importance of early intervention services in increasing access to medical services through established relations with a broad network of health care entry points and HIV medical providers that serve as critical entry points for medical services for uninsured, and underinsured, low-income and rural communities. The Committee specifically intends that funds not be used to supplant other funds available to States for the provision of early intervention services and that these funds are utilized only when existing Federal, State or local funds are inadequate to provide these services. Further, the Committee intends that such services need to be provided according to guidelines established by the CDC and according to the laws and administrative regulations of State and local governments. The Committee expects that the Secretary, working with grantees and the public health community, will provide guidance to establish the appropriate parameters for the use of CARE Act funds for these purposes and to coordinate these activities with existing early intervention services. The Committee recognizes that other funding sources may exist for these services and expects all grantees to seek out and use these funds to enhance medical care to the extent they are reasonably available.

The Committee finds that all counseling for HIV-infected individuals should emphasize that it is the duty of infected individuals to

disclose their infected status to their sexual partners and others who are they potentially may place at risk of infection. The Committee recognizes that proper counseling better enables individuals living with HIV to make such disclosures. The Committee intends for entities providing care under this legislation will provide such counseling and emphasize that it is the continuing duty of the infected individuals to avoid any behaviors that will expose others to HIV.

The Committee heard testimony in 1998 from an HIV infected man who became infected because his partner hid his HIV status and did so after counseling from Federally supported organizations which did not advise him to disclose. The Committee believes that this policy all those who are infected should be provided proper advice to disclose and provided the counseling to do so. Recent studies have found that the continuing epidemic in the United States is being driven by infected individuals who do not disclose their status and continue to engage in risky behaviors. The Committee believes that existing prevention policies have failed to adequately address such behavior and have enabled them to continue. This provision will provide better secondary prevention and protect the infected from other health complications including dual HIV infection.

Rapid HIV Test. The Committee also seeks to expand and coordinate efforts at the NIH and FDA to develop rapid HIV tests. Accurate and affordable rapid HIV tests have many potentially important applications, one of which would be to help diagnose pregnant women whose HIV status is not known late in pregnancy or at the time of labor. The purpose of this initiative is to help increase opportunities for individuals, including pregnant women, to learn their HIV status. The Committee recognizes that labor is not an ideal time to obtain consent for testing or to discuss the implications of a positive test result. It is not the intent of this Committee to diminish the right of patients to make an informed decision to be tested. In establishing or updating relevant guidelines, CDC should address how to ensure that the meaningful decision making ability of patients is preserved. These guidelines should recognize that states have varying laws and policies related to the communication of test results. The Committee encourages the FDA to facilitate CDC's ability to use rapid HIV tests as soon as possible, consistent with the FDA's approval process.

Partner Notification. The results of various regional studies confirm that partner notification is a useful and effective intervention and prevention tool. Infected individuals are less likely to notify partners themselves, but will cooperate with programs conducted by public health professionals. Studies and surveys have also concluded that partners notified about potential exposure to HIV support notification programs.

The Presidential Commission on HIV stated, "public health authorities across the United States must begin immediately to institute confidential partner notification, the system by which intimate contacts of the person carrying sexually transmitted diseases, including HIV, are warned of their exposure."

Partner notification has proven to be highly effective. Up to 90 percent of those who test positive cooperate voluntarily with notification. Further, even higher proportions of those partners con-

tacted—usually 90% or more—voluntarily obtain an HIV test. But only 10 percent or less of people who have recently tested HIV-positive manage, by themselves, to notify their partners.

Partner notification is especially important for women because many HIV-infected women do not engage in high risk behaviors but were infected by a partner who does. Recent studies indicate that AIDS develops more quickly in women who would therefore benefit from being alerted to their condition as early as possible. Partner notification has been credited, in part, by the public health community for the fact that syphilis cases in the U.S. have fallen to the lowest levels in history.

The Committee heard testimony from the State of Florida, which recently enacted a partner notification program, that such “activities are effective interventions for reaching individuals at high risk of HIV infection and are unaware of their risk.” States have been successful in reducing the number of new HIV infections—contrary to national trends—in large part to effective partner notification programs.

The legislation authorizes \$30 million for states to enact such policies, but does not require that they do so as a condition of eligibility for Title II funding. States with systems that are approved by the CDC will receive preference for these grants. No State that does not meet the CDC surveillance recommendations will be eligible for these funds after 2004.

Vulnerable Populations. The Committee is concerned that not all Americans receive the same quality of treatment under the CARE Act. As the GAO found in its report entitled “HIV/AIDS: Use of Ryan White CARE Act and Other Assistance Grant Funds”:

Women also did not fare as well as men on most of the measures. Finally, exposure category was a significant factor; those who had acquired their infection by injecting drugs or through heterosexual sex had less favorable patterns of care than did men who had sex with men [MSM].

Therefore, the Committee strongly encourages the Office of HIV/AIDS Policy and the Office on Women’s Health (OWH) to provide a report to Congress on all activities conducted by the US Department of Health and Human Services that impact women who are infected and affected by HIV/AIDS. The report shall include an evaluation by the OWH of the scope and effectiveness of these activities. It will also identify gaps in prevention and care services and in research involving or targeted towards women living with HIV/AIDS. The HHS Secretary shall direct the appropriate agencies within the Department to collaborate with the OWH on such a report.

Priority for Women, Infants, Children and Youth. The Committee has expanded the existing priority on services for women, infants and children to also include youth. The Committee intends the term “youth” to include persons between the ages of 13 and 24, and the term “children” to include those under the age of 13, including infants.

The Committee emphasizes that the minimum amount established by H.R. 4807 is in no way to be construed as a maximum on how much a planning council may spend on these populations. The Committee also recognizes that these priority populations

often comprise a greater proportion of HIV cases rather than AIDS cases in a local area. If data on HIV, rather than the endstage of AIDS, are available, planning councils should take this into account when allocating resources.

The Committee recognizes that, according to the CDC, young people ages 24 and under account for at least half of new HIV infections. The Committee urges planning councils to assure that more is done to provide appropriate services to youth, including prevention, in coordination with Title IV grantees operating in the area.

Perinatal Transmission. Perinatal transmission of HIV is the leading cause of pediatric cases AIDS, and the Committee recognizes the importance of life-saving newborn screening programs. According to the 1998 Institute of Medicine report "Reducing the Odds: Public Health Screening Programs", these programs have a long pedigree in the public health profession:

The first parental screening program mandated by law was for syphilis in the 1930s and 1940s. In early 1960s, many states mandated newborn screening for PKU, a condition that can lead to mental retardation without dietary interventions, and other inborn errors of metabolism. Screening for other inborn errors of metabolism (congenital hypothyroidism, galactosemia, homocystinuria, histidenemia, maple syrup urine disease, and tyrosinemia) followed in the 1970s. In the early 1970s, many states initiated mandatory screening for sickle cell disease, a disease that had limited treatment options, in a variety of populations. Later in the same decade, maternal serum alpha-fetoprotein tests were introduced, on a voluntary basis, to help detect neural tube defects. Today, specific tests mandated or recommended as standards of practice vary substantially across state lines. Mandatory prenatal and newborn testing for substance abuse is increasingly common.

Despite improved progress in developing effective strategies to reduce perinatal HIV transmission, the CDC estimates that nearly 7,000 HIV-infected women give birth in the United States each year and as many as 400 babies continue to be born with HIV infection each year. Breastfeeding by HIV-infected mothers poses additional significant risk of infection to babies.

Even if there were no effective therapies for perinatal HIV transmission, routine testing still would benefit the public health. As the 1998 IOM report pointed out,

In 1936, Thomas Parran, the U.S. Surgeon General, established a program for controlling syphilis that included mandatory prenatal blood tests * * *. Although these laws were passed before the introduction of antibiotic treatment, they resulted in rapid decline in congenital transmission through case finding * * * contact tracing, and the difficult and less effective therapies available at the time. Perhaps the most important aspect of these screening programs was that by making testing routine, they overcame the resistance of physicians to risk offending patients by suggesting a test for syphilis.

Fortunately, medical advances have made it possible to nearly eliminate perinatal HIV transmission. In 1994, research studies demonstrated that the administration of antiretroviral medication during pregnancy, during labor, and to the infant immediately following birth can significantly reduce the transmission of HIV from an infected mother to her baby. From 1994 to 1999, as a result of these interventions, pediatric AIDS cases resulting from perinatal HIV transmission declined by nearly 80 percent. Subsequent studies have indicated that cesarean sections further reduce the risk of transmission. Studies also indicate that, even if treatment begins shortly after birth, antiretroviral therapy can substantially reduce the chance that an HIV-exposed child will become infected.

Due to the availability of interventions to reduce perinatal HIV transmission and to improve the health of HIV-infected women and their children, it is important to increase the number of pregnant women who receive prenatal care and are tested for HIV. In 1995, the House approved a measure requiring universal HIV testing of all newborns. The American Medical Association recommends HIV testing for all pregnant women and newborns with counseling and recommendations for appropriate treatment. The IOM has recommended the adoption of a national policy of universal HIV testing, with patient notification, as a routine component of prenatal care. Regrettably, according to the IOM, 15 percent of HIV-infected pregnant women receive no prenatal care at all.

The routine offering of HIV testing to pregnant women should be a standard of care. Sufficient information must be provided to a pregnant woman so she can make an informed decision to be tested. Studies show that the vast majority of pregnant women will accept an HIV test if it is offered to them. In addition, testing newborns whose mothers' HIV status is unknown helps to ensure that children at risk for HIV are identified and provided treatment.

The offering of HIV testing to pregnant women and to newborns whose mothers' HIV status is unknown, combined with appropriate counseling and treatment, can significantly reduce perinatal HIV transmission, improve access to medical care for HIV-infected women and children, and provide opportunities to further reduce HIV transmission among adults.

For the reasons cited above, the Committee finds the following: (1) universal, routine offering of HIV testing to pregnant women should be a standard of care; (2) HIV testing of newborns whose mothers' HIV status is unknown a standard of care; and (3) relevant medical organizations, public and private payers of health insurance, and public health officials should issue or update relevant HIV counseling, testing and treatment guidelines accordingly.

The Committee also recognizes the need for additional resources to further reduce perinatal HIV transmission. The legislation authorizes an additional \$20 million for activities to reduce perinatal transmission, including outreach, education, testing and treatment for pregnant women and their newborns.

The current statute requires, as a condition of funding, that States have regulations or measures to adopt CDC guidelines concerning HIV counseling and testing for pregnant women and newborns. Women who initially refuse testing should be encouraged to reconsider at later points in their pregnancy. When appropriate, pregnant women who accept testing when it is initially of-

ferred and test negative should be encouraged to get tested again later in pregnancy.

Additionally, consistent with State laws and regulations, sufficient information should be provided to all pregnant women so they can make an informed decision to be tested for HIV. Adequate training and education should be provided to prenatal care providers on the risks of perinatal transmission, and the importance of offering HIV tests to all pregnant women, the benefits of interventions, and the availability of referral sites for women who test positive should be emphasized.

The Committee also believes that it is also important that appropriate post-test counseling, referrals, and linkages to care for HIV-positive women and their children be provided, and that women are not counseled to terminate their pregnancies on the basis of HIV status. States should also have to show that they are taking steps to increase the proportion of women who receive prenatal care, including targeted outreach and education efforts in areas with highest numbers of women who get no or inadequate prenatal care. Reforms to State insurance laws should require that, if health insurance is in effect for an individual, the insurer involved may not (without the consent of the individual) discontinue the insurance, or alter the terms of the insurance, solely on the basis that an individual has been tested for HIV or is infected with HIV.

The Committee has reserved a portion of the additional funding for States that conduct HIV testing of all newborns, or newborns whose mothers' HIV status is unknown. If newborn testing is conducted, in order to maximize the opportunity for reduction of perinatal transmission after birth, the Committee urges states to assure that test results are provided within 48 hours. The Committee recognizes that HIV test results for the newborn will generally also reveal the HIV status of the mother. Therefore, if a newborn tests positive for HIV, it is essential for the mother to be informed of the test results and provided care in a sensitive manner that is consistent not only with CDC guidelines, but also with appropriate measures to protect the confidentiality of both mother and child.

The Committee encourages all states, including those that do not apply for this additional funding, to take these steps and other activities as necessary to reduce perinatal HIV transmission. States are encouraged to coordinate their activities with those of Title IV grantees and other entities that provide services related to the reduction of perinatal HIV transmission. Where appropriate, states are encouraged to provide a portion of grants under this section to Title IV grantees operating in the State.

To assure that there are no financial barriers to the offering of HIV testing to all pregnant women or to providing treatment to reduce perinatal HIV transmission and improve the health of HIV-positive women and children, the Committee encourages all payers of health insurance, both public and private, to assure that HIV testing and treatment during pregnancy and for the mother and child are covered benefits.

The Committee requires that States report to Congress on the progress toward meeting the recommendations of the IOM. Those who have not made progress toward meeting such recommendations must, as a condition of receiving funding, cooperate with the

CDC and submit a report to the Secretary on progress identifying and overcoming barriers to eliminating perinatal HIV transmission.

The Committee does not intend that this bill detrimentally affect religious practices or religious freedom. However, nothing in this bill is designed to preempt existing or prohibit new State religious accommodation laws that allow those with religious objections to decline to have their newborn infants tested for HIV disease if such exemptions exist under state law for other reportable diseases. Further, religious accommodation laws enacted by recipient States shall have no impact whatsoever on the level of federal funding received by the recipient State.

The Committee heard testimony from Mr. Tom Liberti, Chief, Bureau of HIV/AIDS, Florida Department of Health, who detailed how the enactment of a successful HIV reporting system enabled the state to better address the epidemic, particularly within the African-American and Hispanic communities. The availability of such a system will better ensure that all communities affected are recognized and are receiving appropriate care and medical access, thereby reducing disparities and allowing for the equitable allocation of funds.

Minority AIDS Initiative. While the Ryan White CARE Act, in general, has had significant success in addressing the needs of individuals and communities affected by the disease, ethnic and racial minority communities continue to experience disparities in health outcomes in terms of HIV and AIDS. The legislation includes several provisions that intend to refocus and enhance representation, planning, prioritization, and allocation of CARE Act resources to address disparities in health outcomes and the needs of historically underserved and vulnerable communities.

According to the written testimony of Loretta Davis-Satterla, Director, Division of HIV/AIDS-STD with the Michigan Department of Community Health submitted for the Subcommittee on Health and Environment hearing on May 11, 2000:

In Michigan, confidential HIV reporting has been required by statute since 1989. Confidential HIV reporting has greatly enhanced Michigan's ability to rapidly and effectively respond to the dynamics of this epidemic * * * In contrast to AIDS case surveillance, HIV case surveillance provides data to better characterize populations in which HIV infection has been newly diagnosed, including persons with evidence of recent HIV infection. Compared with persons living with AIDS, those reported living with HIV infection in Michigan are more likely to be women (18% for AIDS vs 26% for HIV) and African Americans (55% for AIDS and 62% for HIV). Approximately 1% of AIDS cases occurred in both persons aged 13-19 years and 20-24 years. In comparison, 4% of HIV cases occurred in persons aged 13-19 years and 13% of HIV cases occurred in persons 20-24 years. Thus, AIDS case surveillance alone does not accurately reflect the extent of the HIV epidemic among African Americans, women, adolescents and young adults.

In addition, the Committee affirms the intent of the Minority AIDS Initiative (MAI) in addressing the unique needs of ethnic and racial minority communities. The initiative is intended to complement and supplement, not supplant, the efforts of the Ryan White CARE Act and other national AIDS programs. The MAI was instituted in response to the overwhelming and disproportionate impact of the HIV epidemic on ethnic and racial minority communities.

The MAI is intended to address the needs of Americans in highly impacted communities by enhancing outreach and education, strengthening technical assistance, and supporting capacity building of ethnic and racial minority community based organizations and institutions and providers to deliver culturally competent and appropriate HIV-related prevention, health care, and support services. The initiative also seeks to expand or fund new research initiatives to develop and evaluate culturally competent intervention strategies directed towards reducing and ultimately eliminating the HIV-related health disparities experienced by ethnic and racial minority populations. In this regard, the MAI may prove to be a significant component of an overall strategy for addressing the disease. The Committee encourages the Department of Health and Human Services to include the MAI in its efforts to achieve an integrated and coordinated system of HIV/AIDS care and treatment. With respect to entities that currently receive or have received planning grants through special initiatives such as the MAI, the Committee intends that these entities will still be eligible for such grants under Part C if they meet the appropriate funding criteria.

MAI funding is intended to be targeted to ethnic and racial minority-governed and staffed organizations and where no such organization exist, to institutions that have a history of providing culturally competent services to the communities and populations they are targeting. The funding is intended to build capacity and infrastructure within these communities, and fill gaps in critically needed HIV and AIDS services. This includes providing primary HIV prevention, increasing access to HIV and related health and support services, and ensuring continuity of care for ethnic and racial minority populations and sub-populations including minority women, youth, MSMs, substance abusers, homeless, incarcerated and recently-released individuals.

Incarcerated Populations. The Committee recognizes that HIV public health interventions implemented in correctional settings have great potential to have a significant impact on the epidemic. The success of in-prison interventions requires continuation of medical treatment and behavior modification following release. Post-release failure of inmates to adhere to HIV medical regimens may pose public health dangers by fostering development and transmission of drug-resistant HIV variants. Also, because the vast majority of inmates will be released to their communities, prison, jail, and similar restricted institutions intervention is vital to reduce HIV transmission to the general public. Therefore, the Committee believes that improved discharge planning and continuity of care between correctional facilities and communities are needed to increase the likelihood that HIV-positive releasees will obtain the care they need and take precautions to avoid spreading the disease.

Effective pre-release programs can also help inmates make positive changes in their lives to avoid returning to crime, with the resulting reduced recidivism rates yielding significant benefits to society. The Committee therefore urges the Secretary to give favorable consideration to grants under the Ryan White CARE Act for programs that provide linkages with correctional discharge planning and other transitional services needed to help HIV-positive inmates move successfully from correctional institutions to their communities. These transitional services, which may be needed up to six months prior to release, may include, but are not limited to, clinical referrals, psychosocial services, enrollment in medical care funding programs, a short-term supply of medications upon release, HIV pre-release identification efforts, HIV prevention education, HIV related counseling, coordination and referral, and linkages for substance abuse treatment, and HIV related case management services and linkages to CARE Act programs in their communities.

In addition to prisons and jails, other residential institutions, such as substance abuse treatment facilities and mental health institutions, also have a high concentration of persons at high risk of HIV infection and pose similar intervention opportunities and challenges. The Committee thus urges the Secretary to give favorable consideration to grants under the Ryan White CARE Act for programs that provide discharge planning and other transitional services, including the types of services enumerated above, which are needed to help HIV-positive institutional residents move successfully from institutions to their communities.

Quality Assurance. The Committee recognizes the importance of having CARE Act grantees ensure that quality services are provided to people living with HIV and that the quality management activities are conducted on an ongoing basis. Quality management activities should: assess the extent to which HIV health services provided under this grant are consistent with Public Health Service guidelines for the treatment of HIV and the treatment and prevention of related opportunistic infections and, as applicable, lead to the development of strategies to ensure that such services are consistent with the guidelines and that social support services are provided in a manner as to gain or enhance the benefits of health care services.

The Committee expects the Secretary to provide States with guidance and technical assistance for establishing quality management programs, including disseminating such models that have been developed by States and are already being utilized by Title II programs and in clinical practice environments. The Committee hopes that States will communicate and coordinate CARE Act requirements with other payers to the extent possible to ensure consistency in quality management activities. The Committee expects that most States have quality management systems in place already and that they utilize mechanisms such as peer chart reviews or patient prescription pattern monitoring. The Committee places responsibility on the Secretary to ensure that PHS guidelines, as well as population characteristics and trends in the use of HIV services, are communicated to all CARE Act grantees and sub-grantees. This information, the Committee believes, will assist grantees in ensuring the highest quality of HIV care among CARE Act providers.

The Committee intends that the Secretary provide clarification and guidance regarding the distinction between use of CARE Act funds for such program expenditures that are covered as either planning and evaluation and funds for program support costs. Program support costs are described as any expenditure related to the provision of delivering or receiving health services supported by CARE Act funds. As applied to the clinical quality programs, these costs include, but are not limited to, activities such as chart review, peer-to-peer review activities, data collection to measure health indicators or outcomes, or other types of activities related to the development or implementation of a clinical quality improvement program. Planning and evaluation costs are related to the collection and analysis of system and process indicators for purposes of determining the impact and effectiveness of funded health-related support services in providing access to and support of individuals and communities within the health delivery system.

HIV Consortia. The Committee intends that States continue to work with local Consortia to ensure that they identify potential disparities in access to HIV care services at the local level, with a special emphasis on those experiencing disparities in access to care, historically underserved populations, and HIV infected persons not in care. However, the Committee does not intend that States and/or Consortia be mandated to consult with all entities referenced as part of the planning process under Part A. The Committee intends that States and Consortia will continue to work with the appropriate entities in their jurisdictions to assess and plan services at the local level. Reference to entities included in the Title I planning process is intended to provide guidance to the States that such entities are important constituencies which the States should endeavor to include in their planning processes. The Committee intends that the States require local Consortia to document their efforts to identify and address access disparities at the local level, as appropriate.

Title II Comprehensive Plan. The comprehensive service delivery plan is an effective way to demonstrate the organization and delivery of CARE Act services, based upon the planning, priority setting, and funding allocations processes conducted by the State. The Committee intends that States may demonstrate compliance with the new requirement of an enhanced process of public participation by indicating in their applications existing mechanisms for consumer and community input, and describing how such mechanisms influence the use and distribution of funds and the number of persons not in care and unmet needs of persons not receiving health services. The Committee intends States to develop a strategy to identify individuals with HIV disease who are not receiving services and to inform and enable such individuals to receive services under Title II. The Committee wants CARE Act providers to work actively to bring into and retain in care those individuals who are unaware of their HIV status and those who are knowledgeable of their status but are not receiving services. As part of this process, the Committee believes strongly in the importance of the States focusing on eliminating disparities in access and services among affected subpopulations and historically underserved communities. The Committee recognizes that the availability or lack of HIV prevalence data in particular States will be reflected in the scope, goals,

timetable and allocation of funds for implementation of the strategy.

The Committee also intends States to develop a strategy to coordinate the provision of Title II services with HIV prevention services and substance abuse prevention and treatment services. The Committee has amended numerous aspects of CARE Act programs to enhance the coordination between HIV prevention and HIV care and treatment services.

The Committee intends that additional factors be reflected in the plan such as disparities in access to medical and health-related support services by subpopulations. Upon the development of measures by the Secretary and Title II grantees, as described above, the needs of persons with HIV not in care should be considered in the comprehensive plan. Both the planning process and the resulting plan should continue to include the participation of, and address the needs of, populations and subpopulations living with HIV and AIDS. The specific needs of populations or subgroups, such as women, people of color, persons who are underinsured or uninsured, youth, homeless persons, persons living in rural areas, or persons with substance abuse or other co-occurring conditions within the State need to be specifically addressed. States should continue to consider the availability of services through other public and private health care payers and providers including Medicaid, the State Children's Health Insurance Program (SCHIP) and other public and private sources of health care reimbursement. States should ensure that there are strong coordinating mechanisms between Ryan White and the State Medicaid programs to assure optimal health care for persons living with HIV disease. States should continue to collaborate with other health care and social service providers and payers through the Statewide Coordinated Statement of Need (SCSN) process. The Committee does not intend to mandate that States devote specific portions of their Title II grant funds to specific activities. The Committee recognizes the need for flexibility for States in the administration of Title II programs in order to ensure that local needs are addressed.

ADAP. The legislation strengthens the ADAP program to assist States that are struggling to provide medications to all of their needy clients. The Committee has also sought to strengthen the ability of local communities, States, and service organizations to reach those communities and populations that have been historically most underserved, as well as those that are experiencing rapid increases in HIV infection and AIDS case counts but that have not been brought into the care system developed under Ryan White. The purpose of these changes is to ensure a strong system of health care delivery and access to therapies commensurate with evolving needs.

This section has been amended to permit States to utilize funds under this section to purchase and maintain health insurance on behalf of individuals with HIV disease whose coverage provides a full range of HIV therapeutics and primary care services. The Committee recognizes the cost-effectiveness and potential cost-savings of such a mechanism in the provision of treatments and the fact that several States have already fully integrated such mechanisms into their treatment provision systems.

Grants for Coordinated Services and Access to Research for Women, Infants, Children and Youth. The Committee does not intend to require Title IV applicants to file separate reports to the Secretary to demonstrate linkages to research and how access to such research is offered to patients. Instead, such reporting may be completed as part of the existing grantee reporting process. The report on the distribution and availability of ongoing and appropriate HIV/AIDS-related research projects shall not be interpreted as requiring the Secretary to recommend the redistribution of funds for such research projects or to act on redistributing these funds based on the report's findings.

Early Intervention Services. The Committee expects that EMAs will provide services to American Indian and Native American peoples. Native Americans and American Indians are eligible for Ryan White services through State and Federal citizenship. The Committee supports better co-ordination of Ryan White services for Native Americans and American Indians in order that they may realize the full potential of HIV/AIDS-related primary care and support services provided through CARE Act funding.

The Committee also recognizes that the US Department of Veterans Affairs is the largest single direct provider of HIV care and services in the US. Over 18,000 veterans received HIV care at VA facilities in 1999. Veterans with HIV infection are eligible to participate in Ryan White Title I programs when they meet eligibility requirements set by Title I Planning Councils, and EMA plans for the delivery of services must account for the availability of VA services. VA facilities are eligible providers of HIV health and support services where appropriate. The Committee expects that HRSA's Bureau of HIV/AIDS shall encourage Ryan White grantees to develop collaborations between providers and VA facilities to optimize coordination and access to care to all persons in Title I EMAs.

The Committee understands that the Secretary has convened a Public Health Service Working Group on HIV Treatment Information Dissemination, which has produced recommendations and a strategy for the dissemination of HIV treatment information to health care providers and patients. Recognizing the importance of such a strategy, the Committee intends that the Secretary issue and begin implementation of the strategy to improve the quality of care received by people living with HIV/AIDS.

Administrative Simplification. The Committee is aware of the enormous administrative burden that the current grant application process places on States and recipients of grants under Part A. The Committee is concerned that the current application process may divert critical resources from the provision of care. Therefore, the Committee directs the Secretary to consult with States and recipients of grants under Part A regarding the coordinated disbursement of funds under Part A with the disbursement of funds under Part B, the implementation of a biennial application process under Parts A and B, and the overall simplification and streamlining of the grant application for funds under Parts A and B. The Committee expects that the Secretary will undertake this consultation with States and entities receiving funds under Part A in an expeditious manner and will work with these States and entities to implement agreed upon strategies as soon as possible.

Audits and Consumer Participation. The Committee intends that to the maximum extent possible the funds made available through this legislation are intended for the actual medical and support services needs of the infected population, and not simply “quality of life” issues. According to a November 13, 1997 New York Times story, some services that have been offered using Federal funds included “free dog walking.” Any funds misallocated through frivolity, waste or outright fraud deny someone else living with HIV much needed care.

At the July 11, 2000 hearing the Subcommittee heard testimony from Jose Fernando Colon, Coordinator for Pacientes de SIDA Pro Politica Sana (AIDS Patients for Sane Policies) in San Juan, Puerto Rico. Mr. Colon detailed for the Committee how millions of dollars of money intended for AIDS services was diverted for personal and political purposes, resulting in numerous Federal Court convictions in Puerto Rico. He testified that in 1993 the Department of Health and Human Services was made aware of possible misconduct, but that no investigation was ever conducted.

The GAO reported to the Congress on October 18, 1999 that they had identified two other cases in which fraud and abuse have occurred in regard to CARE Act funds. However, the GAO did not find such fraud and abuse to be either systemic or widespread among grantees or in CARE Act programs. As HRSA Administrator Claude Fox, MD testified to the Subcommittee:

The GAO has looked at it and said there is not a widespread problem. We agree with the provisions in this bill. We want to do everything that we can do within reason to make sure that these funds are well spent. But we do not believe that it is a widespread problem.

H.R. 4807 includes important provisions to prevent and detect fraud with CARE Act funds.

The legislation also contains important provisions which ensure that not less than 33% of Title I HIV Health Services Planning Councils are composed of individuals who are receiving HIV-related services.

The Committee emphasizes that its intent is to ensure that patients and consumers of Title I services constitute a substantial proportion of Planning Council memberships. The prohibition of officers, employees and consultants is not intended to impede the participation of qualified, motivated volunteers with Title I grantees from serving on Planning Councils where they do not maintain significant financial relationships with such grantees. In contrast to such significant financial relationships, volunteers may be reimbursed reasonable incidental costs, including for training and transportation, which help to facilitate their important contribution to the Planning Councils.

The Committee intends that Planning Councils ensure its members are knowledgeable about their duties, the functions of the Councils, and the Councils’ role in the organization and delivery of HIV/AIDS health and support services. The provision of training guidance and materials to the Councils by HRSA’s Bureau of HIV/AIDS will go far to ensure that Council members, particularly patients and consumers of HIV/AIDS services, can serve effectively

and improve the allocation of resources and the planning and implementation of Title I services.

The Committee also expects Planning Councils to provide assistance, such as transportation and childcare, to facilitate the participation of consumers, particularly those from affected subpopulations and historically underserved communities.

Further, the bill ensures that grants will be available for training members of these planning councils, and that planning council meetings will be open to the public. Mr. Colon stated that these types of reforms will lead to increased accountability, and the Committee agrees with this assessment.

Further, for the first time, the Committee intends that the Secretary may reduce grants to States or political subdivisions of States which fail to prepare and submit audits to the Secretary. From these audits, the Secretary must annually randomly review samples of the audits, ensuring that CARE Act funds are being appropriately expended.

HEARINGS

The Subcommittee on Health and Environment held a hearing on July 11, 2000. The Subcommittee received testimony from: Claude Earl Fox, M.D., M.P.H., Administrator, Health Resources and Services Administration, accompanied by Joseph O'Neil, M.D., M.P.H., Associate Administrator, Bureau of HIV/AIDS, Health Resources and Services Administration; Ms. Janet Heinrich, Associate Director, US General Accounting Office, accompanied by Mr. Jerry Fastrup, Assistant Director, US General Accounting Office; Ms. Jeanne White, National Spokesperson, AIDS Action; Mr. Tom Liberti, Chief, Bureau of HIV/AIDS, Florida Department of Health; Guthrie S. Birkhead, M.D., M.P.H., Director, AIDS Institute, New York State Department of Health; Mr. Joe Davy, Policy Advocate, Columbus AIDS Task Force; Ms. Dorothy Mann, Board Member, AIDS Alliance for Children, Youth & Families; Mr. Jose F. Colon, Coordinator, Pacientes de SIDA Pro Politica Sana and; Mr. Eugene Jackson, Deputy Executive Director for Policy, National Association of People with AIDS.

COMMITTEE CONSIDERATION

On July 13, 2000, the Full Committee met in open markup session and ordered reported H.R. 4807, the Ryan White CARE Act Amendments of 2000, as amended, by a voice vote.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. There were no record votes taken in connection with ordering H.R. 4807 reported. A motion by Mr. Bliley to order H.R. 4807 reported to the House, with an amendment, was agreed to by a voice vote.

The following amendments were agreed to by a voice vote:

An amendment by Mr. Coburn, No. 1, making various technical changes to the bill; and

An amendment by Mr. Strickland, No. 4, ordering States, consortia, and supplemental grant applicants to seek comment

from an expanded body of stakeholders used by Title I EMA cities when preparing their required plans.

The following amendments were withdrawn by unanimous consent:

An amendment by Ms. Eshoo, No. 2, replacing the “hold harmless” provision in the bill with the Senate provision reducing the cut in Title I funds to 2% per year over 5 years; and

An amendment by Ms. DeGette, No. 3, giving States the option to cover pregnant women under the State Children’s Health Insurance Program.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held legislative and oversight hearings and made findings that are reflected in this report.

COMMITTEE ON GOVERNMENT REFORM OVERSIGHT FINDINGS

Pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 4807, the Ryan White CARE Act Amendments of 2000, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 24, 2000.

Hon. TOM BLILEY,
*Chairman, Committee on Commerce,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4807, the Ryan White CARE Act Amendments of 2000.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Julia Christensen.

Sincerely,

STEVEN LIEBERMAN
(For Dan L. Crippen, Director).

Enclosure.

H.R. 4807—Ryan White Care Act Amendments of 2000

Summary: H.R. 4807 would reauthorize programs in title XXVI of the Public Health Services Act, which was created by the Ryan White CARE Act (Public Law 101-381). Programs funded under the Ryan White CARE Act address the needs of individuals living with HIV disease. The bill would amend certain provisions under that title to increase access to care and require that care to be consistent with the guidelines of the Public Health Service (PHS). The bill also would create new grant programs to:

- Pay for health care services for individuals with HIV disease in states ineligible for emergency relief grants;
- Establish partner notification programs in the states, and
- Provide to states technical assistance with setting up data surveillance and reporting systems related to HIV disease and other funding for data collection efforts.

The Health Resources and Services Administration (HRSA) under the Department of Health and Human Services (HHS) administers most of the Ryan White CARE Act programs; small portions are implemented through the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH). Assuming the appropriation of the necessary amounts, CBO estimates that implementing H.R. 4807 would cost \$351 million in 2001 and \$6.7 billion over the 2001–2005 period, without adjusting for inflation. The five-year total would be \$7 billion if adjustments for inflation are included. The legislation would not affect direct spending or receipts; therefore, pay-as-you-go procedures would not apply.

H.R. 4807 contains no private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). It does contain an inter-governmental mandate as defined in UMRA, but it also contains new budget authority for grants that may be used by states to cover the costs associated with the mandate. Consequently, the threshold established in UMRA (\$55 million in 2000, adjusted annually for inflation) would not be exceeded.

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 4807 is shown in Table 1. The costs of this legislation fall within budget function 550 (health).

TABLE 1.—BUDGETARY IMPACT OF H.R. 4807

	By fiscal year, in millions of dollars—					
	2000	2001	2002	2003	2004	2005
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law:						
Budget Authority ¹	1,605	0	0	0	0	0
Estimated Outlays	1,376	1,209	248	64	(?)	0
Without Adjustment for Inflation						
Proposed Changes:						
Estimated Authorization Level	0	1,711	1,711	1,711	1,711	1,711

TABLE 1.—BUDGETARY IMPACT OF H.R. 4807—Continued

	By fiscal year, in millions of dollars—					
	2000	2001	2002	2003	2004	2005
Estimated Outlays	0	351	1,402	1,608	1,676	1,678
Spending Under H.R. 4807						
Estimated Authorization Level ¹	1,605	1,711	1,711	1,711	1,711	1,711
Estimated Outlays	1,376	1,559	1,650	1,672	1,676	1,678
With Adjustments for Inflation						
Proposed Changes:						
Estimated Authorization Level	0	1,793	1,766	1,800	1,834	1,866
Estimated Outlays	0	356	1,431	1,663	1,764	1,798
Spending Under H.R. 4807:						
Estimated Authorization Level ¹	1,605	1,739	1,766	1,800	1,834	1,866
Estimated Outlays	1,376	1,565	1,679	1,728	1,764	1,798

¹The 2000 level is the amount appropriated for that year for title XXVI programs.

²Less than \$500,000.

Basis of estimate: For this estimate, CBO assumes that the bill will be enacted by the end of fiscal year 2000 and that outlays will follow historical spending rates for the authorized activities. Where specified in H.R. 4807, CBO assumes the authorized amounts would be appropriated. Where appropriations of such sums as necessary are authorized, CBO based its estimates on amounts spent in the past for similar types of activities. Table 1 shows two alternative spending paths: one assuming no increase to account for inflation, and one with annual inflation adjustments.

Reauthorization of existing programs

The authorizations for appropriations for most of the programs under the Ryan White CARE Act expire at the end of fiscal year 2000. H.R. 4807 would reauthorize those programs for fiscal years 2001 through 2005. Table 2 shows the amount appropriated in fiscal year 2000, and the estimated authorization levels under H.R. 4807 for fiscal years 2001 through 2005, with adjustments for inflation.

TABLE 2.—TITLE XXVI PROGRAMS: APPROPRIATIONS FOR FISCAL YEAR 2000 AND AMOUNTS AUTHORIZED IN H.R. 4807, WITH ADJUSTMENTS FOR INFLATION

	By fiscal year, in millions of dollars—					
	2000	2001	2002	2003	2004	2005
Programs Administered by HRSA						
Reauthorizations: ¹						
Part A (Title I of the Ryan White CARE Act) emergency relief grants	547	556	566	576	586	597
Part B (Title II) HIV care grants	824	839	853	868	884	900
Part C (Title III) early intervention services	138	141	143	146	149	151
Part D (Title IV) pediatric AIDS: women, children, and youth	51	52	53	54	55	56
Part D (Title IV) evaluations and reports	0	4	4	4	4	4
Part F demonstration and training AIDS education and training centers	27	27	28	28	29	29
Dental reimbursements	8	8	8	8	9	9
Modifications to Current Programs:						
Planning and capacity development grants	0	6	6	6	6	6
AIDS education and training centers	0	15	17	20	20	21
Other activities	0	6	1	1	1	1
New programs:						
Supplemental grants for certain states ineligible for Part A grants	0	0	0	0	3	3

TABLE 2.—TITLE XXVI PROGRAMS: APPROPRIATIONS FOR FISCAL YEAR 2000 AND AMOUNTS AUTHORIZED IN H.R. 4807, WITH ADJUSTMENTS FOR INFLATION—Continued

	By fiscal year, in millions of dollars—					
	2000	2001	2002	2003	2004	2005
Complaint partner notification program	0	30	31	31	32	32
Subtotal	1,595	1,683	1,709	1,743	1,777	1,808
Programs Administered by CDC						
HIV-related services for pregnant women and newborns ¹	10	30	30	30	30	30
Data collection, reports, and other activities	0	25	26	26	26	27
Provisions Administered by NIH						
Expansion of HIV research funds for affordable HIV testing and issuance of reports	0	1	1	1	1	1
Total Proposed Changes	1,605	1,739	1,766	1,800	1,834	1,866

¹The 2000 level is the amount appropriated for that year.

HRSA Programs. The bill would reauthorize several programs organized under different parts of the Ryan White Care Act:

- Part A of title XXVI, (also known as title I of the Ryan White CARE Act), is the Emergency Relief Grant program. It provides grants to eligible metropolitan areas (EMAs) severely affected by the HIV epidemic. The funds are used for outpatient and ambulatory health care and other support services provided by community-based systems to low-income or under-insured people living with HIV/AIDS.

- Part B, (title II of the act), is the HIV Care Grant program. It provides grants to states and territories for health care and social support services. Services are delivered primarily through consortia of providers of HIV services. Some Part B funds also are earmarked to pay for drug treatment for certain individuals with HIV disease. In addition, states may use grant money to help low-income individuals purchase health insurance through Health Insurance Continuation programs.

- Part C, (title III of the act), is the Early Intervention Services program. It awards grants to public and private nonprofit community-based programs that provide comprehensive primary health care services targeting at-risk populations and aim to reduce or prevent HIV-related morbidity.

- Part D, (title IV of the act), contains general provisions. The pediatric AIDS: women, children, and youth program provides funding to improve and expand the primary care and support services for special populations living with HIV disease. The program aims to increase access to comprehensive, coordinated, community-based family-centered systems of care for infected individuals and their families.

- Part F¹ contains the demonstration and training programs. It authorizes a network of regional centers that conduct HIV/AIDS education and training programs for healthcare providers, special projects of national significance relating to the development of innovative models of HIV/AIDS care, and financial assistance to den-

¹There has never been an appropriation for Part E, which requires the Secretary to make grants to state and local governments to assist them in disseminating guidelines to emergency responses employees regarding reducing the risk in the workplace of becoming infected with AIDS.

tal schools for uncompensated oral health care costs for patients with HIV disease.

CBO estimates that reauthorizing those provisions would cost \$325 million in 2001 and \$6.6 billion over the 2001–2005 period.

CDC Programs. H.R. 4807 would authorize a CDC-administered program that provides HIV-related services to pregnant women and newborns. The bill would authorize the appropriation of \$30 million a year and would expand the services covered under the program. If at least \$10 million is appropriated, part of the amount above \$10 million would be set aside for states that comply with certain requirements such as mandatory testing. CBO estimates that this provision would cost \$11 million in 2001 and \$122 million over the 2001–2005 period.

Modifications to current programs

The bill would make several modifications to existing programs. Those changes and their estimated budgetary effects are described below. In total, CBO estimates that implementing these modifications would cost \$5 million in 2001 and \$102 million over the 2001–2005 period.

Planning and Capacity Development Grants. Section 312 of H.R. 4807 would authorize a program of capacity development grants to assist public and nonprofit private entities in expanding their ability to provide primary care and early intervention services to individuals with HIV disease in underserved communities. Under current law, a maximum of 1 percent of the amount appropriated for Part C can be used for planning grants. H.R. 4807 would increase to 5 percent the proportion that could be earmarked for the new capacity development grants and the planning grants. The maximum new capacity development grant would be set at \$150,000 under the bill. CBO estimates this provision would cost \$1 million in 2001 and \$23 million through 2005.

AIDS Education and Training Centers and Dental Reimbursements. H.R. 4807 would allow the Secretary of HHS to fund projects to develop and disseminate treatment guidelines and protocols for prenatal and gynecological care of women with HIV disease. It also would authorize training of health professionals in that area. H.R. 4807 would require the Secretary to develop and implement a strategy for disseminating HIV-related information to health care providers and patients. The bill also would modify the dental school grant program to allow partnership agreements between dental programs and community-based dentists to provide services in unserved areas. Finally, the bill would permit certified dental hygiene programs to receive reimbursement for uncompensated oral health care services provided to individuals with HIV disease under the dental reimbursement program. CBO estimates that those provisions would cost \$3 million in 2001 and \$71 million over the 2000–2005 period.

Other HRSA Activities. H.R. 4807 would require that formula grants reauthorized under Parts A and B use the number of HIV disease cases and AIDS cases in the distribution formulas in fiscal year 2005 and subsequent years. This provision would have no direct impact on federal spending. The bill would require the federal government to assist states with the new data requirements that would directly raise their program costs.

Part A grants. The bill would extend indefinitely the requirement that 50 percent of appropriated funds for Part A be disbursed within 60 days after the appropriation becomes available. (Those funds are disbursed in the form of formula grants.) A “hold harmless” provision in the bill would also change the limit on the amount by which grants to states could decline from year to year. Those provisions would affect the distribution of annual appropriations and the expedited disbursement might affect the pattern at which such appropriations would be spent during the year (by increasing the amounts disbursed within 60 days of appropriation), but CBO anticipates that they would not affect total program spending.

Part B grants. Section 206 of the bill would double the minimum Part B base award to \$200,000 for states with fewer than 90 living cases of AIDS and to \$500,000 for states with 90 or more living cases of AIDS. It would also add the Federated States of Micronesia and the Republic of Palau as entities eligible to receive Part B funds. The bill also would modify the hold harmless formula for Part B grants. CBO estimates those changes would cost less than \$500,000 in 2001 and \$4 million over the 2001–2005 period.

Additional HRSA activities and reports. H.R. 4807 would require several new activities by the Secretary of HHS and many new studies and reports. The Secretary, through the Administrator of HRSA and in consultation with grant recipients, would be required to conduct a review of several administrative procedures for grants provided under Parts A and B, and develop new coordinated and more efficient procedures. Submission of the various plans for implementing such changes to the Congress would be due within 18 to 24 months of enactment.

The bill also would require that the Secretary provide training manuals and guidance materials to the Planning Council members who make allocation decisions about Part A grants. It also would require that the Secretary develop national quantitative incidence data and design a mechanism for its use in making awards for the supplemental grant money that goes to states demonstrating “severe need.”

The bill also would require that the Secretary of HHS, in consultation with others, develop a plan regarding appropriate care following the release of prisoners with HIV disease within two years following enactment.

H.R. 4807 would require federal coordination among federal HIV programs concerning planning, funding, and implementation issues. This provision would affect programs administered by HRSA, CDC, the Substance Abuse and Mental Health Services Administration, and the Health Care Financing Administration. The bill would require biannual reports to the Congress with an analysis of the federal barriers to HIV program integration, including proposals to eliminate those barriers, as well as a status report on the coordination efforts at the federal, state, and local levels.

The Secretary would be required to request that the Institute of Medicine (IOM) complete a study, within two years after the enactment of H.R. 4807, regarding the appropriate epidemiological measures and their relationship to health-related support services for certain individuals with HIV. The Secretary would have to report to the Congress within 90 days of the request’s completion. The bill also would require that the Secretary request IOM to con-

duct a study on the reliability of surveillance systems used by the states and to issue recommendations to improve those systems within three years of enactment. H.R. 4807 also would require that the Secretary request IOM to conduct a study within 18 months of enactment on perinatal transmission of HIV across the states, including an analysis of barriers to the testing of newborns and pregnant women, and to provide state-by-state recommendations to reduce perinatal transmission of HIV.

CBO estimates those activities and reports would cost about \$1 million in 2001 and \$5 million over 2001 through 2005.

New HRSA programs

In addition to reauthorizing current programs and making certain programmatic changes, the bill would provide authorizations for two new provisions in the Ryan White CARE Act that would increase program costs. The estimated appropriations authorized in the bill for these provisions is also shown in Table 2.

New Supplemental Grants for Certain States. Section 207 of H.R. 4807 would create a new supplemental grant program to meet HIV care and support needs in areas that are not eligible for Part A grants. The Secretary of HHS would be required to reserve 50 percent of the increase in funding for Part B grants (other than that earmarked for state AIDS drug assistance programs, or ADAPs) for these supplemental grants—which would be awarded competitively to states in “severe need” for additional resources. However, the program would not begin until the amount appropriated under Part B (excluding ADAP funds) is \$20 million higher than the amount appropriated in 2000. Under the inflation-adjusted assumptions used for this estimate such a trigger would not be reached until 2004. CBO estimates that the new program would have no effect on federal spending in 2001 but would cost \$3 million over the 2001–2005 period.

Compliant Partner Notification Program. H.R. 4807 would establish a new grant program for partner notification, counseling, and referral services. States would have to cooperate with CDC and comply with certain requirements, including information sharing between states, to be eligible to receive funds. The bill would authorize \$30 million for this program in 2001 and such sums as necessary through 2005. Assuming appropriation of the necessary amounts, CBO estimates that implementing this provision would cost \$6 million in 2001 and a total of \$121 million through 2005.

NIH activities and reports

H.R. 4807 would direct the Secretary, through the Director of the NIH, to examine the distribution and availability of HIV-related clinical research programs for women, infants, children, and youth. Although H.R. 4807 does not require submission of a report to the Congress, CBO believes the bill’s intent is to have the results of the evaluation transmitted to the Congress. The bill also would require that NIH expand its research efforts in the development of rapid HIV tests and to provide progress reports to the Congress. CBO estimates that those provisions would cost less than \$500,000 in 2001 and \$5 million over the 2001–2005 period.

CDC activities and reports

H.R. 4807 would authorize a new program for CDC to collect data and provide information support to the Ryan White program and its grantees for planning and evaluation activities. Based on the resources CDC currently devotes to supporting the improvement of states' HIV surveillance systems, CBO estimates that up to an additional 40 percent of that amount would be needed, or about \$25 million starting in fiscal year 2001. It also would require that the Secretary, in consultation with CDC and the Food and Drug Administration, submit an analysis of issues surrounding pre-market reviews and commercial distribution of rapid HIV tests of the Congress within 90 days of enactment. In addition, the bill would require the CDC to establish guidelines for the use of rapid HIV tests, with specific recommendations for states, hospitals, and other entities on the availability of HIV tests for administration to pregnant women in labor or in late-stage pregnancy with unknown HIV status. CBO estimates that those activities and reports would increase costs by \$9 million in 2001 and \$105 million over the 2001–2005 period.

Pay-as-you-go considerations: None.

Estimated impact on state, local, and tribal governments: The bill contains an intergovernmental mandate as defined in UMRA because it would require states to implement recommendations by the Institute on Medicine for increasing the routine testing of pregnant women and newborn children for HIV. States would be required to submit reports that describe their progress toward implementing the recommendations and barriers in the state that inhibit an obstetrician's ability to routinely test pregnant women and newborn infants for HIV.

The bill also would authorize \$30 million annually in grants for testing and treating case of perinatal HIV. CBO assumes that states would be allowed to use these grants to comply with the intergovernmental mandate and that the costs of the mandate would be well below that amount. The bill also would expand the purposes for which a number of grants could be used, including outpatient ambulatory and support services, inpatient case management, and early intervention. Additional requirements for grants include increased outreach, data collection, and implementation of quality management procedures. Such requirements would not be intergovernmental mandates as defined in UMRA because they are conditions of federal assistance.

Estimated impact on the private sector: The bill contains no private-sector mandates as defined in UMRA.

Previous CBO estimate: On May 10, 2000, CBO transmitted a cost estimate for S. 2311, the Ryan White CARE Act Amendments of 2000, as ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on April 12, 2000. The two bills would make different changes to the Ryan White CARE Act, and the two estimates reflect those differences.

Estimated prepared by: Federal Costs: For HRSA: Julia M. Christensen. For CDC: Jeanne M. De Sa. For NIH: Christopher J. Topoleski. Impact on State, Local, and Tribal Governments: Leo Lex. Impacts on the Private Sector: Jennifer Bullard.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title; table of contents

This section provides the short title of the legislation, the “Ryan White CARE Act Amendments of 2000,” and includes a table of contents.

TITLE I—EMERGENCY RELIEF FOR AREAS WITH
SUBSTANTIAL NEED FOR SERVICES

Subtitle A—HIV Health Services Planning Councils

Section 101. Membership of councils

Subsection (a) changes the requirements for representation on an HIV Health Services Planning Council. Under current law, the Council must reflect in its composition the demographics of the epidemic in the eligible area. New language requires that the Council reflect in its composition the demographics of the population of individuals with HIV disease in the eligible area. This subsection clarifies the requirement that representatives to the Council from affected communities must include people with HIV disease. Representatives to the Council who are grantees under other Federal HIV programs may include providers of HIV prevention services. This subsection also adds the new requirement that the Council include representatives of individuals who formerly were Federal, State, or local prisoners, were released from the custody of the penal system during the preceding three years, and had HIV disease when so released.

Subsection (b) establishes a new requirement that at least 33% of the Council must be individuals who are receiving HIV-related services under Part A, the Emergency Relief Grant Program, must not be officers, employees, or consultants to any entity receiving

such a grant, and do not represent such entity. An individual will be considered as receiving such services if the individual is the parent or caregiver of a minor child who is receiving HIV services. This restriction does not apply to entities receiving grants under other parts of the Ryan White CARE Act.

Section 102. Duties of councils

Section 102(a) adds to the duties of the HIV Health Service Planning Council the requirements to determine the size and demographics of the population of individuals with HIV disease and the needs of the population, with particular attention to individuals with HIV disease who are not receiving HIV-related services, and disparities in access and services among affected subpopulations and historically underserved communities.

This provision also rewrites current law on priorities that the Council must take into account in allocating of funds. The Council must take into account the size and demographics of the population with HIV disease; the demonstrated (or probable) cost effectiveness and outcome effectiveness of proposed strategies; the priorities of the communities for whom the services are intended; the availability of government and nongovernmental sources of funding, including Medicaid and the SCHIP program; and the capacity development needs in historically underserved areas. In developing a comprehensive plan for the organization and delivery of health and support services, the Council must include a strategy for identifying individuals with HIV disease who are not receiving services and for enabling such individuals to utilize the services, giving particular attention to eliminating disparities, and including discrete goals, a timetable, and an appropriate allocation of funds and a strategy to coordinate the provision of such services with programs for HIV prevention and for the prevention and treatment of substance abuse. The plan must be compatible with any State or local plan providing HIV services. The Council must coordinate with Federal grantees that provide HIV-related services within their area.

After receipt of a report by the Institute of Medicine, the Secretary of Health and Human Services, in consultation with entities that receive grants under Part A and Part B, must develop epidemiologic measures for establishing the number of individuals living with HIV disease who are not receiving HIV-related services and carrying out the duties of the Council.

The Secretary must provide guidelines and materials for training members of the planning Council regarding their duties to each chief elected official receiving a grant under Part A.

Section 103. Open meetings; other additional provisions

This section sets forth additional provisions with respect to public deliberations of the Planning Council. The Council may not be chaired solely by an employee of the grantee under Part A. Further, Council meetings must be open to the public and held after adequate notice and documents prepared by or made available to the Council must be made available for public inspection and copying. The Council must keep detailed minutes and their accuracy must be certified by the Council chair. This section does not apply

to the disclosure of personal information that would constitute an invasion of privacy, including medical or personnel matters.

Subtitle B—Type and Distribution of Grants

Section 111. Formula grants

Subsection (a) changes current law, which states that Part A grant funds for eligible areas must be distributed not later than 60 days after such funds are made available “for each of the fiscal years 1996 through 2000.” The amendment applies to a generic fiscal year.

Subsection (b) provides that, for grants made for FY2005 and subsequent fiscal years, the cases counted for each 12-month period beginning on or after July 1, 2004, must be cases of HIV disease (as confirmed by the Centers for Disease Control and Prevention(CDC)) rather than cases of acquired immune deficiency syndrome as under current law. The update of the yearly percentages used to determine grant amounts must be reported to the congressional committees of jurisdiction and, as applicable, the updates must take into account HIV cases. This subsection also requires the Secretary to determine whether sufficiently accurate and reliable data exists on cases of HIV disease. If the Secretary determines, by July 1, 2004, that there is not sufficiently accurate and reliable data on cases of HIV disease from all eligible areas, then references in this section to cases of HIV disease do not have any legal effect. From amounts appropriated for CDC grants on data collection, the Secretary is required to reserve funds to make grants and provide technical assistance to States and eligible areas for obtaining data on cases of HIV disease to ensure that data on such cases is available from all States and eligible areas as soon as practicable but not later than the beginning of FY2007.

Subsection (c) revises the limitation on the reduction in funding for a grant from one fiscal year to the next which may occur in certain eligible areas. Under current law, grants made under Part A for fiscal year 2000 cannot be less than 95% of the amount received by the eligible area in fiscal year 1995. This provision stipulates that for each fiscal year in a protection period for an eligible area, the amount of the grant is increased to ensure that: (1) for the first fiscal year in the protection period, the grant is not less than 98% of the amount of the grant made for the base year for the protection period; (2) for any second fiscal year in such period, the grant is not less than 95.7% of the base year grant; (3) for any third fiscal year in such period, the grant is not less than 91.1% of the base year grant; (4) for any fourth fiscal year, the grant is not less than 84.2% of the base year grant; and (5) for any fifth or subsequent fiscal year in such period, the grant is not less than 75% of the base year grant. This provision also defines the base year for a protection period as the fiscal year preceding the trigger grant-reduction year. Further, it defines the first trigger grant-reduction year as the first fiscal year (after FY2000) for which the grant for the area is less than the grant for the preceding fiscal year. A protection period begins with the trigger grant-reduction year and continues until the beginning of the first fiscal year for which the grant equals or exceeds the amount of the grant for the base year. Any subsequent trigger grant-reduction year is the first fiscal year

after the end of the preceding protection period, for which the grant is less than the grant for preceding fiscal year.

Section 112. Supplemental grants

Current law provides a series of factors to be given priority consideration in awarding supplemental grants. Subsection (a) directs that the Secretary must count “severe need” as one-third when weighing factors to determine supplemental grant amounts. It also adds as new factors in determining severe need the current prevalence of HIV disease, the increasing need for HIV-related services, and unmet need for such services. Further, it directs the Secretary to develop a mechanism to use national, quantitative incidence data not later than 18 months after the enactment. The mechanism should be modified to reflect the findings of the IOM report on epidemiological measures and health care for individuals with HIV disease.

Subsection (b) makes conforming amendments to the statute.

Subtitle C—Other Provisions

Section 121. Use of amounts

The legislation makes some technical changes to the general primary purposes for the use of grant funds under Part A regarding outpatient and ambulatory health or support services, and inpatient case management. Subsection (a) specifically defines outpatient and ambulatory support services as including case management, to the extent that such services facilitate, support, or sustain the delivery, or benefits of health services. It also includes outreach activities as a new general primary purpose for the use of grant amounts. The outreach activities are intended to identify individuals with HIV disease who are not receiving HIV-related services.

Subsection (b) authorizes the use of Title I grants for early intervention services. (Under current law, such services are only provided under Title III.) The entities which may receive grants for such services include: public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV disease counseling and testing sites, State health care points of entry or eligible areas, federally qualified health centers, and entities providing early intervention services. The entity must demonstrate to the chief elected official that Federal, State, or local funds are inadequate for the services to be provided and that the entity will supplement and not supplant other available funds for such services.

Subsection (c) specifies that the chief elected official must establish a quality management program to assess the extent to which services are consistent with Public Health Service guidelines for the treatment of HIV disease, and as applicable, to develop strategies to ensure that such services are consistent with the guidelines. Restricts spending on such program to the lesser of 5% of the Title I grant received or \$3 million.

Section 122. Application

In addition to other assurances specified under current law that are to be included on an application, entities within an eligible area

that receive grant funds must maintain relationships with appropriate entities in the area, including those conducting early intervention services.

Section 123. Review of administrative costs and compensation

Each chief elected official must ensure, not later than one year after the date of enactment of this legislation, that the planning Council reviews available data on the administrative costs (including financial compensation and benefits) of entities receiving grants; and determines whether compensation of any officers or employees of such entities exceeds that of the chief elected official.

TITLE II—CARE GRANT PROGRAM

Subtitle A—General Grant Provisions

Section 201. Priority for women, infants, and children

Under current law, a priority for services is provided for women, infants, and children; this section adds youth to this group.

Section 202. Use of grants

Under current law, Part B grants funds may be used to provide a variety of health services for individuals and families with HIV disease including: outpatient and ambulatory health and support services; inpatient case management; outreach activities; establishment and operation of HIV care consortia; home-based and community-based care services; continuity of health insurance coverage; and, therapeutics to treat HIV disease. This section specifies that States may use Part B grant funds for: (1) support services, including case management, to the extent that such services facilitate, support, or sustain the delivery, or benefits of health services for individuals and families with HIV disease; (2) outreach activities that are intended to identify individuals with HIV disease who are not receiving HIV-related services; (3) early intervention services (under current law, such services are only provided under Title III); and (4) quality management program to assess the extent to which services are consistent with Public Health Service guidelines for the treatment of HIV disease, and as applicable, to develop strategies to ensure that such services are consistent with the guidelines. It also restricts spending on quality management to the lesser of 5% of the Part B grant received or \$3 million. (The guidelines and restrictions governing Part B grants for quality management are the same as those required for Part A.)

Section 203. Grants to establish HIV CARE consortia

This section adds new language regarding the assurances and the application submitted by a consortium to a State for Part B grant assistance. Current law requests that a consortium provide a number of assurances along with the application to a State for Part B grant funds. It stipulates that a consortium must provide the State with assurances that it has identified populations with HIV disease, particularly those experiencing disparities in access and services and those who reside in historically underserved communities. In addition, the consortium must provide assurances that its service plan is consistent with the State comprehensive plan for

the organization and delivery of HIV health care and support services. The consortium must also demonstrate in the application for Part B grant funds that adequate planning occurred to address disparities in access and services in historically underserved communities.

Section 204. Provision of treatments

This section makes changes in how States may use funds under Part B to provide treatments for individuals with HIV disease. Current law authorizes States to provide prescription drugs to low-income individuals with HIV disease. New language allows a State to expend grants to pay, on behalf of individuals with HIV disease, the costs of purchasing or maintaining health insurance or plans whose coverage includes a full range of such therapeutics and appropriate primary care services.

Section 205. State application

Subsection (a) makes additions to the information that must be included in the State application for Part B funds (these changes are similar to those made to the duties of the Planning Council under Title). This subsection specifies that a State application must contain determinations of: (1) the size and demographics of the population of individuals with HIV disease; and (2) the needs of the population, with particular attention to individuals with HIV disease who are not receiving HIV-related services, and disparities in access and services among affected subpopulations and historically underserved communities.

The State application must provide a comprehensive plan that, in addition to current law requirements, establishes priorities for the allocation of funds based on: size and demographics of the population with HIV disease; the availability of other governmental and nongovernmental resources; the capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities and rural communities; and the efficiency of the administrative mechanism of the State for rapidly allocating funds to the areas of greatest need. The comprehensive plan must also include: (1) a strategy for identifying individuals with HIV disease who are not receiving services and for enabling such individuals to utilize the services, giving particular attention to eliminating disparities, and including discrete goals, a timetable, and an appropriate allocation of funds; and (2) a strategy to coordinate the provision of such services with programs for HIV prevention and for the prevention and treatment of substance abuse.

Subsection (b) revises the public hearing process. Current law provides that the public health agency administering the grant for the State will conduct public hearings concerning the proposed use and distribution of funds received under Part B. This subsection specifies that the public health agency administering the grant for the State must engage in a public advisory planning process, including public hearings, when developing the comprehensive plan for the State application. This public advisory planning process must include the same participants represented when developing the statewide coordinated statement of need and shall to the extent possible include entities described in section 2602(b)(2).

Subsection (c) requires that, along with the State application for Part B funds, the State must provide an assurance that entities located within areas in which grant activities are carried out must maintain relationships with appropriate entities in the area, including those providing early intervention services.

Section 206. Distribution of funds

Subsection (a) doubles the minimum allotments for grants under Part B. For States with less than 90 living cases of AIDS, the minimum grant is \$200,000 instead of \$100,000 in current law. The minimum grant for States with 90 or more living cases of AIDS is \$500,000 instead of \$250,000 in current law. In addition, each territory is eligible for a minimum funding level of \$50,000; current law does not provide a minimum funding level for territories.

Current law uses an estimate of the number of living cases of AIDS within the State or territory in the formula which determines the amount of a State grant under Part B. Subsection (b) provides that when estimating living cases for grants made for FY2005 and subsequent fiscal years, the cases counted for each 12-month period beginning on or after July 1, 2004, shall be cases of HIV disease (as confirmed by CDC) rather than cases of AIDS, as in current law. However, if the Secretary determines by July 1, 2004, that there is not sufficiently accurate and reliable data on cases of HIV disease from all eligible areas, then references in this section to cases of HIV disease do not have any legal effect.

Subsection (c) revises the limitation on the reduction in funding for a grant from one fiscal year to the next which may occur in certain States.

Subsection (d) provides that each territory is eligible for a minimum funding level of \$50,000, duplicating a change made in this bill by section 206, subsection (a).

Subsection (e) authorizes the Secretary to reserve 2% of AIDS drug assistance program funds to make grants to States whose HIV patients have a need for therapeutics that is not being met by the current ADAP program within the State. These grants are discretionary grants and not formula grants. It also requires such grants to be distributed not later than 240 days after ADAP funds become available. States must match such grants with non-federal contributions of not less than 25% of the costs.

In current law, the term "territory of the United States" is defined as American Samoa, the Commonwealth of the Northern Mariana Islands and the Republic of the Marshall Islands. "State" is defined as the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam. Subsection (f) amends the definition of the territories to include the Federated States of Micronesia, the Republic of Palau, and for purposes of determining minimum grant level, the Commonwealth of Puerto Rico.

Section 207. Supplemental grants for certain states

This section removes a section of current law, which is replaced by section 413. A new supplemental grant program is created for States that have eligible communities with a severe need for comprehensive HIV-related services and which are not eligible for grants under Part A. States must submit an application that details the need for services in such communities. The program be-

comes effective when the amount appropriated to Title II (excluding ADAP) is at least \$20 million greater than the appropriation for Title II in FY2000.

Subtitle B—Provisions Concerning Pregnancy and Perinatal
Transmission of HIV

Section 211. Repeals

This section repeals provisions regarding the testing of pregnant women and newborn infants.

Section 212. Grants

Subsection (a) includes treatment services, in accordance with applicable recommendations of the Secretary, for pregnant women (with HIV disease) and their infants as an additional purpose for making grants. Under current law, this section allows the Secretary to make grants to States that have adopted the CDC guidelines on HIV counseling and voluntary testing of pregnant women. Such grants are used for: counseling pregnant women on HIV disease; outreach efforts to women at risk of HIV who are not receiving prenatal care; voluntary testing; and, offsetting various State costs in implementing this section. Authorizes \$30 million for each of fiscal years 2001 through 2005. When such appropriations are in excess of \$10 million, the Secretary must reserve a percentage for making grants to States that under law have a requirement that all newborn infants be tested for HIV disease; or a requirement that newborn infants born in the State be tested for HIV disease where the attending obstetrician does not know the HIV status of the mother. The percentages to be reserved are: 25% for FY2001, 50% for FY2002, 50% for FY2003, 75% for FY2004, and 75% for FY2005. No grant may exceed \$4 million and if the reserved amounts are not obligated, then the requirement to reserve such amounts will not apply. A State in receipt of such funds under this section must agree that the grant will supplement and not supplant other available funds to carry out the purposes of the grant.

Subsection (b) establishes a special funding rule if FY2001 appropriations are less than \$14 million for this section. The Secretary is required to reserve certain amounts from increased FY2001 funding for Title II that is above such appropriations for FY2000.

Section 213. Study by Institute of Medicine

This section adds a new section requiring the Secretary to request that the Institute of Medicine conduct a study to: (1) determine the number of newborn infants with HIV born in the United States where the attending obstetrician did not know the HIV status of the mother; (2) determine State barriers that prevent or discourage an obstetrician from making it a routine practice to offer pregnant women an HIV test and a routine practice to test newborn infants for HIV disease in circumstances in which the obstetrician does not know the HIV status of the mother; and (3) provide recommendations for each State for reducing perinatal transmission of HIV. It requires the report to be submitted to the appropriate congressional committees, the Secretary, and the chief public health official of each State. Beginning in FY2004, each State is required to report to the Secretary on progress being made toward

meeting such recommendations. For FY2005 and each subsequent fiscal year, the State must demonstrate that it has made reasonable progress toward meeting the recommendations. If the State has not made reasonable progress, the State must cooperate with the CDC Director in carrying out activities toward meeting the recommendations, and the State must submit a report to the Secretary containing a description of any barriers that continue to exist in the State and a description of how the State intends to reduce the incidence of perinatal HIV cases. The Secretary must make funds under section 212 grants available to the States for the purposes of this section and is required to submit the State reports to the appropriate congressional committees.

The Committee recognizes that the IOM completed a report on this topic in 1998. It is not the intent of the Committee to duplicate any material compiled for that report. The study is to make broad recommendations for each State to and assist States in reducing the incidence of perinatal HIV transmission. The Committee recognizes that some States have had few, if any, such cases in recent years. An analysis of the efforts of these states may provide useful information to states that continue to have higher rates of perinatal HIV transmission.

Subtitle C—Certain Partner Notification Programs

Section 221. Grants for compliant partner notification programs

This section adds a new subpart to the Ryan White CARE Act that provides grants for partner notification programs. It authorizes appropriations of \$30 million for FY2001 and such sums as necessary for each of the fiscal years 2002 through 2005 for grants to States to carry out programs to provide partner counseling and referral services. In order to receive a grant under this new subpart, a State must have the following policies in effect: (1) a program for partner notification to inform partners of individuals with HIV disease that the partners may have been exposed to HIV; (2) a system for confidentially reporting positive test results for HIV; (3) specific counseling and referral measures; (4) reports to CDC on the number of individuals solicited for names of partners, the number who provided the names, and the number of notified partners; (5) cooperation with CDC in a national program of partner notification in which information is shared between public health officers of the States. In making grants, the Secretary must give preference for each of the fiscal years FY2001 through FY2003 to States whose reporting systems for cases of HIV disease produce sufficiently accurate and reliable data. A State may not receive a grant for FY2004 or subsequent fiscal years unless its reporting system produces reliable data.

TITLE III—EARLY INTERVENTION SERVICES

Subtitle A—Formula Grants for States

Section 301. Repeal of program

This section repeals subpart I of part C of title XXVI of the PHS Act. (Subpart I was not reauthorized in 1995.) Subpart I provided formula grants to States for early intervention services such as HIV testing and counseling, other clinical or diagnostic services,

and referrals to providers of health support services or biomedical research facilities.

Subtitle B—Categorical Grants

Section 311. Preferences in making grants

Under current law, the Secretary must give preference to any qualified applicants that are experiencing an increase in the burden of providing services regarding HIV disease. This new provision adds that the Secretary must give preference to those that will expend the grant to provide services in underserved or rural areas.

Section 312. Planning and development grants

Current law allows the use of planning and development grants to assist entities in expanding their capacity to provide early intervention services. Subsection (a) provides that the grants are to be used to assist entities in expanding their capacity to provide services, including early intervention, in low-income communities and affected subpopulations that are underserved. Such grants may not be used to purchase or improve land, or to purchase, construct, or permanently improve any building or other facility.

Current law provides that planning grants under this section to provide early intervention services may not exceed \$50,000. Subsection (b) specifies that grants for early intervention services under paragraph (1)(A) may not exceed \$50,000, and grants for capacity development for low-income and underserved populations under paragraph (1)(B) may not exceed \$150,000 and their duration may not exceed three years.

Subsection (c) increases to five percent (currently one percent) the amount of appropriations for this subpart that may be used to carry out this section.

Section 313. Authorization of appropriations

This section extends authorized appropriations of such sums as necessary for this subpart for each of the fiscal years 2001 through 2005.

Subtitle C—General Provisions

Section 321. Provision of certain counseling services

Presently, current law specifies what additional information (such as early interventions services, health care referrals) is to be conveyed to an individual receiving a positive result on an HIV test. This section adds new language specifying that when grant applicants counsel individuals regarding a positive HIV test result, they must provide counseling that: (1) emphasizes the duty of infected individuals to disclose their infected status to their sexual partners and their partners in the sharing of hypodermic needles; (2) provides advice on the manner in which such disclosures can be made; and (3) emphasizes the continuing duty to avoid any behaviors that will expose others to HIV.

Section 322. Additional required agreements

This section adds new language provides that the applicant will not expend more than 10%, instead of the current 7.5%, for admin-

istrative expenses, including planning and evaluation of the grant. In addition, new language specifies that applicants are required to establish a quality management program to assess the extent to which medical services under this title are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections and that improvements in access to and quality of medical services are addressed.

TITLE IV—OTHER PROGRAMS AND ACTIVITIES

Subtitle A—Certain Programs for Research, Demonstrations, or Training

Section 401. Grants for coordinated services and access to research for women, infants, children, and youth

This section removes language in current law specifying that a significant number of women, infants, children and youth who are patients of the applicant will be participating in research projects. This section provides new language specifying that grant applicants must demonstrate linkages to research and how access to such research is being offered to patients. The Secretary, in coordination with the Director of the National Institutes of Health (NIH), is required to examine the distribution and availability of appropriate HIV-related research projects to enhance and expand HIV-related research, especially in communities that are under represented with respect to such projects. Grantees must also implement a quality management program. Authorized appropriations are extended through FY2005.

Section 402. AIDS education and training centers

The Committee believes that the Dental Reimbursement Program is a cost-effective program that provides quality oral health care to people living with HIV/AIDS, and trains providers to effectively and safely deliver care to these patients. The Committee has reauthorized the program and maintained its current format of providing retrospective reimbursement to dental schools and residency programs. In addition, the Committee has established new grants for community-based care to support collaborative efforts between dental education programs and community-based providers directed at providing oral health care to patients with HIV disease in currently unserved areas and communities without dental education programs.

Although the Dental Program has been successful, there is still a large HIV/AIDS population that has not benefitted because there is not a dental education institution participating in their area. These patients are also in need of dental services that could be provided at community sites if more community-based providers would partner with a dental school or residency program. In these partnerships, dental students or residents could provide treatment for HIV/AIDS patients in underserved communities under the direction of a community-based dentist who would serve as adjunct faculty. By encouraging dental educational institutions to partner with community-based providers, the Committee intends to address the unmet need in these areas by ensuring that dental treatment

for the HIV/AIDS population is available in all areas of the country, not just where dental schools are located.

Current law allows eligible entities to use grant funds for the training of health personnel in the diagnosis, treatment and prevention of HIV disease, including the prevention of the perinatal transmission of the disease and the prevention and treatment of opportunistic infections. Subsection (a) provides that grants may be used to train health professionals in prenatal and other gynecological care for women with HIV disease. The Secretary may also make grants to such entities to develop protocols for the medical care of women with HIV disease, including prenatal and other gynecological care. In addition, the bill directs the Secretary to, not later than 90 days after enactment, issue and begin implementation of a strategy for the dissemination of HIV treatment information to health care providers and patients.

Under current law, the Secretary may make grants to assist schools and programs with respect to oral health care to patients with HIV disease. Such schools and programs include: (1) dental schools and post doctoral dental education programs; and (2) dental hygiene programs that are accredited by the Commission on Dental Accreditation. Subsection (b) provides that the Secretary may also make grants to schools and programs, as described in the previous sentence, that partner with community-based dentists to provide oral health care to patients with HIV disease in unserved areas. The partnerships must permit the training of dental students and residents and the participation of community dentists as adjunct faculty.

Subsection (c) authorizes appropriations of such sums as necessary for programs under this section for fiscal years 2001 through 2005.

Subtitle B—General Provisions in Title XXVI

Section 411. Evaluations and reports

This section authorizes appropriations for the Secretary to evaluate programs under the Ryan White CARE Act for each of the fiscal years 2001 through 2005.

Section 412. Data collection through centers for disease control and prevention

This section redesignates section 2675 as section 2675A, and adds a new section 2675 which authorizes appropriations to the Secretary (acting through the Director of CDC) of such sums as may be necessary for each of the fiscal years 2001 through 2005 to collect and provide data for program planning and evaluation activities. That authorization is in addition to other authorizations for such purpose.

Section 413. Coordination

Current law provides that the Secretary will assure that the Health Resources and Services Administration (HRSA) and CDC will coordinate the planning and funding of programs authorized under this title to assure that health support services for individuals with HIV disease are integrated with each other and that the continuity of care of individuals with HIV is enhanced. This section

provides that the Secretary must ensure that there is coordination of the planning, funding, and implementation of Federal HIV programs regarding continuity of care and prevention services among the following agencies: HRSA, CDC, SAMHSA, and the Health Care Financing Administration (HCFA). In addition, the Secretary must consult with other Federal agencies, including the Department of Veterans Affairs, as needed and utilize planning information submitted to such agencies by the States. This section also requires that the Secretary report biennially to the appropriate congressional committees on the coordination efforts at the Federal, State, and local levels. The report should include a description of Federal barriers to HIV program integration and a strategy for eliminating such barriers. It also inserts "prevention services" after the term "continuity of care" each place the term appears.

Section 414. Plan regarding release of prisoners with HIV disease

This section adds a new subsection to section 2675A which directs the Secretary to develop a plan for the medical case management of and the provision of support services to individuals who were Federal or State prisoners and had HIV disease on the date they were released from custody. The Secretary must consult with the Attorney General, the Director of the Bureau of Prisons, the States, eligible areas and certain grant recipients in developing such plan. The Secretary must report to the Congress on such a plan not later than two years after the date of enactment of this legislation.

Section 415. Audits

Section 2675B stipulates that for FY2002 and subsequent fiscal years, the Secretary may reduce grant amounts to a State or political subdivision of a State for a fiscal year, if the State or subdivision fails to prepare audits for the second preceding fiscal year. The Secretary must annually submit representative samples of such audits to the Congress.

Section 416. Administrative simplification

Section 2675C requires the Secretary, after consultations with specified entities receiving grants under this title, to: (1) Develop a plan for coordinating the disbursement of grants to eligible areas under Part A with the disbursement of grants to States under Part B; (2) make a determination on whether the efficiency of grantees would be improved by their submitting applications biennially rather than annually; and (3) develop a plan for simplifying the process for applications by eligible areas under Part A and States under Part B. The Secretary must submit both plans to the Congress not later than 18 months after the date of enactment of this bill. The Secretary must submit the determination to Congress not later than 2 years after the date of enactment. The Secretary must complete implementation of both plans not later than 2 years after the date of their submission.

Section 417. Authorization of appropriations for Parts A and B

This section authorizes appropriations for fiscal years 2001 through 2005 to carry out Part A (Title I) grants to eligible areas, and Part B (Title II) CARE grants to States.

TITLE V—GENERAL PROVISIONS

Section 501. Studies by Institute of Medicine

Subsection (a) requires that the Secretary ask the Institute of Medicine to conduct a study that provides the following: (1) a determination of whether the surveillance system of each State regarding HIV provides for the reporting of cases of infection in a manner that is sufficient to provide adequate and reliable information on the number of such cases and the demographic characteristics of such cases, both for the State in general and for specific geographic areas; (2) a determination of whether such information is sufficiently accurate for purposes of grant formulas to eligible areas under Part A and States under Part B; and (3) recommendations on the manner in which a State can improve its surveillance system.

Subsection (b) requires that the Secretary ask the Institute of Medicine to conduct a study on appropriate epidemiologic measures and their relation to the financing and delivery of health services to low-income, uninsured and underinsured people living with HIV disease. The study should consider existing and needed health care and epidemiological data and its relation to efficiency and effectiveness of care delivery, quality of care, resource allocation, and access to HIV services. The study should also determine the actual costs, potential savings, and financial impact of modifying the Medicaid program to establish eligibility for medical assistance on the basis of HIV infection rather than providing assistance only if the infection has progressed to AIDS.

Subsection (c) authorizes the Secretary to contract with other entities if the Institute of Medicine declines to conduct the study. Subsection (d) directs the Secretary to report to the appropriate congressional committees not later than three years after the date of enactment of this Act for the surveillance study, and not later than two years after enactment for the epidemiological study.

Section 502. Development of rapid HIV test

Subsection (a) requires the Director of NIH to expand, intensify, and coordinate research and other activities of NIH for the development of reliable and affordable tests for HIV disease that can rapidly be administered and whose results can be rapidly obtained. Requires periodic progress reports to the appropriate congressional committees. It also authorizes appropriations as necessary for FY2001 through 2005.

Subsection (b) requires that the Secretary, in consultation with the Director of CDC and the Commissioner of Food and Drugs, submit to the appropriate committees a report describing the progress made towards, and barriers to, the premarket review and commercial distribution of rapid HIV tests. The report must (1) to assess the public health need for, and benefits of, rapid HIV tests; (2) make recommendations regarding the need for expedited review of rapid HIV test applications submitted to the Center for Biologics Evaluation and Research (including criteria for expedited review for favorable recommendations); and (3) specify whether the barriers to premarket review include the unnecessary application of requirements concerning donor screening.

Subsection (c) requires that the Director of CDC, promptly after commercial distribution of a rapid HIV test begins, establish or update guidelines that include recommendations for States, hospitals, and other appropriate entities regarding the ready availability of such tests for administration to pregnant women who are in labor or in the late stage of pregnancy and whose HIV status is not known to the attending obstetrician.

TITLE VI—EFFECTIVE DATE

Section 601. *Effective date*

This section establishes the effective date of the legislation as October 1, 2000, or upon the date of its enactment, whichever occurs later.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * *

TITLE XXVI—HIV HEALTH CARE SERVICES PROGRAM

PART A—EMERGENCY RELIEF FOR AREAS WITH SUBSTANTIAL NEED FOR SERVICES

* * * * *

SEC. 2602. ADMINISTRATION AND PLANNING COUNCIL.

(a) * * *

(b) HIV HEALTH SERVICES PLANNING COUNCIL.—

(1) ESTABLISHMENT.—To be eligible for assistance under this part, the chief elected official described in subsection (a)(1) shall establish or designate an HIV health services planning council that shall reflect in its composition the [demographics of the epidemic in the eligible area involved,] *demographics of the population of individuals with HIV disease in the eligible area involved*, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations. Nominations for membership on the council shall be identified through an open process and candidates shall be selected based on locally delineated and publicized criteria. Such criteria shall include a conflict-of-interest standard that is in accordance with paragraph (5).

(2) REPRESENTATION.—The HIV health services planning council shall include representatives of—

(A) * * *

* * * * *

(G) affected communities, including people with HIV disease **[or AIDS]** and historically underserved groups and subpopulations;

* * * * *

(K) grantees under section 2671, or, if none are operating in the area, representatives of organizations with a history of serving children, youth, women, and families living with HIV and operating in the area; **[and]**

(L) grantees under other Federal HIV programs**[.]**, including but not limited to providers of HIV prevention services; and

(M) representatives of individuals who formerly were Federal, State, or local prisoners, were released from the custody of the penal system during the preceding three years, and had HIV disease as of the date on which the individuals were so released.

(3) METHOD OF PROVIDING FOR COUNCIL.—

(A) * * *

* * * * *

[(C) CHAIRPERSON.—A planning council may not be chaired solely by an employee of the grantee.]

* * * * *

(4) DUTIES.—The planning council established or designated under paragraph (1) shall—

(A) determine the size and demographics of the population of individuals with HIV disease;

(B) determine the needs of such population, with particular attention to—

(i) individuals with HIV disease who are not receiving HIV-related services; and

(ii) disparities in access and services among affected subpopulations and historically underserved communities;

[(A)] (C) establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds under a grant based on the—

[(i) documented needs of the HIV-infected population;

[(ii) cost and outcome effectiveness of proposed strategies and interventions, to the extent that such data are reasonably available (either demonstrated or probable);

[(iii) priorities of the HIV-infected communities for whom the services are intended; and

[(iv) availability of other governmental and non-governmental resources;]

(i) size and demographics of the population of individuals with HIV disease (as determined under subparagraph (A)) and the needs of such population (as determined under subparagraph (B));

(ii) demonstrated (or probable) cost effectiveness and outcome effectiveness of proposed strategies and inter-

ventions, to the extent that data are reasonably available;

(iii) priorities of the communities with HIV disease for whom the services are intended;

(iv) availability of other governmental and non-governmental resources to provide HIV-related services to individuals and families with HIV disease, including the State plan under title XIX of the Social Security Act (relating to the Medicaid program) and the program under title XXI of such Act (relating to the program for State children's health insurance); and

(v) capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities;

[(B) develop a comprehensive plan for the organization and delivery of health services described in section 2604 that is compatible with any existing State or local plan regarding the provision of health services to individuals with HIV disease;]

(D) develop a comprehensive plan for the organization and delivery of health and support services described in section 2604 that—

(i) includes a strategy for identifying individuals with HIV disease who are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds;

(ii) includes a strategy to coordinate the provision of such services with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment services for such abuse; and

(iii) is compatible with any State or local plan for the provision of services to individuals with HIV disease;

[(C)] (E) assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area, and at the discretion of the planning council, assess the effectiveness, either directly or through contractual arrangements, of the services offered in meeting the identified needs;

[(D)] (F) participate in the development of the statewide coordinated statement of need initiated by the State public health agency responsible for administering grants under part B; [and]

[(E)] (G) establish methods for obtaining input on community needs and priorities which may include [public meetings,] public meetings (in accordance with paragraph (7)), conducting focus groups, and convening ad-hoc panels[.]; and

(H) coordinate with Federal grantees that provide HIV-related services within the eligible area.

* * * * *

(5) CONFLICTS OF INTEREST.—

(A) * * *

* * * * *

(C) COMPOSITION OF COUNCIL.—*The following applies regarding the membership of a planning council under paragraph (1):*

(i) *Not less than 33 percent of the council shall be individuals who are receiving HIV-related services pursuant to a grant under section 2601(a), are not officers, employees, or consultants to any entity that receives amounts from such a grant, and do not represent any such entity, and reflect the demographics of the population of individuals with HIV disease as determined under paragraph (4)(A). For purposes of the preceding sentence, an individual shall be considered to be receiving such services if the individual is a parent of, or a caregiver for, a minor child who is receiving such services.*

(ii) *With respect to membership on the planning council, clause (i) may not be construed as having any effect on entities that receive funds from grants under any of parts B through F but do not receive funds from grants under section 2601(a), on officers or employees of such entities, or on individuals who represent such entities.*

* * * * *

(7) PUBLIC DELIBERATIONS.—*With respect to a planning council under paragraph (1), the following applies:*

(A) *The council may not be chaired solely by an employee of the grantee under section 2601(a).*

(B) *In accordance with criteria established by the Secretary:*

(i) *The meetings of the council shall be open to the public and shall be held only after adequate notice to the public.*

(ii) *The records, reports, transcripts, minutes, agenda, or other documents which were made available to or prepared for or by the council shall be available for public inspection and copying at a single location.*

(iii) *Detailed minutes of each meeting of the council shall be kept. The accuracy of all minutes shall be certified to by the chair of the council.*

(iv) *This subparagraph does not apply to any disclosure of information of a personal nature that would constitute a clearly unwarranted invasion of personal privacy, including any disclosure of medical information or personnel matters.*

* * * * *

(d) PROCESS FOR ESTABLISHING ALLOCATION PRIORITIES.—*Promptly after the date of the submission of the report required in section 501(b) of the Ryan White CARE Act Amendments of 2000 (relating to the relationship between epidemiological measures and health care for certain individuals with HIV disease), the Secretary,*

in consultation with entities that receive amounts from grants under section 2601(a) or 2611, shall develop epidemiologic measures—

(1) for establishing the number of individuals living with HIV disease who are not receiving HIV-related health services; and

(2) for carrying out the duties under subsection (b)(4) and section 2617(b).

(e) TRAINING GUIDANCE AND MATERIALS.—The Secretary shall provide to each chief elected official receiving a grant under 2601(a) guidelines and materials for training members of the planning council under paragraph (1) regarding the duties of the council.

SEC. 2603. TYPE AND DISTRIBUTION OF GRANTS.

(a) GRANTS BASED ON RELATIVE NEED OF AREA.—

(1) * * *

(2) EXPEDITED DISTRIBUTION.—Not later than 60 days after an appropriation becomes available to carry out this part [for each of the fiscal years 1996 through 2000] for a fiscal year, the Secretary shall, except in the case of waivers granted under section 2605(c), disburse 50 percent of the amount appropriated under section 2677 for such fiscal year through grants to eligible areas under section 2601(a), in accordance with paragraph (3). The Secretary shall reserve an additional percentage of the amount appropriated under section 2677 for a fiscal year for grants under part A to make grants to eligible areas under section 2601(a) in accordance with paragraph (4).

(3) AMOUNT OF GRANT.—

(A) * * *

* * * * *

(C) ESTIMATE OF LIVING CASES.—The amount determined in this subparagraph is an amount equal to the product of—

(i) the number of cases of acquired immune deficiency syndrome in the eligible area during each year in the most recent 120-month period for which data are available with respect to all eligible areas, as indicated by the number of such cases reported to and confirmed by the Director of the Centers for Disease Control and Prevention for each year during such period, *except that (subject to subparagraph (D)), for grants made pursuant to this paragraph for fiscal year 2005 and subsequent fiscal years, the cases counted for each 12-month period beginning on or after July 1, 2004, shall be cases of HIV disease (as reported to and confirmed by such Director) rather than cases of acquired immune deficiency syndrome; and*

(ii) with respect to—

(I) * * *

* * * * *

(X) the tenth year during such period, .88.

The yearly percentage described in subparagraph (ii) shall be updated biennially by the Secretary, after consultation with the Centers for Disease Control and Prevention, and shall be reported to the congressional committees of jurisdiction. The first such update shall occur prior to the de-

termination of grant awards under this part for fiscal year 1998. Updates shall as applicable take into account the counting of cases of HIV disease pursuant to clause (i).

(D) DETERMINATION OF SECRETARY REGARDING DATA ON HIV CASES.—

(i) *IN GENERAL.*—Not later than July 1, 2004, the Secretary shall determine whether there is data on cases of HIV disease from all eligible areas (reported to and confirmed by the Director of the Centers for Disease Control and Prevention) sufficiently accurate and reliable for use for purposes of subparagraph (C)(i). In making such a determination, the Secretary shall take into consideration the findings of the study under section 501(b) of the Ryan White CARE Act Amendments of 2000 (relating to the relationship between epidemiological measures and health care for certain individuals with HIV disease), the fiscal impact of the use of such data, the impact of the use of such data on the organization and delivery of HIV-related services in eligible areas, and the fiscal impact of not using such data.

(ii) *EFFECT OF ADVERSE DETERMINATION.*—If under clause (i) the Secretary determines that data on cases of HIV disease is not sufficiently accurate and reliable for use for purposes of subparagraph (C)(i), then notwithstanding such subparagraph, for any fiscal year prior to fiscal year 2007 the references in such subparagraph to cases of HIV disease do not have any legal effect.

(iii) *GRANTS AND TECHNICAL ASSISTANCE REGARDING COUNTING OF HIV CASES.*—Of the amounts appropriated under section 2675 for a fiscal year, the Secretary shall reserve amounts to make grants and provide technical assistance to States and eligible areas with respect to obtaining data on cases of HIV disease to ensure that data on such cases is available from all States and eligible areas as soon as is practicable but not later than the beginning of fiscal year 2007.

[(D)] (E) UNEXPENDED FUNDS.—The Secretary may, in determining the amount of a grant for a fiscal year under this paragraph, adjust the grant amount to reflect the amount of unexpended and uncanceled grant funds remaining at the end of the fiscal year preceding the year for which the grant determination is to be made. The amount of any such unexpended funds shall be determined using the financial status report of the grantee.

[(4) INCREASE IN GRANT.—With respect to an eligible area under section 2601(a), the Secretary shall increase the amount of a grant under paragraph (2) for a fiscal year to ensure that such eligible area receives not less than—

[(A)] with respect to fiscal year 1996, 100 percent;

[(B)] with respect to fiscal year 1997, 99 percent;

[(C)] with respect to fiscal year 1998, 98 percent;

[(D)] with respect to fiscal year 1999, 96.5 percent; and

[(E)] with respect to fiscal year 2000, 95 percent;

of the amount allocated for fiscal year 1995 to such entity under this subsection.】

(4) INCREASES IN GRANT.—

(A) IN GENERAL.—For each fiscal year in a protection period for an eligible area, the Secretary shall increase the amount of the grant made pursuant to paragraph (2) for the area to ensure that—

(i) for the first fiscal year in the protection period, the grant is not less than 98 percent of the amount of the grant made for the eligible area pursuant to such paragraph for the base year for the protection period;

(ii) for any second fiscal year in such period, the grant is not less than 95.7 percent of the amount of such base year grant;

(iii) for any third fiscal year in such period, the grant is not less than 91.1 percent of the amount of the base year grant;

(iv) for any fourth fiscal year in such period, the grant is not less than 84.2 percent of the amount of the base year grant; and

(v) for any fifth or subsequent fiscal year in such period, the grant is not less than 75 percent of the amount of the base year grant.

(B) BASE YEAR; PROTECTION PERIOD.—With respect to grants made pursuant to paragraph (2) for an eligible area:

(i) The base year for a protection period is the fiscal year preceding the trigger grant-reduction year.

(ii) The first trigger grant-reduction year is the first fiscal year (after fiscal year 2000) for which the grant for the area is less than the grant for the area for the preceding fiscal year.

(iii) A protection period begins with the trigger grant-reduction year and continues until the beginning of the first fiscal year for which the amount of the grant for the area equals or exceeds the amount of the grant for the base year for the period.

(iv) Any subsequent trigger grant-reduction year is the first fiscal year, after the end of the preceding protection period, for which the amount of the grant is less than the amount of the grant for the preceding fiscal year.

(b) SUPPLEMENTAL GRANTS.—

(1) IN GENERAL.—Not later than 150 days after the date on which appropriations are made under section 2677 for a fiscal year, the Secretary shall disburse the remainder of amounts not disbursed under section 2603(a)(2) for such fiscal year for the purpose of making grants under section 2601(a) to eligible areas whose application under section 2605(b)—

(A) * * *

* * * * *

(E) demonstrates that resources will be allocated in accordance with the local demographic incidence of AIDS in-

cluding appropriate allocations for services for infants, children, *youth*, women, and families with HIV disease;

* * * * *

(2) **[(DEFINITION) AMOUNT OF GRANT.—**
(A) IN GENERAL.—*The amount of each grant made for purposes of this subsection shall be determined by the Secretary based on a weighting of factors under paragraph (1), with severe need under subparagraph (B) of such paragraph counting one-third.*

[(A) (B) SEVERE NEED.—In determining severe need in accordance with paragraph (1)(B), the Secretary shall consider the ability of the qualified applicant to expend funds efficiently and the impact of relevant factors on the cost and complexity of delivering health care and support services to individuals with HIV disease in the eligible area, including factors such as—

(i) sexually transmitted diseases, substance abuse, tuberculosis, severe mental illness, or other comorbid factors determined relevant by the Secretary;

(ii) new or growing subpopulations of individuals with HIV disease; **[(and]**

(iii) homelessness**].**;

(iv) *the current prevalence of HIV disease;*

(v) *an increasing need for HIV-related services, including relative rates of increase in the number of cases of HIV disease; and*

(vi) *unmet need for such services, as determined under section 2602(b)(4).*

[(B) (C) PREVALENCE.—In determining the impact of the factors described in subparagraph **[(A) (B)]**, the Secretary shall, to the extent practicable, use national, quantitative incidence data that are available for each eligible area. Not later than **[(2 years after the date of enactment of this paragraph)] 18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000**, the Secretary shall develop a mechanism to utilize such data. *Such a mechanism shall be modified to reflect the findings of the study under section 501(b) of the Ryan White CARE Act Amendments of 2000 (relating to the relationship between epidemiological measures and health care for certain individuals with HIV disease).* In the absence of such data, the Secretary may consider a detailed description and qualitative analysis of severe need, as determined under subparagraph **[(A) (B)]**, including any local prevalence data gathered and analyzed by the eligible area.

[(C) (D) PRIORITY.—Subsequent to the development of the quantitative mechanism described in subparagraph **[(B) (C)]**, the Secretary shall phase in, over a 3-year period beginning in fiscal year 1998, the use of such a mechanism to determine the severe need of an eligible area compared to other eligible areas and to determine, in part, the amount of supplemental funds awarded to the eligible area under this part.

[(4) AMOUNT OF GRANT.—The amount of each grant made for purposes of this subsection shall be determined by the Secretary based on the application submitted by the eligible area under section 2605(b).]

[(5)] (4) FAILURE TO SUBMIT.—

(A) * * *

* * * * *

SEC. 2604. USE OF AMOUNTS.

(a) * * *

(b) PRIMARY PURPOSES.—

(1) IN GENERAL.—The chief elected official shall use amounts received under a grant under section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of delivering or enhancing [HIV-related—] *HIV-related services, as follows:*

(A) [outpatient and ambulatory health and support services, including case management, substance abuse treatment and] *Outpatient and ambulatory health services, including substance abuse treatment, mental health treatment, and comprehensive treatment services, which shall include treatment education and prophylactic treatment for opportunistic infections, for individuals and families with HIV disease;* and].

(B) *Outpatient and ambulatory support services (including case management), to the extent that such services facilitate, support, or sustain the delivery, or benefits of health services for individuals and families with HIV disease.*

[(B) inpatient case management] (C) *Inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities.*

(D) *Outreach activities that are intended to identify individuals with HIV disease who are not receiving HIV-related services, and that are—*

(i) *necessary to implement the strategy under section 2602(b)(4)(D), including activities facilitating the access of such individuals to HIV-related primary care services at entities described in paragraph (3);*

(ii) *conducted in a manner consistent with the requirements under sections 2605(a)(3) and 2651(b)(2); and*

(iii) *supplement, and do not supplant, such activities that are carried out with amounts appropriated under section 317.*

* * * * *

(3) EARLY INTERVENTION SERVICES.—

(A) IN GENERAL.—*The purposes for which a grant under section 2601 may be used include providing to individuals with HIV disease early intervention services described in section 2651(b)(2) (including referrals under subparagraph (C) of such section), subject to subparagraph (B). The entities through which such services may be provided under the grant include public health departments, emergency rooms,*

substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV disease counseling and testing sites, health care points of entry specified by States or eligible areas, federally qualified health centers, and entities described in section 2652(a).

(B) CONDITIONS.—With respect to an entity that proposes to provide early intervention services under subparagraph (A), such subparagraph applies only if the entity demonstrates to the satisfaction of the chief elected official for the eligible area involved that—

(i) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and

(ii) the entity will expend funds pursuant to such subparagraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved.

[(3)] (4) PRIORITY FOR WOMEN, INFANTS AND CHILDREN.—For the purpose of providing health and support services to infants, children, *youth*, and women with HIV disease, including treatment measures to prevent the perinatal transmission of HIV, the chief elected official of an eligible area, in accordance with the established priorities of the planning council, shall use, from the grants made for the area under section 2601(a) for a fiscal year, not less than the percentage constituted by the ratio of the population in such area of infants, children, *youth*, and women with acquired immune deficiency syndrome to the general population in such area of individuals with such syndrome.

(c) QUALITY MANAGEMENT.—

(1) REQUIREMENT.—The chief elected official of an eligible area that receives a grant under this part shall provide for the establishment of a quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines.

(2) USE OF FUNDS.—From amounts received under a grant awarded under this part for a fiscal year, the chief elected official of an eligible area may (in addition to amounts to which subsection (f)(1) applies) use for activities associated with the quality management program required in paragraph (1) not more than the lesser of—

(A) 5 percent of amounts received under the grant; or

(B) \$3,000,000.

[(c)] (d) LIMITED EXPENDITURES FOR PERSONNEL NEEDS.—

(1) * * *

* * * * *

[(d)] (e) REQUIREMENT OF STATUS AS MEDICAID PROVIDER.—

(1) * * *

[(e)] (f) ADMINISTRATION.—

(1) IN GENERAL.—The chief executive officer of an eligible area shall not use in excess of 5 percent of amounts received under a grant awarded under this part for administration. In the case of entities and subcontractors to which such officer allocates amounts received by the officer under the grant, the officer shall ensure that, of the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not exceed 10 percent (without regard to whether particular entities expend more than 10 percent for such expenses).

* * * * *

[(f)] (g) CONSTRUCTION.—A State may not use amounts received under a grant awarded under this part to purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or to make cash payments to intended recipients of services.

SEC. 2605. APPLICATION.

(a) IN GENERAL.—To be eligible to receive a grant under section 2601, an eligible area shall prepare and submit to the Secretary an application, in accordance with subsection (c) regarding a single application and grant award, at such time, in such form, and containing such information as the Secretary shall require, including assurances adequate to ensure—

(1) * * *

* * * * *

(3) *that entities within the eligible area that receive funds under a grant under section 2601(a) will maintain relationships with appropriate entities in the area, including entities described in section 2604(b)(3);*

[(3)] (4) that entities within the eligible area that will receive funds under a grant provided under section 2601(a) shall participate in an established HIV community-based continuum of care if such continuum exists within the eligible area;

[(4)] (5) that funds received under a grant awarded under this part will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service—

(A) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

(B) by an entity that provides health services on a prepaid basis;

[(5)] (6) to the maximum extent practicable, that—

(A) HIV health care and support services provided with assistance made available under this part will be provided without regard—

(i) * * *

* * * * *

[(6)] (7) that the applicant has participated, or will agree to participate, in the statewide coordinated statement of need process where it has been initiated by the State public health agency responsible for administering grants under part B, and

ensure that the services provided under the comprehensive plan are consistent with the statewide coordinated statement of need.

* * * * *

PART B—CARE GRANT PROGRAM

Subpart I—General Grant Provisions

SEC. 2611. GRANTS.

(a) * * *

(b) **PRIORITY FOR WOMEN, INFANTS AND CHILDREN.**—For the purpose of providing health and support services to infants, children, *youth*, and women with HIV disease, including treatment measures to prevent the perinatal transmission of HIV, a State shall use, of the funds allocated under this part to the State for a fiscal year, not less than the percentage constituted by the ratio of the population in the State of infants, children, *youth*, and women with acquired immune deficiency syndrome to the general population in the State of individuals with such syndrome.

* * * * *

SEC. 2612. GENERAL USE OF GRANTS.

(a) *IN GENERAL.*—A State may use amounts provided under grants made under this part—

(1) * * *

(b) *SUPPORT SERVICES; OUTREACH.*—*The purposes for which a grant under this part may be used include delivering or enhancing the following:*

(1) *Support services under section 2611(a) (including case management) to the extent that such services facilitate, support, or sustain the delivery, or benefits of health services for individuals and families with HIV disease.*

(2) *Outreach activities that are intended to identify individuals with HIV disease who are not receiving HIV-related services, and that are—*

(A) *necessary to implement the strategy under section 2617(b)(4)(B);*

(B) *conducted in a manner consistent with the requirement under section 2617(b)(6)(G); and*

(C) *supplement, and do not supplant, such activities that are carried out with amounts appropriated under section 317.*

(c) *EARLY INTERVENTION SERVICES.*—

(1) *IN GENERAL.*—*The purposes for which a grant under this part may be used include providing to individuals with HIV disease early intervention services described in section 2651(b)(2) (including referrals under subparagraph (C) of such section), subject to paragraph (2). The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV disease counseling and testing sites,*

health care points of entry specified by States or eligible areas, federally qualified health centers, and entities described in section 2652(a).

(2) *CONDITIONS.*—With respect to an entity that proposes to provide early intervention services under paragraph (1), such paragraph applies only if the entity demonstrates to the satisfaction of the State involved that—

(A) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and

(B) the entity will expend funds pursuant to such paragraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved.

(d) *QUALITY MANAGEMENT.*—

(1) *REQUIREMENT.*—Each State that receives a grant under this part shall provide for the establishment of a quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines.

(2) *USE OF FUNDS.*—From amounts received under a grant awarded under this part for a fiscal year, the State may (in addition to amounts to which section 2618(c)(5) applies) use for activities associated with the quality management program required in paragraph (1) not more than the lesser of—

- (A) 5 percent of amounts received under the grant; or
- (B) \$3,000,000.

SEC. 2613. GRANTS TO ESTABLISH HIV CARE CONSORTIA.

(a) * * *

(b) *ASSURANCES.*—

(1) *REQUIREMENT.*—To receive assistance from a State under subsection (a), an applicant consortium shall provide the State with assurances that—

(A) within any locality in which such consortium is to operate, the populations and subpopulations of individuals and families with HIV disease have been identified by the consortium, particularly those experiencing disparities in access and services and those who reside in historically underserved communities;

(B) the service plan established under subsection (c)(2) by such consortium is consistent with the comprehensive plan under 2617(b)(4) and addresses the special care and service needs of the populations and subpopulations identified under subparagraph (A); and

* * * * *

(c) *APPLICATION.*—

(1) *IN GENERAL.*—To receive assistance from the State under subsection (a), a consortium shall prepare and submit to the State, an application that—

(A) * * *

* * * * *

(D) demonstrates that the consortium has created a mechanism to evaluate periodically—

(i) * * *

(ii) the cost-effectiveness of the mechanisms employed by the consortium to deliver comprehensive care; [and]

(E) demonstrates that the consortium will report to the State the results of the evaluations described in subparagraph (D) and shall make available to the State or the Secretary, on request, such data and information on the program methodology that may be required to perform an independent evaluation[.]; and

(F) demonstrates that adequate planning occurred to address disparities in access and services and historically underserved communities.

(2) CONSULTATION.—In establishing the plan required under paragraph (1)(B), the consortium shall consult with—

(A) * * *

(B) not less than one community-based organization that is organized solely for the purpose of providing HIV-related support services to individuals with HIV disease; [and]

(C) grantees under section 2671, or, if none are operating in the area, representatives in the area of organizations with a history of serving children, youth, women, and families living with HIV[.]; and

(D) entities described in section 2602(b)(2).

The organization to be consulted under subparagraph (B) shall be at the discretion of the applicant consortium.

* * * * *

SEC. 2616. PROVISION OF TREATMENTS.

(a) * * *

* * * * *

(e) *USE OF HEALTH INSURANCE AND PLANS.*—In carrying out subsection (a), a State may expend a grant under this part to provide the therapeutics described in such subsection by paying on behalf of individuals with HIV disease the costs of purchasing or maintaining health insurance or plans whose coverage includes a full range of such therapeutics and appropriate primary care services.

SEC. 2617. STATE APPLICATION.

(a) * * *

(b) DESCRIPTION OF INTENDED USES AND AGREEMENTS.—The application submitted under subsection (a) shall contain—

(1) * * *

(2) a determination of the size and demographics of the population of individuals with HIV disease in the State;

(3) a determination of the needs of such population, with particular attention to—

(A) individuals with HIV disease who are not receiving HIV-related services; and

(B) disparities in access and services among affected subpopulations and historically underserved communities;

[(2)] (4) a [comprehensive plan for the organization] *comprehensive plan that describes the organization* and delivery of HIV health care and support services to be funded with assistance received under this part that shall include a description of the purposes for which the State intends to use such assistance[, including—], and that—

(A) *establishes priorities for the allocation of funds within the State based on—*

(i) *size and demographics of the population of individuals with HIV disease (as determined under paragraph (2)) and the needs of such population (as determined under paragraph (3));*

(ii) *availability of other governmental and non-governmental resources to provide HIV-related services to individuals and families with HIV disease;*

(iii) *capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities and rural communities; and*

(iv) *the efficiency of the administrative mechanism of the State for rapidly allocating funds to the areas of greatest need within the State;*

(B) *includes a strategy for identifying individuals with HIV disease who are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and including discrete goals, a timetable, and an appropriate allocation of funds;*

(C) *includes a strategy to coordinate the provision of such services with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment services for such abuse;*

[(A)] (D) *describes the services and activities to be provided and an explanation of the manner in which the elements of the program to be implemented by the State with such assistance will maximize the quality of health and support services available to individuals with HIV disease throughout the State;*

[(B)] (E) *provides a description of the manner in which services funded with assistance provided under this part will be coordinated with other available related services for individuals with HIV disease; and*

[(C)] (F) *provides a description of how the allocation and utilization of resources are consistent with the statewide coordinated statement of need (including traditionally underserved populations and subpopulations) developed in partnership with other grantees in the State that receive funding under this title; and*

[(3)] (5) *an assurance that the public health agency administering the grant for the State will periodically convene a meeting of individuals with HIV disease, representatives of grantees under each part under this title, providers, and public*

agency representatives for the purpose of developing a state-wide coordinated statement of need; and

[(4)] (6) an assurance by the State that—

[(A) the public health agency that is administering the grant for the State will conduct public hearings concerning the proposed use and distribution of the assistance to be received under this part;]

(A) the public health agency that is administering the grant for the State engages in a public advisory planning process, including public hearings, that includes the participants under paragraph (5), and entities described in section 2602(b)(2), in developing the comprehensive plan under paragraph (4) and commenting on the implementation of such plan;

* * * * *

(E) the State will maintain HIV-related activities at a level that is equal to not less than the level of such expenditures by the State for the 1-year period preceding the fiscal year for which the State is applying to receive a grant under this part; [and]

(F) the State will ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service—

(i) * * *

(ii) by an entity that provides health services on a prepaid basis[.]; and

(G) entities within areas in which activities under the grant are carried out will maintain relationships with appropriate entities in the area, including entities described in section 2612(c);

* * * * *

SEC. 2618. DISTRIBUTION OF FUNDS.

(b) AMOUNT OF GRANT TO STATE.—

(1) MINIMUM ALLOTMENT.—Subject to the extent of amounts made available under section 2677, the amount of a grant to be made under this part for—

(A) each of the several States and the District of Columbia for a fiscal year shall be the greater of—

(i)(I) with respect to a State or District that has less than 90 living cases of acquired immune deficiency syndrome, as determined under paragraph (2)(D), ~~[\$100,000]~~ \$200,000; or

(II) with respect to a State or District that has 90 or more living cases of acquired immune deficiency syndrome, as determined under paragraph (2)(D), ~~[\$250,000]~~ \$500,000;

(ii) an amount determined under paragraph (2) and then, as applicable, increased under paragraph (2)(H); and

(B) each territory of the United States, as defined in paragraph (3), shall be the greater of \$50,000 or an amount determined under paragraph (2).

(2) DETERMINATION.—

(A) FORMULA.—The amount referred to in paragraph (1)(A)(ii) for a State and paragraph (1)(B) for a territory of the United States shall be the product of—

(i) an amount equal to the amount appropriated under section 2677 for the fiscal year involved for grants under part B, subject to **subparagraph (H) subparagraphs (H) and (I)**; and

* * * * *

(D) ESTIMATE OF LIVING CASES.—The amount determined in this subparagraph is an amount equal to the product of—

(i) the number of cases of acquired immune deficiency syndrome in the State or territory during each year in the most recent 120-month period for which data are available with respect to all States and territories, as indicated by the number of such cases reported to and confirmed by the Director of the Centers for Disease Control and Prevention for each year during such period, *except that (subject to subparagraph (E)), for grants made pursuant to this paragraph for fiscal year 2005 and subsequent fiscal years, the cases counted for each 12-month period beginning on or after July 1, 2004, shall be cases of HIV disease (as reported to and confirmed by such Director) rather than cases of acquired immune deficiency syndrome*; and

(E) DETERMINATION OF SECRETARY REGARDING DATA ON HIV CASES.—*If under 2603(a)(3)(D)(i) the Secretary determines that data on cases of HIV disease is not sufficiently accurate and reliable, then notwithstanding subparagraph (D) of this paragraph, for any fiscal year prior to fiscal year 2007 the references in such subparagraph to cases of HIV disease do not have any legal effect.*

(E) (F) PUERTO RICO, VIRGIN ISLANDS, GUAM.—For purposes of subparagraph (D), the cost index for Puerto Rico, the Virgin Islands, and Guam shall be 1.0.

(F) (G) UNEXPENDED FUNDS.—The Secretary may, in determining the amount of a grant for a fiscal year under this subsection, adjust the grant amount to reflect the amount of unexpended and uncanceled grant funds remaining at the end of the fiscal year preceding the year for which the grant determination is to be made. The amount of any such unexpended funds shall be determined using the financial status report of the grantee.

(G) LIMITATION.—

(i) IN GENERAL.—The Secretary shall ensure that the amount of a grant awarded to a State or territory for a fiscal year under this part is equal to not less than—

(I) with respect to fiscal year 1996, 100 percent;

(II) with respect to fiscal year 1997, 99 percent;

(III) with respect to fiscal year 1998, 98 percent;

(IV) with respect to fiscal year 1999, 96.5 percent; and

[(V) with respect to fiscal year 2000, 95 percent; of the amount such State or territory received for fiscal year 1995 under this part. In administering this subparagraph, the Secretary shall, with respect to States that will receive grants in amounts that exceed the amounts that such States received under this part in fiscal year 1995, proportionally reduce such amounts to ensure compliance with this subparagraph. In making such reductions, the Secretary shall ensure that no such State receives less than that State received for fiscal year 1995.]

[(ii) RATABLE REDUCTION.—If the amount appropriated under section 2677 and available for allocation under this part is less than the amount appropriated and available under this part for fiscal year 1995, the limitation contained in clause (i) shall be reduced by a percentage equal to the percentage of the reduction in such amounts appropriated and available.]

(H) LIMITATION.—

(i) IN GENERAL.—The Secretary shall ensure that the amount of a grant awarded to a State or territory under section 2611 for a fiscal year is not less than—

(I) with respect to fiscal year 2001, 99 percent;

(II) with respect to fiscal year 2002, 98 percent;

(III) with respect to fiscal year 2003, 97 percent;

(IV) with respect to fiscal year 2004, 96 percent;

and

(V) with respect to fiscal year 2005, 95 percent; of the amount such State or territory received for fiscal year 2000 under such section. In administering this subparagraph, the Secretary shall, with respect to States or territories that will under such section receive grants in amounts that exceed the amounts that such States received under such section for fiscal year 2000, proportionally reduce such amounts to ensure compliance with this subparagraph. In making such reductions, the Secretary shall ensure that no such State receives less than that State received for fiscal year 2000.

(ii) RATABLE REDUCTION.—If the amount appropriated under section 2677 for a fiscal year and available for grants under section 2611 is less than the amount appropriated and available under such section for fiscal year 2000, the limitation contained in clause (i) shall be reduced by a percentage equal to the percentage of the reduction in such amounts appropriated and available.

[(H) APPROPRIATIONS FOR TREATMENT DRUG PROGRAM.—

With respect to]

(I) APPROPRIATIONS FOR TREATMENT DRUG PROGRAM.—

(i) FORMULA GRANTS.—With respect to the fiscal year involved, if under section 2677 an appropriations Act provides an amount exclusively for carrying out section 2616, the portion of such amount allocated to a State shall be the product of—

[(i)] (I) [100] 98 percent of such amount; and

[(ii)] (II) the percentage constituted by the ratio of the State distribution factor for the State (as determined under subparagraph (B)) to the sum of the State distribution factors for all States.

(ii) SUPPLEMENTAL TREATMENT DRUG GRANTS.—

(I) IN GENERAL.—With respect to the fiscal year involved, if under section 2677 an appropriations Act provides an amount exclusively for carrying out section 2616, and such amount is not less than the amount so provided for the preceding fiscal year, the Secretary shall reserve 2 percent of such amount for making grants to States whose population of individuals with HIV disease has, as determined by the Secretary, a need for quantities of therapeutics described in section 2616(a) greater than the quantities available pursuant to clause (i). Such a grant is available for purposes of obtaining such therapeutics. The Secretary shall carry out this clause as a program of discretionary grants, and not as a program of formula grants.

(II) DISTRIBUTION OF GRANTS.—The Secretary shall disburse all amounts under grants under subclause (I) for a fiscal year not later than 240 days after the date on which the amount referred to in such subclause with respect to section 2616 becomes available.

(III) REQUIREMENT OF MATCHING FUNDS.—A condition for receiving a grant under subclause (I) is that the State agree to make available (directly or through donations from public or private entities) non-Federal contributions toward the costs of obtaining the therapeutics involved in an amount that is not less than 25 percent of such costs (determined in the same manner as under 2617(d)(2)(A)).

* * * * *
(3) DEFINITIONS.—As used in this subsection—

(A) * * *

(B) the term “territory of the United States” means, American Samoa, the Commonwealth of the Northern Mariana Islands, [and the Republic of the Marshall Islands] the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau, and only for purposes of paragraph (1) the Commonwealth of Puerto Rico.

* * * * *

[SEC. 2621. COORDINATION.

[The Secretary shall ensure that the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the Substance Abuse and Mental Health Services Administration coordinate the planning and implementation of Federal HIV programs in order to facilitate the local development of a complete continuum of HIV-related services for individuals with HIV disease and those at risk of such disease. Not later than October

1, 1996, and biennially thereafter, the Secretary shall submit to the appropriate committees of the Congress a report concerning coordination efforts under this title at the Federal, State, and local levels, including a statement of whether and to what extent there exist Federal barriers to integrating HIV-related programs.】

SEC. 2621. SUPPLEMENTAL GRANTS.

(a) *IN GENERAL.*—From amounts available pursuant to subsection (d) for a fiscal year, the Secretary shall make grants to States that meet the conditions to receive grants under section 2611, and that have one or more eligible communities, for the purpose of providing in such communities comprehensive services of the type described in section 2612(a) to supplement the development and care activities, primary care, and support services otherwise provided in such communities by the State under a grant under section 2611.

(b) *ELIGIBLE COMMUNITY.*—For purposes of this section, the term “eligible community” means a geographic area that—

(1) is not within any eligible area as defined in section 2607; and

(2) has a severe need for supplemental financial assistance to combat the HIV epidemic, according to criteria developed by the Secretary in consultation with the States, including evidence of underserved or rural areas or both.

(c) *APPLICATION.*—A grant under subsection (a) may be made to a State if the State submits to the Secretary, as part of the State application submitted under section 2617, such information as required to apply for funds under this section as determined by the Secretary in consultation with the States.

(d) *FUNDING.*—

(1) *IN GENERAL.*—For the purpose of making grants under subsection (a) for a fiscal year, the Secretary shall reserve 50 percent of the amount specified in paragraph (2).

(2) *INCREASES IN PART B FUNDING.*—

(A) *IN GENERAL.*—For purposes of paragraph (1), the amount specified in this paragraph is the amount by which the amount appropriated under section 2677 for the fiscal year involved and available for carrying out part B is an increase over the amount so appropriated and available for the preceding fiscal year, subject to subparagraphs (B) and (C).

(B) *INITIAL ALLOCATION YEAR.*—The allocation under paragraph (1) shall not be made until the first fiscal year for which the amount appropriated under section 2677 for the fiscal year involved and available for carrying out part B is an increase of not less than \$20,000,000 over the amount so appropriated and available for fiscal year 2000, subject to subparagraph (C).

(C) *EXCLUSION REGARDING SEPARATE TREATMENT DRUG GRANTS.*—Each determination under subparagraph (A) or (B) of the amount appropriated under section 2677 for a fiscal year and available for carrying out part B shall be made without regard to any amount to which section 2618(b)(2)(I)(i) applies.

* * * * *

Subpart II—Provisions Concerning Pregnancy and Perinatal Transmission of HIV

SEC. 2625. CDC GUIDELINES FOR PREGNANT WOMEN.

(a) * * *

* * * * *

(c) ADDITIONAL FUNDS REGARDING WOMEN AND INFANTS.—

(1) IN GENERAL.—If a State provides the certification required in subsection (a) and is receiving funds under part B for a fiscal year, the Secretary may (from the amounts available pursuant to paragraph (2)) make a grant to the State for the fiscal year for the following purposes:

(A) * * *

* * * * *

(F) *Making available to pregnant women with HIV disease, and to the infants of women with such disease, treatment services for such disease in accordance with applicable recommendations of the Secretary.*

[(2) FUNDING.—For purposes of carrying out this subsection, there are authorized to be appropriated \$10,000,000 for each of the fiscal years 1996 through 2000. Amounts made available under section 2677 for carrying out this part are not available for carrying out this section unless otherwise authorized.]

(2) FUNDING.—

(A) AUTHORIZATION OF APPROPRIATIONS.—*For the purpose of carrying out this subsection, there are authorized to be appropriated \$30,000,000 for each of the fiscal years 2001 through 2005. Amounts made available under section 2677 for carrying out this part are not available for carrying out this section unless otherwise authorized.*

(B) ALLOCATIONS FOR CERTAIN STATES.—

(i) IN GENERAL.—*Of the amounts appropriated under subparagraph (A) for a fiscal year in excess of \$10,000,000, the Secretary shall reserve the applicable percentage under clause (ii) for making grants under paragraph (1) to States that under law (including under regulations or the discretion of State officials) have—*

(I) *a requirement that all newborn infants born in the State be tested for HIV disease; or*

(II) *a requirement that newborn infants born in the State be tested for HIV disease in circumstances in which the attending obstetrician for the birth does not know the HIV status of the mother of the infant.*

(ii) APPLICABLE PERCENTAGE.—*For purposes of clause (i), the applicable amount for a fiscal year is as follows:*

(I) *For fiscal year 2001, 25 percent.*

(II) *For fiscal year 2002, 50 percent.*

(III) *For fiscal year 2003, 50 percent.*

(IV) *For fiscal year 2004, 75 percent.*

(V) *For fiscal year 2005, 75 percent.*

(C) *CERTAIN PROVISIONS.*—*With respect to grants under paragraph (1) that are made with amounts reserved under subparagraph (B) of this paragraph:*

(i) Such a grant may not be made in an amount exceeding \$4,000,000.

(ii) If pursuant to clause (i) or pursuant to an insufficient number of qualifying applications for such grants (or both), the full amount reserved under subparagraph (B) for a fiscal year is not obligated, the requirement under such subparagraph to reserve amounts ceases to apply.

* * * * *

(4) *MAINTENANCE OF EFFORT.*—*A condition for the receipt of a grant under paragraph (1) is that the State involved agree that the grant will be used to supplement and not supplant other funds available to the State to carry out the purposes of the grant.*

* * * * *

SEC. 2626. PERINATAL TRANSMISSION OF HIV DISEASE; CONTINGENT REQUIREMENT REGARDING STATE GRANTS UNDER THIS PART.

(a) * * *

* * * * *

[(d) **DETERMINATION BY SECRETARY.**—Not later than 180 days after the expiration of the 18-month period beginning on the date on which the system is implemented under subsection (c), the Secretary shall publish in the Federal Register a determination of whether it has become a routine practice in the provision of health care in the United States to carry out each of the activities described in paragraphs (1) through (4) of section 2627. In making the determination, the Secretary shall consult with the States and with other public or private entities that have knowledge or expertise relevant to the determination.

[(e) **CONTINGENT APPLICABILITY.**—

[(1) **IN GENERAL.**—If the determination published in the Federal Register under subsection (d) is that (for purposes of such subsection) the activities involved have become routine practices, paragraph (2) shall apply on and after the expiration of the 18-month period beginning on the date on which the determination is so published.

[(2) **REQUIREMENT.**—Subject to subsection (f), the Secretary shall not make a grant under part B to a State unless the State meets not less than one of the following requirements:

[(A) A 50 percent reduction (or a comparable measure for States with less than 10 cases) in the rate of new cases of AIDS (recognizing that AIDS is a suboptimal proxy for tracking HIV in infants and was selected because such data is universally available) as a result of perinatal transmission as compared to the rate of such cases reported in 1993 (a State may use HIV data if such data is available).

[(B) At least 95 percent of women in the State who have received at least two prenatal visits (consultations) prior to 34 weeks gestation with a health care provider or provider

group have been tested for the human immunodeficiency virus.

[(C) The State has in effect, in statute or through regulations, the requirements specified in paragraphs (1) through (5) of section 2627.

[(f) **LIMITATION REGARDING AVAILABILITY OF FUNDS.**—With respect to an activity described in any of paragraphs (1) through (4) of section 2627, the requirements established by a State under this section apply for purposes of this section only to the extent that the following sources of funds are available for carrying out the activity:

[(1) Federal funds provided to the State in grants under part B or under section 2625, or through other Federal sources under which payments for routine HIV testing, counseling or treatment are an eligible use.

[(2) Funds that the State or private entities have elected to provide, including through entering into contracts under which health benefits are provided. This section does not require any entity to expend non-Federal funds.

[SEC. 2627. TESTING OF PREGNANT WOMEN AND NEWBORN INFANTS.

[An activity or requirement described in this section is any of the following:

[(1) In the case of newborn infants who are born in the State and whose biological mothers have not undergone prenatal testing for HIV disease, that each such infant undergo testing for such disease.

[(2) That the results of such testing of a newborn infant be promptly disclosed in accordance with the following, as applicable to the infant involved:

[(A) To the biological mother of the infant (without regard to whether she is the legal guardian of the infant).

[(B) If the State is the legal guardian of the infant:

[(i) To the appropriate official of the State agency with responsibility for the care of the infant.

[(ii) To the appropriate official of each authorized agency providing assistance in the placement of the infant.

[(iii) If the authorized agency is giving significant consideration to approving an individual as a foster parent of the infant, to the prospective foster parent.

[(iv) If the authorized agency is giving significant consideration to approving an individual as an adoptive parent of the infant, to the prospective adoptive parent.

[(C) If neither the biological mother nor the State is the legal guardian of the infant, to another legal guardian of the infant.

[(D) To the child's health care provider.

[(3) That, in the case of prenatal testing for HIV disease that is conducted in the State, the results of such testing be promptly disclosed to the pregnant woman involved.

[(4) That, in disclosing the test results to an individual under paragraph (2) or (3), appropriate counseling on the human immunodeficiency virus be made available to the indi-

vidual (except in the case of a disclosure to an official of a State or an authorized agency).

[(5) With respect to State insurance laws, that such laws require—

[(A) that, if health insurance is in effect for an individual, the insurer involved may not (without the consent of the individual) discontinue the insurance, or alter the terms of the insurance (except as provided in subparagraph (C)), solely on the basis that the individual is infected with HIV disease or solely on the basis that the individual has been tested for the disease or its manifestation;

[(B) that subparagraph (A) does not apply to an individual who, in applying for the health insurance involved, knowingly misrepresented the HIV status of the individual; and

[(C) that subparagraph (A) does not apply to any reasonable alteration in the terms of health insurance for an individual with HIV disease that would have been made if the individual had a serious disease other than HIV disease.

For purposes of this subparagraph, a statute or regulation shall be deemed to regulate insurance for purposes of this paragraph only to the extent that such statute or regulation is treated as regulating insurance for purposes of section 514(b)(2) of the Employee Retirement Income Security Act of 1974.]

* * * * *

SEC. 2630. RECOMMENDATIONS FOR REDUCING INCIDENCE OF PERINATAL TRANSMISSION.

(a) *STUDY BY INSTITUTE OF MEDICINE.—*

(1) *IN GENERAL.—The Secretary shall request the Institute of Medicine to enter into an agreement with the Secretary under which such Institute conducts a study to provide the following:*

(A) *For the most recent fiscal year for which the information is available, a determination of the number of newborn infants with HIV born in the United States with respect to whom the attending obstetrician for the birth did not know the HIV status of the mother.*

(B) *A determination for each State of any barriers, including legal barriers, that prevent or discourage an obstetrician from making it a routine practice to offer pregnant women an HIV test and a routine practice to test newborn infants for HIV disease in circumstances in which the obstetrician does not know the HIV status of the mother of the infant.*

(C) *Recommendations for each State for reducing the incidence of cases of the perinatal transmission of HIV, including recommendations on removing the barriers identified under subparagraph (B).*

If such Institute declines to conduct the study, the Secretary shall enter into an agreement with another appropriate public or nonprofit private entity to conduct the study.

(2) *REPORT.*—The Secretary shall ensure that, not later than 18 months after the effective date of this section, the study required in paragraph (1) is completed and a report describing the findings made in the study is submitted to the appropriate committees of the Congress, the Secretary, and the chief public health official of each of the States.

(b) *PROGRESS TOWARD RECOMMENDATIONS.*—Each State shall comply with the following (as applicable to the fiscal year involved):

(1) For fiscal year 2004, the State shall submit to the Secretary a report describing the actions taken by the State toward meeting the recommendations specified for the State under subsection (a)(1)(C).

(2) For fiscal year 2005 and each subsequent fiscal year—

(A) the State shall make reasonable progress toward meeting such recommendations; or

(B) if the State has not made such progress—

(i) the State shall cooperate with the Director of the Centers for Disease Control and Prevention in carrying out activities toward meeting the recommendations; and

(ii) the State shall submit to the Secretary a report containing a description of any barriers identified under subsection (a)(1)(B) that continue to exist in the State; as applicable, the factors underlying the continued existence of such barriers; and a description of how the State intends to reduce the incidence of cases of the perinatal transmission of HIV.

(c) *SUBMISSION OF REPORTS TO CONGRESS.*—The Secretary shall submit to the appropriate committees of the Congress each report received by the Secretary under subsection (b)(2)(B)(ii).

Subpart III—Certain Partner Notification Programs

SEC. 2631. GRANTS FOR PARTNER NOTIFICATION PROGRAMS.

(a) *IN GENERAL.*—In the case of States whose laws or regulations are in accordance with subsection (b), the Secretary, subject to subsection (c)(2), may make grants to the States for carrying out programs to provide partner counseling and referral services.

(b) *DESCRIPTION OF COMPLIANT STATE PROGRAMS.*—For purposes of subsection (a), the laws or regulations of a State are in accordance with this subsection if under such laws or regulations (including programs carried out pursuant to the discretion of State officials) the following policies are in effect:

(1) The State requires that the public health officer of the State carry out a program of partner notification to inform partners of individuals with HIV disease that the partners may have been exposed to the disease.

(2)(A) In the case of a health entity that provides for the performance on an individual of a test for HIV disease, or that treats the individual for the disease, the State requires, subject to subparagraph (B), that the entity confidentially report the positive test results to the State public health officer in a manner recommended and approved by the Director of the Centers for Disease Control and Prevention, together with such addi-

tional information as may be necessary for carrying out such program.

(B) The State may provide that the requirement of subparagraph (A) does not apply to the testing of an individual for HIV disease if the individual underwent the testing through a program designed to perform the test and provide the results to the individual without the individual disclosing his or her identity to the program. This subparagraph may not be construed as affecting the requirement of subparagraph (A) with respect to a health entity that treats an individual for HIV disease.

(3) The program under paragraph (1) is carried out in accordance with the following:

(A) Partners are provided with an appropriate opportunity to learn that the partners have been exposed to HIV disease, subject to subparagraph (B).

(B) The State does not inform partners of the identity of the infected individuals involved.

(C) Counseling and testing for HIV disease are made available to the partners and to infected individuals, and such counseling includes information on modes of transmission for the disease, including information on prenatal and perinatal transmission and preventing transmission.

(D) Counseling of infected individuals and their partners includes the provision of information regarding therapeutic measures for preventing and treating the deterioration of the immune system and conditions arising from the disease, and the provision of other prevention-related information.

(E) Referrals for appropriate services are provided to partners and infected individuals, including referrals for support services and legal aid.

(F) Notifications under subparagraph (A) are provided in person, unless doing so is an unreasonable burden on the State.

(G) There is no criminal or civil penalty on, or civil liability for, an infected individual if the individual chooses not to identify the partners of the individual, or the individual does not otherwise cooperate with such program.

(H) The failure of the State to notify partners is not a basis for the civil liability of any health entity who under the program reported to the State the identity of the infected individual involved.

(I) The State provides that the provisions of the program may not be construed as prohibiting the State from providing a notification under subparagraph (A) without the consent of the infected individual involved.

(4) The State annually reports to the Director of the Centers for Disease Control and Prevention the number of individuals from whom the names of partners have been sought under the program under paragraph (1), the number of such individuals who provided the names of partners, and the number of partners so named who were notified under the program.

(5) The State cooperates with such Director in carrying out a national program of partner notification, including the sharing of information between the public health officers of the States.

(c) *REPORTING SYSTEM FOR CASES OF HIV DISEASE.*—

(1) *PREFERENCE IN MAKING GRANTS THROUGH FISCAL YEAR 2003.*—*In making grants under subsection (a) for each of the fiscal years 2001 through 2003, the Secretary shall give preference to States whose reporting systems for cases of HIV disease produce data on such cases that is sufficiently accurate and reliable for use for purposes of section 2618(b)(2)(D)(i).*

(2) *ELIGIBILITY CONDITION AFTER FISCAL YEAR 2003.*—*For fiscal year 2004 and subsequent fiscal years, a State may not receive a grant under subsection (a) unless the reporting system of the State for cases of HIV disease produces data on such cases that is sufficiently accurate and reliable for purposes of section 2618(b)(2)(D)(i).*

(d) *AUTHORIZATION OF APPROPRIATIONS.*—*For the purpose of carrying out this section, there are authorized to be appropriated \$30,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 through 2005.*

* * * * *

PART C—EARLY INTERVENTION SERVICES

【Subpart I—Formula Grants for States

【SEC. 2641. ESTABLISHMENT OF PROGRAM.

【(a) *ALLOTMENTS FOR STATES.*—For the purposes described in subsection (b), the Secretary, acting through the Director of the Centers for Disease Control and Prevention and in consultation with the Administrator of the Health Resources and Services Administration, shall for each of the fiscal years 1991 through 1995 make an allotment for each State in an amount determined in accordance with section 2649. The Secretary shall make payments, as grants, to each State from the allotment for the State for the fiscal year involved if the Secretary approves for the fiscal year an application submitted by the State pursuant to section 2665.

【(b) *PURPOSES OF GRANTS.*—

【(1) *IN GENERAL.*—The Secretary may not make a grant under subsection (a) unless the State involved agrees to expend the grant for the purposes of providing, on an outpatient basis, each of the early intervention services specified in paragraph (2) with respect to HIV disease.

【(2) *SPECIFICATION OF EARLY INTERVENTION SERVICES.*—The early intervention services referred to in paragraph (1) are—

【(A) counseling individuals with respect to HIV disease in accordance with section 2662;

【(B) testing individuals with respect to such disease, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease;

【(C) referrals described in paragraph (3);

【(D) other clinical and diagnostic services with respect to HIV disease, and periodic medical evaluations of individuals with the disease; and

[(E) providing the therapeutic measures described in subparagraph (B).

[(3) REFERRALS.—The services referred to in paragraph (2)(C) are referrals of individuals with HIV disease to appropriate providers of health and support services, including, as appropriate—

(A) to entities receiving amounts under part A or B for the provision of such services;

[(B) to biomedical research facilities of institutions of higher education that offer experimental treatment for such disease, or to community-based organizations or other entities that provide such treatment; or

[(C) to grantees under section 2671, in the case of pregnant women.

[(4) REQUIREMENT OF AVAILABILITY OF ALL EARLY INTERVENTION SERVICES THROUGH EACH GRANTEE.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that each of the early intervention services specified in paragraph (2) will be available through the State. With respect to compliance with such agreement, a State may expend the grant to provide the early intervention services directly, and may expend the grant to enter into agreements with public or nonprofit private entities under which the entities provide the services.

[(5) OPTIONAL SERVICES.—A State receiving a grant under subsection (a)—

[(A) may expend not more than 5 percent of the grant to provide early intervention services through making grants to hospitals that—

[(i) for the most recent fiscal year for which the data is available, have admitted—

[(I) not fewer than 250 individuals with acquired immune deficiency syndrome; or

[(II) a number of such individuals constituting 20 percent of the number of inpatients of the hospital admitted during such period;

[(ii) agree to offer and encourage such services with respect to inpatients of the hospitals; and

[(iii) agree that subsections (c) and (d) of section 2644 will apply to the hospitals to the same extent and in the same manner as such subsections apply to entities described in such section;

[(B) may expend the grant to provide outreach services to individuals who may have HIV disease, or may be at risk of the disease, and who may be unaware of the availability and potential benefits of early treatment of the disease, and to provide outreach services to health care professionals who may be unaware of such availability and potential benefits; and

[(C) may, in the case of individuals who seek early intervention services from the grantee, expend the grant—

[(i) for case management to provide coordination in the provision of health care services to the individuals and to review the extent of utilization of the services by the individuals; and

[(ii) to provide assistance to the individuals regarding establishing the eligibility of the individuals for financial assistance and services under Federal, State, or local programs providing for health services, mental health services, social services, or other appropriate services.

[(6) ALLOCATIONS.—

[(A) Subject to subparagraphs (B) and (C), the Secretary may not make a grant under subsection (a) unless the State involved agrees—

[(i) to expend not less than 35 percent of the grant to provide the early intervention services specified in subparagraphs (A) through (C) of paragraph (2); and

[(ii) to expend not less than 35 percent of the grant to provide the early intervention services specified in subparagraphs (D) and (E) of such paragraph.

[(B) With respect to compliance with the agreement under subparagraph (A), amounts reserved by a State for fiscal year 1991 for purposes of clauses (i) and (ii) of such subparagraph may be expended to provide the services specified in paragraph (5).

[(C) The Secretary shall ensure that, of the amounts appropriated under section 2650 for fiscal year 1991, an amount equal to \$130,000,000 is expended to provide the early intervention services specified in subparagraphs (A) through (C) of paragraph (2).

[SEC. 2642. PROVISION OF SERVICES THROUGH MEDICAID PROVIDERS.

[(a) IN GENERAL.—Subject to subsection (b), the Secretary may not make a grant under section 2641 to a State unless, in the case of any service described in subsection (b) of such section that is available pursuant to the State plan approved under title XIX of the Social Security Act for the State—

[(1) the State will provide the service through a State entity, and the State entity has entered into a participation agreement under the State plan and is qualified to receive payments under such plan; or

[(2) the State will enter into an agreement with a public or nonprofit private entity under which the entity will provide the service, and the entity has entered into such a participation agreement and is qualified to receive such payments.

[(b) WAIVER REGARDING CERTAIN SECONDARY AGREEMENTS.—

[(1) IN GENERAL.—In the case of an entity making an agreement pursuant to subsection (a)(2) regarding the provision of services, the requirement established in such subsection regarding a participation agreement shall be waived by the Secretary if the entity does not, in providing health care services, impose a charge or accept reimbursement available from any third-party payor, including reimbursement under any insurance policy or under any Federal or State health benefits program.

[(2) ACCEPTANCE OF VOLUNTARY DONATIONS.—A determination by the Secretary of whether an entity referred to in paragraph (1) meets the criteria for a waiver under such subparagraph shall be made without regard to whether the entity ac-

cepts voluntary donations for the purpose of providing services to the public.

[SEC. 2643. REQUIREMENT OF MATCHING FUNDS.

[(a) IN GENERAL.—In the case of any State to which the criterion described in subsection (c) applies, the Secretary may not make a grant under section 2641 unless the State agrees that, with respect to the costs to be incurred by the State in carrying out the purpose referred to in such subsection, the State will, subject to subsection (b)(2), make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount equal to—

[(1) for the first fiscal year for which such criterion applies to the State, not less than $16\frac{2}{3}$ percent of such costs (\$1 for each \$5 of Federal funds provided in the grant);

[(2) for any second such fiscal year, not less than 20 percent of such costs (\$1 for each \$4 of Federal funds provided in the grant);

[(3) for any third such fiscal year, not less than 25 percent of such costs (\$1 for each \$3 of Federal funds provided in the grant); and

[(4) for any subsequent fiscal year, not less than $33\frac{1}{3}$ percent of such costs (\$1 for each \$2 of Federal funds provided in the grant).

[(b) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—

[(1) IN GENERAL.—Non-Federal contributions required in subsection (a) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, and any portion of any service subsidized by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

[(2) INCLUSION OF CERTAIN AMOUNTS.—

[(A) In making a determination of the amount of non-Federal contributions made by a State for purposes of subsection (a), the Secretary shall, subject to subparagraph (B), include any non-Federal contributions provided by the State for HIV-related services, without regard to whether the contributions are made for programs established pursuant to this title.

[(B) In making a determination for purposes of subparagraph (A), the Secretary may not include any non-Federal contributions provided by the State as a condition of receiving Federal funds under any program under this title (except for the program established in section 2641) or under other provisions of law.

[(c) APPLICABILITY OF MATCHING REQUIREMENT.—

[(1) PERCENTAGE OF NATIONAL NUMBER OF CASES.—

[(A) The criterion referred to in subsection (a) is, with respect to a State, that the number of cases of acquired immune deficiency syndrome reported to and confirmed by the Director of the Centers for Disease Control and Prevention for the State for the period described in subparagraph (B) constitutes more than 1 percent of the number of such cases reported to and confirmed by the Director for the United States for such period.

[(B) The period referred to in subparagraph (A) is the 2-year period preceding the fiscal year for which the State involved is applying to receive a grant under section 2641.

[(2) EXEMPTION.—For purposes of paragraph (1), the number of cases of acquired immune deficiency syndrome reported and confirmed for the Commonwealth of Puerto Rico for any fiscal year shall be deemed to be less than 1 percent.

[(d) DIMINISHED STATE CONTRIBUTION.—With respect to a State that does not make available the entire amount of the non-Federal contribution referred to in subsection (a), the State shall continue to be eligible to receive Federal funds under a grant under section 2641, except that the Secretary in providing Federal funds under the grant shall provide such funds (in accordance with the ratios prescribed in paragraph (1)) only with respect to the amount of funds contributed by such State.

[SEC. 2644. OFFERING AND ENCOURAGING EARLY INTERVENTION SERVICES.

[(a) IN GENERAL.—The Secretary may not make a grant under section 2641 unless, in the case of entities to which the State provides amounts from the grant for the provision of early intervention services, the State involved agrees that—

[(1) if the entity is a health care provider that regularly provides treatment for sexually transmitted diseases, the entity will offer and encourage such services with respect to individuals to whom the entity provides such treatment;

[(2) if the entity is a health care provider that regularly provides treatment for intravenous substance abuse, the entity will offer and encourage such services with respect to individuals to whom the entity provides such treatment;

[(3) if the entity is a family planning clinic, the entity will offer and encourage such services with respect to individuals to whom the entity provides family planning services and whom the entity has reason to believe has HIV disease; and

[(4) if the entity is a health care provider that provides treatment for tuberculosis, the entity will offer and encourage such services with respect to individuals to whom the entity provides such treatment.

[(b) SUFFICIENCY OF AMOUNT OF GRANT.—With respect to compliance with the agreement made under subsection (a), an entity to which subsection (a) applies may be required to offer, encourage, and provide early intervention services only to the extent that the amount of the grant is sufficient to pay the costs of offering, encouraging, and providing the services.

[(c) CRITERIA FOR OFFERING AND ENCOURAGING.—Subject to section 2641(b)(4), an entity to which subsection (a) applies is, for purposes of such subsection, offering and encouraging early intervention services with respect to the individuals involved if the entity—

[(1) offers such services to the individuals, and encourages the individuals to receive the services, as a regular practice in the course of providing the health care involved; and

[(2) provides the early intervention services only with the consent of the individuals.

[SEC. 2645. NOTIFICATION OF CERTAIN INDIVIDUALS RECEIVING BLOOD TRANSFUSIONS.

[(a) IN GENERAL.—The Secretary may not make a grant under section 2641 unless the State involved provides assurances satisfactory to the Secretary that, with respect to individuals in the State receiving, between January 1, 1978, and April 1, 1985 (inclusive), a transfusion of whole blood or a blood-clotting factor, the State will provide public education and information for the purpose of—

[(1) encouraging the population of such individuals to receive early intervention services; and

[(2) informing such population of any health facilities in the geographic area involved that provide such services.

[(b) RULE OF CONSTRUCTION.—An agreement made under subsection (a) may not be construed to require that, in carrying out the activities described in such subsection, a State receiving a grant under section 2641 provide individual notifications to the individuals described in such subsection.

[SEC. 2646. REPORTING AND PARTNER NOTIFICATION.

[(a) REPORTING.—The Secretary may not make a grant under section 2641 unless, with respect to testing for HIV disease, the State involved provides assurances satisfactory to the Secretary that the State will require that any entity carrying out such testing confidentially report to the State public health officer information sufficient—

[(1) to perform statistical and epidemiological analyses of the incidence in the State of cases of such disease;

[(2) to perform statistical and epidemiological analyses of the demographic characteristics of the population of individuals in the State who have the disease; and

[(3) to assess the adequacy of early intervention services in the State.

[(b) PARTNER NOTIFICATION.—The Secretary may not make a grant under section 2641 unless the State involved provides assurances satisfactory to the Secretary that the State will require that the public health officer of the State, to the extent appropriate in the determination of the officer, carry out a program of partner notification regarding cases of HIV disease.

[(c) RULES OF CONSTRUCTION.—An agreement made under this section may not be construed—

[(1) to require or prohibit any State from providing that identifying information concerning individuals with HIV disease is required to be submitted to the State; or

[(2) to require any State to establish a requirement that entities other than the public health officer of the State are required to make the notifications referred to in subsection (b).

[SEC. 2647. REQUIREMENT OF STATE LAW PROTECTION AGAINST INTENTIONAL TRANSMISSION.

[(a) IN GENERAL.—The Secretary may not make a grant under section 2641 to a State unless the chief executive officer determines that the criminal laws of the State are adequate to prosecute any HIV infected individual, subject to the condition described in subsection (b), who—

[(1) makes a donation of blood, semen, or breast milk, if the individual knows that he or she is infected with HIV and in-

tends, through such donation, to expose another HIV in the event that the donation is utilized;

[(2) engages in sexual activity if the individual knows that he or she is infected with HIV and intends, through such sexual activity, to expose another to HIV; and

[(3) injects himself or herself with a hypodermic needle and subsequently provides the needle to another person for purposes of hypodermic injection, if the individual knows that he or she is infected and intends, through the provision of the needle, to expose another to such etiologic agent in the event that the needle is utilized.

[(b) CONSENT TO RISK OF TRANSMISSION.—The State laws described in subsection (a) need not apply to circumstances under which the conduct described in paragraphs (1) through (3) of subsection (a) if the individual who is subjected to the behavior involved knows that the other individual is infected and provides prior informed consent to the activity.

[(c) STATE CERTIFICATION WITH RESPECT TO REQUIRED LAWS.—With respect to complying with subsection (a) as a condition of receiving a grant under section 2641, the Secretary may not require a State to enact any statute, or to issue any regulation, if the chief executive officer of the State certifies to the Secretary that the laws of the State are adequate. The existence of a criminal law of general application, which can be applied to the conduct described in paragraphs (1) through (3) of subsection (a), is sufficient for compliance with this section.

[(d) TIME LIMITATIONS WITH RESPECT TO REQUIRED LAWS.—With respect to receiving a grant under section 2641, if a State is unable to certify compliance with subsection (a), the Secretary may make a grant to a State under such section if—

[(1) for each of the fiscal years 1991 and 1992, the State provides assurances satisfactory to the Secretary that by not later than October 1, 1992, the State will have in place or will establish the prohibitions described in subsection (a); and

[(2) for fiscal year 1993 and subsequent fiscal years, the State has established such prohibitions.

[SEC. 2648. TESTING AND OTHER EARLY INTERVENTION SERVICES FOR STATE PRISONERS.

[(a) IN GENERAL.—In addition to grants under section 2641, the Secretary may make grants to States for the purpose of assisting the States in providing early intervention services to individuals sentenced by the State to a term of imprisonment. The Secretary may make such a grant only if the State involved requires, subject to subsection (d), that—

[(1) the services be provided to such individuals; and

[(2) each such individual be informed of the requirements of subsection (c) regarding testing and be informed of the results of such testing of the individual.

[(b) REQUIREMENT OF MATCHING FUNDS.—

[(1) IN GENERAL.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that, with respect to the costs to be incurred by the State in carrying out the purpose described in such subsection, the State will make available (directly or through donations from public or

private entities) non-Federal contributions toward such costs in an amount equal to—

[(A) for the first fiscal year of payments under the grant, not less than \$1 for each \$2 of Federal funds provided in the grant; and

[(B) for any subsequent fiscal year of such payments, not less than \$1 for each \$1 of Federal funds provided in the grant.

[(2) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, and services (or portions of services) subsidized by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

[(c) TESTING.—The Secretary may not make a grant under subsection (a) unless—

[(1) the State involved requires that, subject to subsection (d), any individual sentenced by the State to a term of imprisonment be tested for HIV disease—

[(A) upon entering the State penal system; and

[(B) during the 30-day period preceding the date on which the individual is released from such system;

[(2) with respect to informing employees of the penal system of the results of such testing of the individual, the State—

[(A) upon the request of any such employee, provides the results to the employee in any case in which the medical officer of the prison determines that there is a reasonable basis for believing that the employee has been exposed by the individual to such disease; and

[(B) informs the employees of the availability to the employees of such results under the conditions described in subparagraph (A);

[(3) with respect to informing the spouse of the individual of the results of such testing of the individual, the State—

[(A) upon the request of the spouse, provides such results to the spouse prior to any conjugal visit and provides such results to the spouse during the period described in paragraph (1)(B); and

[(B) informs the spouse of the availability to the spouse of such results under the conditions described in subparagraph (A);

[(4) with respect to such testing upon entering the State penal system of such an individual who has been convicted of rape or aggravated sexual assault, the State—

[(A) upon the request of the victim of the rape or assault, provides such results to the victim; and

[(B) informs the victim of the availability to the victim of such results; and

[(5) the State, except as provided in any of paragraphs (2) through (4), maintains the confidentiality of the results of testing for HIV disease in each prison operated by the State or with amounts provided by the State, and makes disclosures of such results only as medically necessary.

[(d) DETERMINATION OF PRISONS SUBJECT TO REQUIREMENT.—

[(1) IN GENERAL.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that the requirement established in such subsection regarding the provision of early intervention services to inmates will apply only to inmates who are incarcerated in prisons with respect to which the State public health officer, after consultation with the chief State correctional officer, has, on the basis of the criteria described in paragraph (2), determined that the provision of such services is appropriate with respect to the public health and safety.

[(2) DESCRIPTION OF CRITERIA.—The criteria to be considered for purposes of paragraph (1) are—

[(A) with respect to the geographic areas in which inmates of the prison involved resided before incarceration in the prison—

[(i) the severity of the epidemic of HIV disease in the areas during the period in which the inmates resided in the areas; and

[(ii) the incidence, in the areas during such period, of behavior that places individuals at significant risk of developing HIV disease; and

[(B) the extent to which medical examinations conducted by the State for inmates of the prison involved indicate that the inmates have engaged in such behavior.

[(e) APPLICABILITY OF PROVISIONS REGARDING INFORMED CONSENT, COUNSELING, AND OTHER MATTERS.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that sections 2641(b)(4), 2662, and 2664(c) will apply to the provision of early intervention services pursuant to the grant in the same manner and to the same extent as such sections apply to the provision of such services by grantees under section 2641.

[(f) REQUIREMENT OF APPLICATION.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

[(g) RULE OF CONSTRUCTION.—With respect to testing inmates of State prisons for HIV disease without the consent of the inmates, the agreements made under this section may not be construed to authorize, prohibit, or require any State to conduct such testing, except as provided in subparagraphs (A) and (B) of subsection (c)(1).

[(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1988 through 1995.

[SEC. 2649. DETERMINATION OF AMOUNT OF ALLOTMENTS.

[(a) MINIMUM ALLOTMENT.—Subject to the extent of amounts made available in appropriations Acts, the amount of an allotment under section 2641(a) for a State for a fiscal year shall be the greater of—

[(1) \$100,000 for each of the several States, the District of Columbia, and the Commonwealth of Puerto Rico, and \$50,000 for each of the territories of the United States other than the Commonwealth of Puerto Rico; and

[(2) an amount determined under subsection (b).

[(b) DETERMINATION UNDER FORMULA.—The amount referred to in subsection (a)(2) is the product of—

[(1) an amount equal to the amount appropriated under section 2650 for the fiscal year involved; and

[(2) a percentage equal to the quotient of—

[(A) an amount equal to the number of cases of acquired immune deficiency syndrome reported to and confirmed by the Director of the Centers for Disease Control and Prevention for the State involved for the most recent fiscal year for which such data is available; divided by

[(B) an amount equal to the number of cases of acquired immune deficiency syndrome reported to and confirmed by the Director of the Centers for Disease Control and Prevention for the United States for the most recent fiscal year for which such data is available.

[(c) CERTAIN ALLOCATIONS BY SECRETARY.—

[(1) DISCRETIONARY GRANTS TO CERTAIN STATES.—After determining the amount of an allotment under subsection (a) for a fiscal year, the Secretary shall reduce the amount of the allotment of each State by 10 percent. From the amounts available as a result of such reductions, the Secretary shall, on a discretionary basis, make grants to States receiving allotments for the fiscal year involved. Such grants shall be made subject to each of the agreements and assurances required as a condition of receiving grants under section 2641.

[(2) GRANTS TO CERTAIN POLITICAL SUBDIVISIONS.—

[(A)(i) In the case of a State containing any political subdivision described in clause (ii), the Secretary shall, subject to subparagraph (B), make a reduction in the amount of the allotment under subsection (a) for the State for each fiscal year in an amount necessary for carrying out subparagraphs (B) and (C) with respect to the political subdivision. Any such reduction shall be in addition to the reduction required in paragraph (1) for the fiscal year involved.

[(ii) The political subdivision referred to in clause (i) is any political subdivision that received a cooperative agreement from the Secretary, acting through the Director of the Centers for Disease Control and Prevention, for fiscal year 1990 for programs to provide counseling and testing with respect to acquired immune deficiency syndrome.

[(B) In the case of a State described in subparagraph (A), the Secretary shall, from the amounts made available as a result of reductions under such subparagraph, make a grant each fiscal year to each political subdivision described in such subparagraph that exists in the State if the political subdivision involved agrees that the provisions of subparts II and III will apply to the political subdivision to the same extent and in the same manner as such subparts apply to entities receiving grants under section 2651(a).

[(C) Grants under subparagraph (B) for a fiscal year for a political subdivision shall be provided in an amount equal to the amount received by the political subdivision

in fiscal year 1990 under the cooperative agreement described in subparagraph (A).

[(d) DISPOSITION OF CERTAIN FUNDS APPROPRIATED FOR ALLOTMENTS.—

[(1) IN GENERAL.—Any amounts available pursuant to paragraph (2) shall, in accordance with paragraph (3), be allotted by the Secretary each fiscal year to States receiving payments under section 2641(a) for the fiscal year (other than any State referred to in paragraph (2)(C)). The Secretary shall make payments, as grants, to each such State from any such allotment for the State for the fiscal year involved.

[(2) SPECIFICATION OF AMOUNTS.—The amounts referred to in paragraph (1) are any amounts that are not paid to States under section 2641(a) as a result of—

[(A) the failure of any State to submit an application under section 2651;

[(B) the failure, in the determination of the Secretary, of any State to prepare the application in compliance with such section or to submit the application within a reasonable period of time; or

[(C) any State informing the Secretary that the State does not intend to expend the full amount of the allotment made to the State.

[(3) AMOUNT OF ALLOTMENT.—The amount of an allotment under paragraph (1) for a State for a fiscal year shall be an amount equal to the product of—

[(A) an amount equal to the amount available pursuant to paragraph (2) for the fiscal year involved; and

[(B) the percentage determined under subsection (b)(2) for the State.

[(e) TRANSITION RULES.—

[(1) For the fiscal years 1991 through 1993, the amount of an allotment under section 2641 shall be the greater of the amount determined under subsection (a) and an amount equal to the amount applicable under paragraph (2) for the fiscal year involved.

[(2) For purposes of paragraph (1)—

[(A) the amount applicable for fiscal year 1991 is an amount equal to the amount received by the State involved from the Secretary, acting through the Director of the Centers for Disease Control and Prevention, for fiscal year 1990 for the provision of counseling and testing services with respect to HIV;

[(B) the amount applicable for fiscal year 1992 is 85 percent of the amount specified in subparagraph (A); and

[(C) the amount applicable for fiscal year 1993 is 70 percent of the amount specified in subparagraph (A).

[SEC. 2649A. MISCELLANEOUS PROVISIONS.

[(The Secretary may not make a grant under section 2641 unless—

[(1) the State involved submits to the Secretary a comprehensive plan for the organization and delivery of the early intervention services to be funded with the grant that includes a description of the purposes for which the State intends to use such assistance, including—

[(A) the services and activities to be provided and an explanation of the manner in which the elements of the program to be implemented by the State with the grant will maximize the quality of early intervention services available to individuals with HIV disease throughout the State; and

[(B) a description of the manner in which services funded with the grant will be coordinated with other available related services for individuals with HIV disease; and

[(2) the State agrees that—

[(A) the public health agency administering the grant will conduct public hearings regarding the proposed use and distribution of the grant;

[(B) to the maximum extent practicable, early intervention services delivered pursuant to the grant will be provided without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the individual with HIV disease;

[(C) early intervention services under the grant will be provided in settings accessible to low-income individuals with HIV disease; and

[(D) outreach to low-income individuals with HIV disease will be provided to inform such individuals of the services available pursuant to the grant.

[SEC. 2650. AUTHORIZATION OF APPROPRIATIONS.

For the purpose of making grants under section 2641, there are authorized to be appropriated \$230,000,000 for fiscal year 1991, and such sums as may be necessary for each of the fiscal years 1992 through 1995.

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Subpart II—Categorical Grants

* * * * *

SEC. 2653. PREFERENCES IN MAKING GRANTS.

(a) * * *

* * * * *

(d) UNDERSERVED AND RURAL AREAS.—Of the applicants who qualify for preference under this section, the Secretary shall give preference to applicants that will expend the grant under section 2651 to provide early intervention under such section in rural areas or in areas that are underserved with respect to such services.

SEC. 2654. MISCELLANEOUS PROVISIONS.

(a) * * *

* * * * *

(c) PLANNING AND DEVELOPMENT GRANTS.—

(1) IN GENERAL.—The Secretary may provide [planning grants, in an amount not to exceed \$50,000 for each such grant, to public and nonprofit private entities for the purpose of enabling such entities to provide HIV early intervention services.] *planning grants to public and nonprofit private entities for purposes of—*

(A) enabling such entities to provide HIV early intervention services; and

(B) assisting the entities in expanding their capacity to provide HIV-related health services, including early intervention services, in low-income communities and affected subpopulations that are underserved with respect to such services (subject to the condition that a grant pursuant to this subparagraph may not be expended to purchase or improve land, or to purchase, construct, or permanently improve, other than minor remodeling, any building or other facility).

* * * * *

(4) AMOUNT AND DURATION OF GRANTS.—

(A) EARLY INTERVENTION SERVICES.—A grant under paragraph (1)(A) may be made in an amount not to exceed \$50,000.

(B) CAPACITY DEVELOPMENT.—

(i) AMOUNT.—A grant under paragraph (1)(B) may be made in an amount not to exceed \$150,000.

(ii) DURATION.—The total duration of a grant under paragraph (1)(B), including any renewal, may not exceed 3 years.

[(4)] (5) LIMITATION.—Not to exceed [1] 5 percent of the amount appropriated for a fiscal year under section 2655 may be used to carry out this section.

SEC. 2655. AUTHORIZATION OF APPROPRIATIONS.

For the purpose of making grants under section 2651, there are authorized to be appropriated such sums as may be necessary [in each of the fiscal years 1996, 1997, 1998, 1999, and 2000.] for each of the fiscal years 2001 through 2005.

Subpart III—General Provisions

* * * * *

SEC. 2662. PROVISION OF CERTAIN COUNSELING SERVICES.

(a) * * *

* * * * *

(c) COUNSELING OF INDIVIDUALS WITH POSITIVE TEST RESULTS.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, if the results of testing for HIV disease indicate that the individual has the disease, the applicant will provide to the individual appropriate counseling regarding such disease, including—

(1) * * *

* * * * *

(3) providing counseling [on]—

(A) on the availability, through the applicant, of early intervention services;

(B) on the availability in the geographic area of appropriate health care, mental health care, and social and support services, including providing referrals for such services, as appropriate;

[(C) the benefits] (C)(i) that explains the benefits of locating and counseling any individual by whom the infected individual may have been exposed to HIV and any individual whom the infected individual may have exposed to HIV; and

(ii) that emphasizes it is the duty of infected individuals to disclose their infected status to their sexual partners and their partners in the sharing of hypodermic needles; that provides advice to infected individuals on the manner in which such disclosures can be made; and that emphasizes that it is the continuing duty of the individuals to avoid any behaviors that will expose others to HIV;

(D) on the availability of the services of public health authorities with respect to locating and counseling any individual described in subparagraph (C).

* * * * *

SEC. 2664. ADDITIONAL REQUIRED AGREEMENTS.

(a) * * *

* * * * *

(g) ADMINISTRATION OF GRANT.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that—

(1) * * *

* * * * *

(3) the applicant will not expend more than [7.5] 10 percent including planning and evaluation of the grant for administrative expenses with respect to the grant; [and]

(4) the applicant will submit evidence that the proposed program is consistent with the statewide coordinated statement of need and agree to participate in the ongoing revision of such statement of need[.]; and

(5) the applicant will provide for the establishment of a quality management program to assess the extent to which medical services funded under this title that are provided to patients are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections and that improvements in the access to and quality of medical services are addressed.

* * * * *

PART D—GENERAL PROVISIONS

SEC. 2671. GRANTS FOR COORDINATED SERVICES AND ACCESS TO RESEARCH FOR WOMEN, INFANTS, CHILDREN, AND YOUTH.

(a) * * *

(b) PROVISIONS REGARDING PARTICIPATION IN RESEARCH.—

(1) IN GENERAL.—With respect to the projects of research with which an applicant under subsection (a) is concerned, the Secretary may make a grant under such subsection to the applicant only if the following conditions are met:

(A) * * *

* * * * *

[(C) For the first and second fiscal years for which grants under subsection (a) are to be made to the applicant, the applicant agrees that, not later than the end of the second fiscal year of receiving such a grant, a significant number of women, infants, children, and youth who are patients of the applicant will be participating in the projects of research.

[(D) Except as provided in paragraph (3) (and paragraph (4), as applicable), for the third and subsequent fiscal years for which such grants are to be made to the applicant, the Secretary has determined that a significant number of such individuals are participating in the projects.]

(C) The applicant will demonstrate linkages to research and how access to such research is being offered to patients.

* * * * *

[(3) SIGNIFICANT PARTICIPATION; CONSIDERATION BY SECRETARY OF CERTAIN CIRCUMSTANCES.—In administering the requirement of paragraph (1)(D), the Secretary shall take into account circumstances in which a grantee under subsection (a) is temporarily unable to comply with the requirement for reasons beyond the control of the grantee, and shall in such circumstances provide to the grantee a reasonable period of opportunity in which to reestablish compliance with the requirement.

[(4) SIGNIFICANT PARTICIPATION; TEMPORARY WAIVER FOR ORIGINAL GRANTEES.—

[(A) IN GENERAL.—In the case of an applicant under subsection (a) who received a grant under such subsection for fiscal year 1995, the Secretary may, subject to subparagraph (B), provide to the applicant a waiver of the requirement of paragraph (1)(D) if the Secretary determines that the applicant is making reasonable progress toward meeting the requirement.

[(B) TERMINATION OF AUTHORITY FOR WAIVERS.—The Secretary may not provide any waiver under subparagraph (A) on or after October 1, 1998. Any such waiver provided prior to such date terminates on such date, or on such earlier date as the Secretary may specify.]

[(f) APPLICATION.—]

(f) ADMINISTRATION.—

(1) APPLICATION.—A grant under subsection (a) may be made only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

(2) QUALITY MANAGEMENT PROGRAM.—A grantee under this section shall implement a quality management program.

(g) COORDINATION WITH NATIONAL INSTITUTES OF HEALTH.—The Secretary shall develop and implement a plan that provides for the coordination of the activities of the National Institutes of Health with the activities carried out under this section. In carrying out the preceding sentence, the Secretary shall ensure that projects of research conducted or supported by such Institutes are made aware of applicants and grantees under subsection (a), shall require that

the projects, as appropriate, enter into arrangements for purposes of such subsection, and shall require that each project entering into such an arrangement inform the applicant or grantee under such subsection of the needs of the project for the participation of women, infants, children, and youth. *In addition, the Secretary, in coordination with the Director of such Institutes, shall examine the distribution and availability of appropriate HIV-related research projects with respect to grantees under subsection (a) for purposes of enhancing and expanding HIV-related research, especially within communities that are underrepresented with respect to such projects.*

* * * * *

(j) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years **[1996 through 2000]** *2001 through 2005.*

* * * * *

SEC. 2674. EVALUATIONS AND REPORTS.

(a) * * *

* * * * *

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of the fiscal years **[1991 through 1995]** *2001 through 2005.*

* * * * *

SEC. 2675. DATA COLLECTION.

For the purpose of collecting and providing data for program planning and evaluation activities under this title, there are authorized to be appropriated to the Secretary (acting through the Director of the Centers for Disease Control and Prevention) such sums as may be necessary for each of the fiscal years 2001 through 2005. Such authorization of appropriations is in addition to other authorizations of appropriations that are available for such purpose.

SEC. [2675] 2675A. COORDINATION.

[(a) REQUIREMENT.—The Secretary shall assure that the Health Resources and Services Administration and the Centers for Disease Control and Prevention will coordinate the planning of the funding of programs authorized under this title to assure that health support services for individuals with HIV disease are integrated with each other and that the continuity of care of individuals with HIV disease is enhanced. In coordinating the allocation of funds made available under this title the Health Resources and Services Administration and the Centers for Disease Control and Prevention shall utilize planning information submitted to such agencies by the States and entities eligible for support.]

(a) REQUIREMENT.—The Secretary shall ensure that the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Health Care Financing Administration coordinate the planning, funding, and implementation of Federal HIV programs to enhance the continuity of care and prevention services for individuals with HIV disease or those at risk of such disease. The Secretary shall consult with other Federal agen-

cies, including the Department of Veterans Affairs, as needed and utilize planning information submitted to such agencies by the States and entities eligible for support.

(b) *REPORT.*—The Secretary shall biennially prepare and submit to the appropriate committees of the Congress a report concerning the coordination efforts at the Federal, State, and local levels described in this section, including a description of Federal barriers to HIV program integration and a strategy for eliminating such barriers and enhancing the continuity of care and prevention services for individuals with HIV disease or those at risk of such disease.

[(b)] (c) *INTEGRATION BY STATE.*—As a condition of receipt of funds under this title, a State shall assure the Secretary that health support services funded under this title will be integrated with each other, that programs will be coordinated with other available programs (including Medicaid) and that the continuity of care and prevention services of individuals with HIV disease is enhanced.

[(c)] (d) *INTEGRATION BY LOCAL OR PRIVATE ENTITIES.*—As a condition of receipt of funds under this title, a local government or private nonprofit entity shall assure the Secretary that services funded under this title will be integrated with each other, that programs will be coordinated with other available programs (including Medicaid) and that the continuity of care and prevention services of individuals with HIV is enhanced.

(e) *RECOMMENDATIONS REGARDING RELEASE OF PRISONERS.*—After consultation with the Attorney General and the Director of the Bureau of Prisons, with States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary, consistent with the coordination required in subsection (a), shall develop a plan for the medical case management of and the provision of support services to individuals who were Federal or State prisoners and had HIV disease as of the date on which the individuals were released from the custody of the penal system. The Secretary shall submit the plan to the Congress not later than two years after the date of the enactment of the Ryan White CARE Act Amendments of 2000.

SEC. 2675B. AUDITS.

For fiscal year 2002 and subsequent fiscal years, the Secretary may reduce the amounts of grants under this title to a State or political subdivision of a State for a fiscal year if, with respect to such grants for the second preceding fiscal year, the State or subdivision fails to prepare audits in accordance with the procedures of section 7502 of title 31, United States Code. The Secretary shall annually select representative samples of such audits, prepare summaries of the selected audits, and submit the summaries to the Congress.

SEC. 2675C. ADMINISTRATIVE SIMPLIFICATION REGARDING PARTS A AND B.

(a) *COORDINATED DISBURSEMENT.*—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall develop a plan for coordinating the disbursement of appropriations for grants under part A with the disbursement of appropriations for grants under part B in order to assist grantees and other recipients

of amounts from such grants in complying with the requirements of such parts. The Secretary shall submit the plan to the Congress not later than 18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000. Not later than two years after the date on which the plan is so submitted, the Secretary shall complete the implementation of the plan, notwithstanding any provision of this title that is inconsistent with the plan.

(b) **BIENNIAL APPLICATIONS.**—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall make a determination of whether the administration of parts A and B by the Secretary, and the efficiency of grantees under such parts in complying with the requirements of such parts, would be improved by requiring that applications for grants under such parts be submitted biennially rather than annually. The Secretary shall submit such determination to the Congress not later than two years after the date of the enactment of the Ryan White CARE Act Amendments of 2000.

(c) **APPLICATION SIMPLIFICATION.**—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall develop a plan for simplifying the process for applications under parts A and B. The Secretary shall submit the plan to the Congress not later than 18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000. Not later than two years after the date on which the plan is so submitted, the Secretary shall complete the implementation of the plan, notwithstanding any provision of this title that is inconsistent with the plan.

[SEC. 2677. AUTHORIZATION OF APPROPRIATIONS.

[(a) IN GENERAL.—Subject to subsection (b), there are authorized to be appropriated to make grants under parts A and B, such sums as may be necessary for each of the fiscal years 1996 through 2000.

[(b) DEVELOPMENT OF METHODOLOGY.—

[(1) IN GENERAL.—With respect to each of the fiscal years 1997 through 2000, the Secretary shall develop and implement a methodology for adjusting the percentages allocated to part A and part B to account for grants to new eligible areas under part A and other relevant factors. Not later than July 1, 1996, the Secretary shall prepare and submit to the appropriate committees of Congress a report regarding the findings with respect to the methodology developed under this paragraph.

[(2) FAILURE TO IMPLEMENT.—If the Secretary determines that such a methodology under paragraph (1) cannot be developed, there are authorized to be appropriated—

[(A) such sums as may be necessary to carry out part A for each of the fiscal years 1997 through 2000; and

[(B) such sums as may be necessary to carry out part B for each of the fiscal years 1997 through 2000.]

SEC. 2677. AUTHORIZATION OF APPROPRIATIONS.

(a) **PART A.**—For the purpose of carrying out part A, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

(b) PART B.—For the purpose of carrying out part B, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

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PART F—DEMONSTRATION AND TRAINING

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Subpart II—AIDS Education and Training Centers

SEC. 2692. HIV/AIDS COMMUNITIES, SCHOOLS, AND CENTERS.

(a) SCHOOLS; CENTERS.—

(1) IN GENERAL.—The Secretary may make grants and enter into contracts to assist public and nonprofit private entities and schools and academic health science centers in meeting the costs of projects—

(A) **training** to train health personnel, including practitioners in programs under this title and other community providers, in the diagnosis, treatment, and prevention of HIV disease, including the prevention of the perinatal transmission of the disease **and including**, including measures for the prevention and treatment of opportunistic infections, and including (as applicable to the type of health professional involved), prenatal and other gynecological care for women with HIV disease;

(B) to train the faculty of schools of, and graduate departments or programs of, medicine, nursing, osteopathic medicine, dentistry, public health, allied health, and mental health practice to teach health professions students to provide for the health care needs of individuals with HIV disease; **and**

(C) to develop and disseminate curricula and resource materials relating to the care and treatment of individuals with such disease and the prevention of the disease among individuals who are at risk of contracting the disease~~...~~; and

(D) to develop protocols for the medical care of women with HIV disease, including prenatal and other gynecological care for such women.

* * * * *

(b) DENTAL SCHOOLS.—

[(1) IN GENERAL.—The Secretary may make grants to assist dental schools and programs described in section 777(b)(4)(B) with respect to oral health care to patients with HIV disease.]

(1) IN GENERAL.—

(A) GRANTS.—The Secretary may make grants to dental schools and programs described in subparagraph (B) to assist such schools and programs with respect to oral health care to patients with HIV disease.

(B) ELIGIBLE APPLICANTS.—For purposes of this subsection, the dental schools and programs referred to in this subparagraph are dental schools and programs that were described in section 777(b)(4)(B) as such section was in ef-

fect on the day before the date of enactment of the Health Professions Education Partnerships Act of 1998 (Public Law 105-392) and in addition dental hygiene programs that are accredited by the Commission on Dental Accreditation.

(2) APPLICATION.—Each dental school or program described in section [777(b)(4)(B)] *the section referred to in paragraph (1)(B)* may annually submit an application documenting the unreimbursed costs of oral health care provided to patients with HIV disease by that school or hospital during the prior year.

* * * * *

(5) COMMUNITY-BASED CARE.—*The Secretary may make grants to dental schools and programs described in paragraph (1)(B) that partner with community-based dentists to provide oral health care to patients with HIV disease in unserved areas. Such partnerships shall permit the training of dental students and residents and the participation of community dentists as adjunct faculty.*

(c) AUTHORIZATION OF APPROPRIATIONS.—

(1) SCHOOLS; CENTERS.—For the purpose of grants under subsection (a), there are authorized to be appropriated such sums as may be necessary for each of the [fiscal years 1996 through 2000] *fiscal years 2001 through 2005.*

[(2) DENTAL SCHOOLS.—For the purpose of grants under subsection (b), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1996 through 2000.]

(2) DENTAL SCHOOLS.—

(A) IN GENERAL.—*For the purpose of grants under paragraphs (1) through (4) of subsection (b), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.*

(B) COMMUNITY-BASED CARE.—*For the purpose of grants under subsection (b)(5), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.*

* * * * *

ADDITIONAL VIEWS

While I support the overall goal of the Coburn-Waxman Ryan White CARE Act Amendments of 2000, H.R. 4807, I must take issue with one key provision of the bill, the “hold harmless” provision for Title I Eligible Metropolitan Areas (EMAs). I herewith express my strong objections to this provision and urge that it be modified.

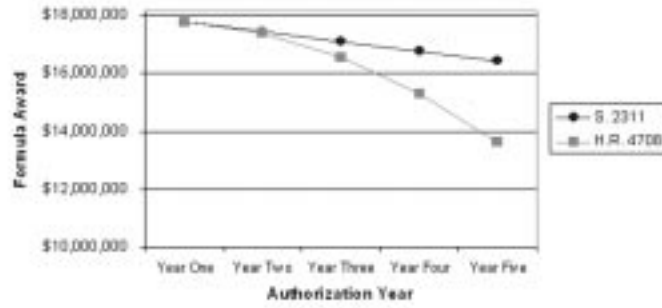
The original CARE Act legislation of 1990 included two factors in Title I formula grants: cumulative AIDS cases and “density.” The “density factor” took into account the number of AIDS cases per 100,000 people in a given EMA. When the CARE Act was reauthorized in 1996, the criteria for Title I formula grants were changed. A “ten year weighted case band,” which gives greater “weight” to recently diagnosed AIDS cases on the theory that this information is more likely to measure “living AIDS cases,” was substituted for the count of cumulative AIDS cases and the density factor was eliminated entirely. These changes, particularly the removal of the density factor, necessitated the inclusion of a “hold harmless” provision to prevent EMAs from experiencing dramatic funding losses.

Under current law, a Title I EMA can lose no more than one percent of its funding each year, allowing for a five percent loss over five years. H.R. 4807 would alter this dramatically by allowing an EMA to lose 25 percent of its funding over five years. The result will be a rapid decline among systems of care and reduced access to vital HIV/AIDS services.

The Senate bill reauthorizing the CARE Act, S. 2301, alters the “hold harmless” provision to allow for a 10 percent reduction in funding for an EMA over five years, a doubling of the rate in the current law. The Senate provision allows for a reasonable re-directing of resources without undermining systems of care through huge funding losses. I urge the Conferees to adopt the Senate provision when this bill goes to Conference.

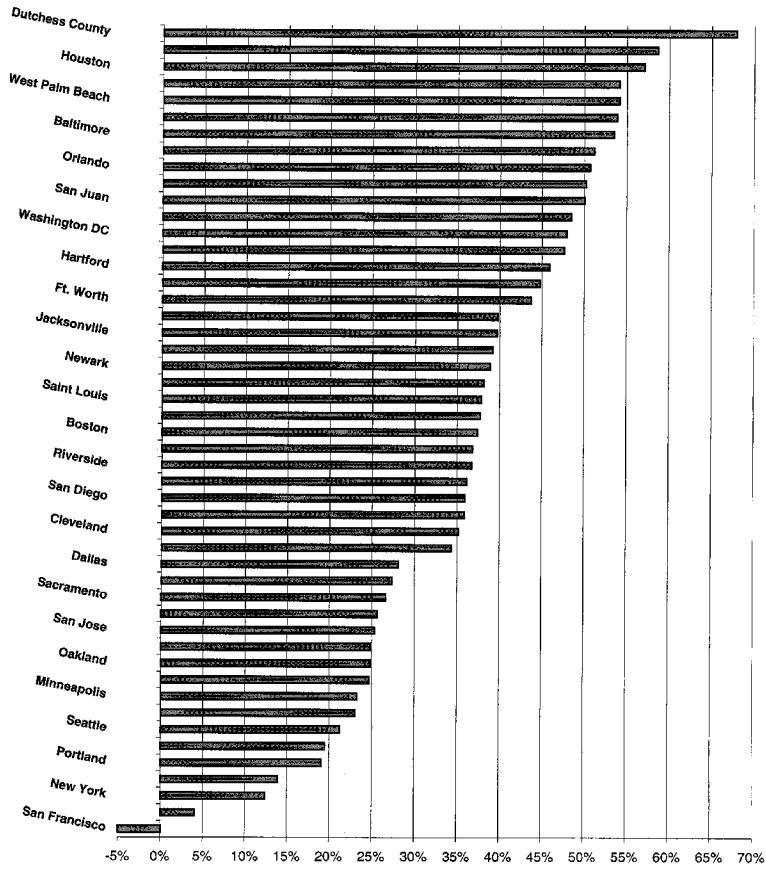
The 25 percent formula reduction included in H.R. 4807 is troubling for many reasons. The only EMA likely to experience the full 25% reduction in funding is San Francisco, meaning that this change will directly impact my constituents.

**IMPACT OF HOLD HARMLESS PROVISIONS OF
S. 2311 AND H.R. 4708 ON FUNDING FOR THE
SAN FRANCISCO EMA**



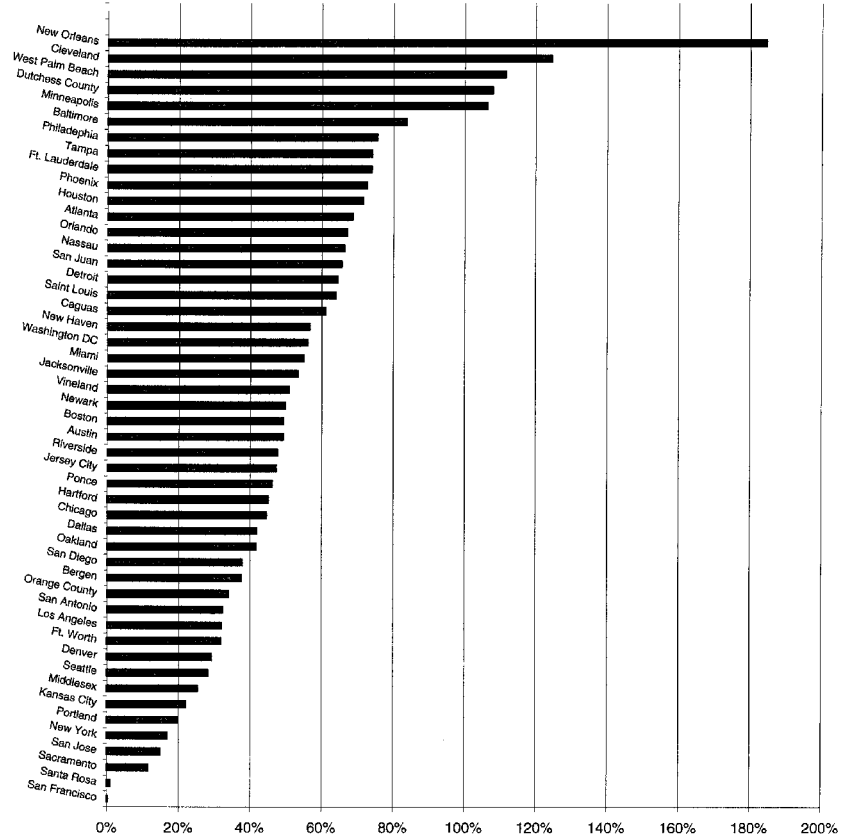
It has been stated that San Francisco receives “too much” money relative to the number of people living with HIV/AIDS. This is false. The AIDS epidemic is still a national crisis and no EMA, including San Francisco, receives enough CARE Act funding to meet all the needs of those living with HIV/AIDS. As more people with HIV live longer due to life-saving but expensive combination therapies, the strain on public health systems is increasing, not decreasing. Reducing an EMA’s Title I funding by 25 percent would seriously destabilize systems of care in that community.

**Title I Funding Comparison
Formula Awards FY 1996-FY 2000**



Change In Formula Funding (percent change from FY 96-FY 00)
 Chart does not include Las Vegas or Norfolk; these EMAs did not receive funding in FY 96
 Average change: increase of 36.25%

Title I Funding Comparison 1996-2000
(Includes total Title I allocation)



Increase in total Title I Funding (percent change from FY 96-FY 00)
Chart does not include Las Vegas or Norfolk; these EMAs did not receive funding in FY 96
Average increase: 53.65%

The ten year weighted case band that is used to allocate Title I formula funding seriously undercounts the number of people accessing CARE Act services. As noted previously, a recently diagnosed AIDS case is given greater "weight" under this formula. However, the use of highly active antiretroviral therapy has made this method of measurement far less accurate. Combination therapies have allowed many people with AIDS to live longer than 10 years and prevented many with HIV from advancing to an AIDS diagnosis as quickly as in the past. As a result, more people than ever are utilizing CARE Act services but many of them aren't being counted in the current Title I formula methodology. The hold harmless provision in H.R. 4807 would have the effect of punishing EMAs like San Francisco for effective intervention to care for and prolong the lives of those with HIV.

Proponents of the 25 percent hold harmless provision have offered a per capita analysis of each EMA to show that San Francisco receives too much in CARE Act funds. This argument is misleading and obscures the fact that CARE Act funding is designed to support public health systems in cities where large numbers of AIDS cases threaten the system with collapse and is not tied to individuals with AIDS. A per capita analysis ignores other relevant factors as well, such as the wide variance in cost of care among geographic areas, making direct comparison very difficult. Similarly, CARE Act services are accessed at varying rates in different areas.

I support the reauthorization of the Ryan White CARE Act; however, it's vital that the more moderate Senate position on the hold harmless issue be adopted in Conference and I urge my colleagues to do so.

ANNA G. ESHOO.

