

Calendar No. 548

106TH CONGRESS }
2d Session }

SENATE

{ REPORT
{ 106-294

RYAN WHITE CARE ACT AMENDMENTS OF 2000

MAY 15, 2000.—Ordered to be printed

Mr. JEFFORDS, from the Committee on Health, Education, Labor,
and Pensions, submitted the following

REPORT

[To accompany S. 2311]

The Committee on Health, Education, Labor, and Pensions, to which was referred to the bill (S. 2311) to revise and extend the Ryan White CARE Act programs under title XXVI of the Public Health Service Act, to improve access to health care and the quality of health care under such programs, and to provide for the development of increased capacity to provide health care and related support services to individuals and families with HIV disease, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill (as amended) do pass.

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I. SUMMARY OF THE BILL

The Ryan White CARE Act Amendments of 2000, S. 2311 reauthorizes title XXVI of the Public Health Service Act to ensure that individuals living with HIV and AIDS receive health care and related support services. The legislation contains authorization for appropriations and programmatic changes to ensure the CARE Act

programs respond to evolving demographic trends in the HIV/AIDS epidemic and advances in treatment and care.

1. The current four-title structure of the Ryan White Care Act is maintained

Title I: Provides emergency relief grants to eligible metropolitan areas (EMA's) disproportionately affected by the HIV epidemic to provide primary care and HIV-related support services to people with HIV and AIDS. One-half of the title I funding is distributed by formula; the remaining one-half is distributed competitively, based on severity of need criteria.

Title II: Provides grants to States and territories to improve the quality of health care and support services for individuals with HIV disease and their families. The funds are used: to provide medical support services; to continue insurance payments; to provide home care services; and to purchase medications necessary for the care of these individuals. Funding for title II is distributed by formula.

Title III(b): Supports early intervention services on an outpatient basis—including counseling; testing; referrals; and clinical, diagnostic, and other therapeutic services. This funding is distributed by competitive grants.

Title IV: Provides grants for services and access to research for children and families. This funding is distributed by competitive grants.

2. Planning requirements for titles I and II are augmented to strengthen service planning and priority setting

States and title I planning councils are directed to consider the availability of other funding sources, such as Medicaid and the State Children's Health Insurance Program (SCHIP); the consideration of capacity development needs to ensure accessible and effective service delivery capacity; and the phased-in requirement of planning for individuals with HIV disease not currently in care. Homeless service providers are included in the list of service providers on planning councils and State consortia.

3. Grantees of all titles are required to institute quality management programs

At present, there is no consistent assessment of the quality and effectiveness of CARE Act-funded programs. The new provisions require grantees to develop systems of quality management to assess and improve the quality of primary care and support services, and to ensure that medical services provided to patients are consistent with the most recent Public Health Service (PHS) guidelines for the treatment of HIV disease and related opportunistic infections. The Secretary is directed to develop appropriate tools and measures to assist grantees in the implementation of quality management programs.

4. Organizations that contract with Ryan White grantees under titles I and II must develop and maintain referral relationships with points of entry to the health care system

Referral relationship between CARE Act grantees and key points of entry to the health care system will facilitate access to and entry into care and early intervention services for persons newly diagnosed with HIV disease, persons unaware of their risk for HIV infection, and those knowledgeable of their HIV status but not in care.

5. Support services funded through the act are required to be health care related

In order to ensure that the focus of Ryan White services remains on improving health outcomes of people with HIV and AIDS, support services funded through the act must facilitate or enhance the delivery, continuity, or benefits of health services. Appropriate types of support services are more clearly outlined and the intent of support services is defined.

6. Early intervention activities are authorized services under titles I and II

At present, grantees funded under titles I and II cannot support early intervention services (EIS) with Ryan White funding. S. 2311 authorizes grantees to include certain services to support early intervention and provide linkages into care among populations at high risk for HIV infection. Funding will be limited to only those provider sites serving as key points of entry or current Ryan White-funded medical sites. Sites must demonstrate that funds for these services supplement but do not supplant existing funds, that other funds are unavailable, and that EIS will be provided in accordance with existing provisions in the act.

7. Grant awards for title I EMA's protected from precipitous declines in funding

The current hold harmless provision, which expires in the year 2000, is modified and extended through 2005. This update retains the hold harmless provision but protects EMA's from losing more than 2 percent of funding per fiscal year over the next 5-year reauthorization period, for a maximum reduction of 10 percent over 5 years. The intent is to support stability in health care capacity and avert rapid shifting of funds.

8. The existing set-asides for infants, children, and women in titles I and II are required to be allocated proportionately according to the percentage that each group represents in the eligible area

The current set-aside for infants, children, and women in titles I and II does not require that a proportional amount be spent on each subgroup. Thus, a grantee may spend all of the set-aside funding on one group at the expense of another. This change reflects the intent of the provision that funds be set aside to address the health care needs of each of these vulnerable subpopulations.

9. A supplemental grant is created within title II to meet HIV care and support needs in non-EMA areas

There are a large number of areas within States that do not meet the definition of a title I EMA but that nevertheless experience significant numbers of people living with AIDS. This provision stipulates that these areas, including emerging communities defined as cities with between 1000 and 1999 reported AIDS cases in the most recent 5-year period, be allocated 50 percent of new appropriations to address the growing need in these areas. States can apply for these supplemental awards by describing the severity of need and the manner in which funds are to be used.

10. The AIDS Drug Assistance Program is continued with an authorization for medical management services and a supplemental grant for States experiencing shortfalls in program funding

With this reauthorization, up to 10 percent of AIDS Drug Assistance Program (ADAP) funds will be allowed to support services that directly encourage, support, and enhance adherence with treatment regimens, including medical monitoring. A supplemental grant is instituted for those States unable to provide full ADAP benefits to individuals living at or below 200 percent of the Federal poverty level (FPL).

The Secretary is authorized to reserve 3 percent of ADAP appropriations for this purpose, which shall be awarded to those States to be used only for the purchase of therapeutics. States are required to match the Federal supplement at a rate of 1:4.

11. The minimum title II base award is increased

The current minimum grants are increased 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. These increases will improve the base funding available to States for the capacity development of health system programs and infrastructure. The Federated States of Micronesia and the Republic of Palau are included as entities eligible to receive title II funds.

12. Capacity development grants allowed under title III

Within title III, capacity development grants are allowed for underserved, low-income urban and low-income rural areas, to a maximum of \$150,000 over a 3-year period. These grants are intended to help grantees expand capacity, preparedness, and expertise to deliver primary care, particularly in underserved communities where infrastructure for the provision of HIV services is inadequate. To accommodate the addition of a new grant category, the percentage of appropriations under this section that can be used for planning and capacity development grants is increased from 1 percent to 5 percent.

13. The administrative cap for the directly funded title III programs is increased

The administrative cap for TITLE II grants is raised from 7.5 percent to 10 percent to correspond with the 10 percent cap on individual contractors in title I.

14. Rural and underserved areas receive preferential consideration for title III grant funding applications

Currently, rural and underserved areas are not able to compete successfully for planning grants and early intervention service grants due to the lack of infrastructure and experience with the Ryan White CARE Act programs. This gap in services available is increasingly important, as the HIV and AIDS epidemic extends into rural communities. A preference for these areas will allow program administrators to target capacity development and planning grants and the delivery of primary care services to rural communities with a growing need for HIV services, while not excluding urban areas from consideration for future grants nor reducing funding to current grants in urban areas.

15. Removes the requirement that title IV grantees enroll a “significant number” of patients in research projects

Title IV provides an important link between women, children, and families affected by HIV/AIDS and HIV-related clinical research programs. The “significant number” requirement is deleted here to remove the incentive for providers to inappropriately encourage or pressure patients to enroll in research programs. To maintain appropriate access to research opportunities, providers are required to develop better documentation of the linkages between care and research. The Secretary of Health and Human Services (HHS), through the National Institutes of Health (NIH), is also directed to examine the distribution and availability of HIV-related clinical programs for purposes of enhancing and expanding access to clinical trials.

16. The Secretary is directed to review administrative and program support expenses for title IV, in consultation with grantees

In order to assure that children, youth, women, and families have access to quality HIV-related health and support services and research opportunities, the Secretary is directed to work with title IV grantees to review expenses related to administrative, program support, and direct service-related activities.

17. IOM requested to study the Ryan White CARE Act

The Secretary is required to contract with the Institute of Medicine (IOM) to complete a study, within 2 years after the enactment of this act, that examines changing trends in the HIV/AIDS epidemic and the financing and delivery of primary care and support services for low-income, uninsured, and underinsured individuals with HIV disease and to make recommendation regarding the most effective use of scarce Federal resources.

The purpose of the study would be to examine key factors associated with the effective and efficient financing and delivery of HIV services (including the quality of services, health outcomes, and cost-effectiveness). The committee expects that the study would include examination of CARE Act financing of services in relation to existing public sector financing (e.g., Medicaid, Medicare, State programs) and private health coverage; general demographics (race/ethnicity, socioeconomic status, age, gender, geographic location) and comorbidities (e.g., substance use, mental health issues, home-

lessness) of individuals with HIV disease; regional variations in the financing and costs of HIV service delivery; the availability and utility of health outcomes measures and data for measuring quality of Ryan White-funded service; and available epidemiological tools and data sets necessary for local and national resource planning and allocation decisions, including an assessment of implementation of HIV infection reporting as it impacts these factors.

II. BACKGROUND AND NEED FOR THE LEGISLATION

A. GENERAL BACKGROUND

In March, 1990, Congress enacted the Ryan White CARE Act, honoring Ryan White, a young man who taught the Nation to respond to the HIV/AIDS epidemic with hope and action rather than fear. By spring, 1990, over 128,000 people had been diagnosed with AIDS in the United States; 78,000 had died of the disease. The CARE Act was reauthorized in 1996, in recognition of the fact that the epidemic continued to spread and that primary care and support services provided through the act were still vitally important to people with HIV and AIDS and the health care systems in their communities.

In testimony before the committee, Sandra Thurman, director of the Office of National AIDS Policy, outlined the success of the CARE Act since the last reauthorization:

The CARE Act has helped to: reduce both the frequency and length of expensive inpatient hospitalizations by at least 30 percent; reduce AIDS mortality by 70 percent; reduce mother-to-child transmission of HIV by 75 percent; and enhance both the length and quality of life for people living with AIDS. Between 1995 and 1997, the Nation has seen a 30 percent decline in HIV-related hospitalizations—resulting in nearly 1 million fewer HIV-related hospital days. This represents a saving of more than \$1 billion—money much more effectively invested in enabling people with HIV to live healthier and more productive lives. These positive outcomes highlight why the Ryan White CARE Act reauthorization is so imperative. We stand at a critical juncture in this pandemic—and we must be sure that the success of the CARE Act does not breed complacency but constructive action. Increasingly, the AIDS epidemic in the United States parallels the pandemic globally—with more and more disenfranchised people caught in the crossfire.

Today, more than 711,000 cases of AIDS have been reported to the Centers for Disease Control and Prevention (CDC). More than 420,000 men, women, and children have died as the epidemic has spread over the last 20 years, to both new populations and new geographic areas. The epidemic continues to grow, touching larger numbers of people and more segments of our society. The heterosexual transmission rate continues to increase; women, teenagers, and minorities are increasingly being affected. Both suburban and rural areas of the country are now feeling the full impact of the epidemic. Those areas must now confront the same social, eco-

conomic, and personal challenges that the original urban epicenters have been facing since 1981.

The continued expansion of the AIDS epidemic in America is a certainty. Yet, diagnosed AIDS cases measure only a portion of the problem. The CDC estimates that there are between 800,000 and 900,000 people currently living with HIV in the United States, with 40,000 new infections annually. In addition to new infections and persons living with HIV infection who are not in care, individuals in treatment are living longer with the disease, increasing demands on the health care system. Hundreds of thousands of these Americans will require health care services for HIV-related conditions in the future. This ongoing crisis will severely challenge the Nation's health care system well into the new century.

While a cure for HIV has eluded scientists, science has made significant progress in developing treatments for HIV disease since the last reauthorization. Therapies now exist that, for many people, can help slow the progression of HIV and allow the immune system to recover some of its ability to resist opportunistic infections associated with AIDS. These therapies, used alone and in combination, have drastically reduced the number of deaths from AIDS and the number of new AIDS cases over the last 4 years. In addition, prenatal administration of AZT and active outreach to and counseling of pregnant women have nearly eliminated the perinatal transmission of HIV. These developments have resulted in longer survival rates for people diagnosed with AIDS and have highlighted the importance of and need for early intervention and early treatment.

Public policy must follow the expanding epidemic and incorporate the advances in scientific and medical information regarding HIV. Effective policy should also address the increasing service needs that the epidemic creates and integrate the advances in knowledge, understanding, and treatment of the disease. With the introduction of potent antiretroviral therapies, for example, patient demand for financial assistance has increased rapidly, precipitating a financial crisis in AIDS drug assistance programs across the country. As the epidemic, the affected communities and populations, and the medical response continue to change, public policy must be flexible enough to meet unexpected challenges.

The Ryan White CARE Act was originally enacted in 1990 in response to the need for HIV primary care and support services. The major focus of public policy prior to the CARE Act was on research, public education, surveillance, and prevention. These activities are still a necessary priority and continue to receive attention and funding through the National Institutes of Health and the Centers for Disease Control and Prevention. In contrast, the CARE Act has helped people with HIV and AIDS to obtain primary care and support services to save and improve their lives. The CARE Act has played a critical role in the Nation's response to the AIDS epidemic.

The public health burden and the economic burden of the AIDS epidemic have not been reduced since the CARE Act was passed. While the CARE Act has been a lifeline of support to many people, need for services continues to grow faster than the resources available. In fact, the steady expansion and changed demographics of

the epidemic and the increasing survival rates for people living with AIDS have increased the stress on local health care systems in some areas. This strain is felt both in urban centers where the epidemic continues to rage, and in smaller cities and rural areas, where the epidemic is expanding rapidly.

In response, the committee ordered favorably reported S. 2311, the Ryan White CARE Act Amendments of 2000. This reauthorization provides accessible HIV primary care and support services to the increasing number of people who need them. Ryan White-funded, community-based, neighborhood health clinics and social service agencies have helped alleviate the impact on acute care centers, where much of the AIDS care was originally provided. Furthermore, the CARE Act provides reimbursement for services that went unreimbursed for too long and threatened the stability of the Nation's health care system. With Federal assistance, Americans who might otherwise become ill and burden our already overcrowded hospital emergency rooms can remain healthy, working, and productive members of our society.

B. HIV DISEASE IN URBAN AREAS

HIV and AIDS continue to place a heavy burden on the citizens and health care systems of the Nation's metropolitan areas. Currently, 51 eligible metropolitan areas (EMA's) receive title I emergency relief funding, compared to only 16 when the CARE Act was originally passed. Seventy-five percent of the new AIDS diagnoses are reported in the current EMA's. In addition, many non-EMA metropolitan areas have AIDS caseloads that fall just short of the 2000 caseloads needed for title I eligibility. These are the new epicenters where the AIDS epidemic is seriously straining the local health care infrastructure and negatively affecting the health of whole communities. These urban areas must address not only the epidemic, but also other co-occurring conditions including tuberculosis, homelessness, substance abuse, mental illness, and other sexually transmitted diseases (STD's). These conditions vastly complicate the treatment of HIV/AIDS and necessitate an array of support services to sustain and enhance medical care.

HIV-specific problems and general health care delivery issues continue to challenge public health officials. Municipal hospitals bear a disproportionate share of the AIDS burden. People with HIV disease are drawn to these urban facilities, even as other pressures reduce the ability of these facilities to respond to the needs of people with HIV. Private hospitals, for example, continue to cut back on charity care, and the large public hospitals are now forced to care for a growing population of AIDS patients and people with HIV as they continue to serve the neediest and struggle to maintain financial viability.

C. HIV IN RURAL AREAS AND SMALLER METROPOLITAN AREAS

While the AIDS epidemic continues in urban areas of the country, the number of new cases diagnosed in small urban centers and suburban and rural areas has reached alarming levels. According to the HIV/AIDS surveillance reports published by the Centers for Disease Control and Prevention, the proportion of all AIDS cases reported in areas with under 500,000 population has grown to

nearly 16 percent, over 111,000 cases. Of these, 40,000 cases, or 6 percent of cases, were reported in rural areas with less than 50,000 in population. As the epidemic has expanded into rural, suburban, and small urban areas, local health care systems have often been unable to meet the growing demand for medical and support services.

The problems created by HIV disease in rural areas are often similar to those experienced in large cities; however, these problems are exacerbated by poor health care infrastructure and limited experience with HIV/AIDS care. The lack of trained primary care providers, absence of long-term care facilities, scarcity of resources, and a scattered population are additional obstacles that may be faced in developing coordinated outpatient services programs. Small rural hospitals and other rural providers may not be able to provide the highly specialized services often required by some persons with HIV disease. When primary care services are unavailable, individuals and families must travel long distances to receive necessary care. Furthermore, rural health care systems must address not only the epidemic, but also other co-occurring conditions including homelessness, tuberculosis, substance abuse, mental illness, and other STD's.

In testifying before the committee, Dr. Chris Grace, who provides medical services to people with HIV/AIDS in Vermont through Ryan White funding, summed up the challenges facing rural people with HIV:

HIV infection is a complex medical, psycho-social, and economic illness. Numerous barriers impede the provision of care to persons with this illness in rural areas. Because of these barriers, patients may not seek health care or may be forced to travel long distances for expert care. Delays in seeking care could increase the risk of complications, hospitalizations, and death. Barriers to accessing HIV health care include: the complexities of HIV care, long travel distances, confidentiality, limited health insurance, limited psychiatric and substance abuse care, [and] limited mass transportation.

Some States have been able to adapt to the challenges and have developed care systems that can better reach the rural and suburban populations in need of services. Many States, however, struggle to meet the health care needs of rural citizens and low-income citizens, and the additional challenges of HIV and AIDS have further stressed typically weak rural health care systems. The demand and need for assistance in these areas will only continue to rise in the coming years.

D. THE EPIDEMIC IN COMMUNITIES OF COLOR

The AIDS epidemic has dealt a particularly severe blow to communities of color which represent 67 percent of new AIDS cases reported from June, 1998, to June, 1999. The extent of the disproportionate impact of the epidemic on racial and ethnic communities can be seen most dramatically when the percentage of AIDS cases in specific communities of color is compared with their percentage representation in United States population census. African-Ameri-

cans represented 45 percent of all AIDS cases but only 12 percent of the United States population in 1998. Hispanics represented 20 percent of cases and only 13 percent of United States population for the same year. When we examine new cases of HIV infection, we find that 74 percent of new HIV infections through June, 1999, are in communities of color. Of these, African-Americans account for 54 percent of new infections and Hispanics 19 percent. Women account for 30 percent of all new HIV infections, and 82 percent of these new infections are in women of color. HIV remains the leading cause of death among African-Americans between the ages of 29 and 44, and the third leading cause of death among Hispanics in this age group.

The impact of HIV and AIDS on minority communities is compounded in rural and underserved areas, like the rural South, where health care infrastructure is limited. The existing health care systems are often inaccessible to minority populations, resulting in limited or no access to treatment and care services. For example, Native Americans and American Indians are eligible for Ryan White services through State and Federal citizenship and yet often find it difficult to access services that are geographically distant or that are poorly coordinated with the Indian Health Service provider. These limitations translate into a greater disease burden and poorer health outcomes in the very communities least able to address their health care needs. The need for assistance and services to meet the needs of these affected populations has been growing rapidly as the epidemic has established itself in minority communities across the Nation.

E. CHILDREN AND FAMILIES WITH HIV DISEASE

HIV is increasingly spread through unprotected heterosexual contact. As HIV is spread through unprotected heterosexual sex, and through intravenous drug users and their sexual partners, entire families can become infected. These families will need a full range of HIV health care and support services. As of June, 1999, nearly 9,000 children had received an AIDS diagnosis. The number of cases of AIDS among women has also been steadily rising. While women currently represent 17 percent of cumulative AIDS cases, the CDC estimates that women make up 30 percent of all new reported AIDS cases in the last year. Thus, as HIV reaches into new communities, the women, children, and families are often hit the hardest by this epidemic.

Many families find that obtaining access to essential services can be a complicated and frustrating process. Women have the most limited access to health care of any group infected with HIV, and they frequently experience difficulty advocating effectively for their children. The availability of health care and support services for HIV-infected women and children "under one roof" is critical. Case management services can exemplify the family-centered services the CARE Act can and should provide. The committee heard eloquent testimony, from a woman living with HIV, about how CARE Act-funded services have helped her maintain her health and care for her children. This courageous woman explained how she thought being HIV-positive was a death sentence and how her case

manager has helped her manage the responsibilities of being a parent and being HIV-positive. As she said:

* * * [W]here it not for this wonderful bill called Ryan White, Fenway [clinic] could not have been there for me and offered the services that have kept my life going these past 9 years.

F. THE NEED FOR S. 2311

The CARE Act was originally passed in 1990 and reauthorized in 1996 to address some of the most pressing problems in health services delivery raised by the HIV epidemic. Today, S. 2311 represents the continuation of that comprehensive approach. The necessity of the Ryan White CARE Act programs is clear, as more people live longer with this disease and the planning, the adequate funding, and the delivery of HIV-related health care services rise in importance. Because our Nation's health care system was totally unprepared for the magnitude of the AIDS and HIV epidemic, the planning, funding, and capacity required to mount an appropriate response lagged.

The Ryan White CARE Act of 1990 was designed and passed with near unanimity in the Senate to address those capacity shortfalls. Two national commissions recommended and supported the principles underlying the CARE Act as the most effective means to address the burgeoning needs of people living with HIV/AIDS. A recent report from the U.S. General Accounting Office (GAO) found that the CARE Act continues to be the most effective means of getting care to people with HIV and AIDS most in need of assistance. The CARE Act is serving high numbers of minorities, the poor, and the uninsured. CARE Act providers also see a greater number of women than do other, non-Ryan White providers, and at higher rates than the representation of women in the AIDS population. This study found that the majority of CARE Act funds are used for direct medical services, with the remaining funds going to services that support medical services, such as case management. CARE Act providers were also well within their administrative limits. Critically, the GAO found that CARE Act funding has been able to respond to changes and evolving trends in the epidemic, in particular to meet the demands of rapidly changing medical treatments and disease progression. The CARE Act, its providers, and its administrators have been successful in realizing the goal of getting desperately needed, high-quality services to those most in need.

In considering reauthorization of the CARE Act, the committee has received input from a wide variety of sources. Dr. David Satcher, Surgeon General of the United States, and Sandra Thurman, Director of the White House Office of National AIDS Policy, testified before the committee that the structure of the CARE Act has worked well over the last 10 years and that it provides a solid basis on which to build an effective response to the changing epidemic over the next 5 years. National AIDS organizations, including the AIDS Action Council, the CAEAR Coalition, the National Association of State and Territorial AIDS Directors, AIDS Alliance, the National Association of People with AIDS, the National Minor-

ity AIDS Coalition, and National Organizations Responding to AIDS (a consortium of 175 organizations) also provided valuable input. These groups, as well as mayors; governors; Federal, State, and local public health officials; CARE Act-funded service providers; and, most important, people living with HIV disease, are all in agreement that the CARE Act has been a success and a lifeline of support to hundreds of thousands of people.

The committee heard testimony from individuals and organizations which supported the existing, 4-title structure of the act, its emphasis and reliance upon local planning and decision making, and its flexibility in meeting the needs of people living with HIV. They also testified that the need for emergency relief remains as urgent today as it was in 1990. While the CARE Act has provided a lifeline of support and relieved some of the strain, it has not stopped the epidemic from dangerously taxing already overburdened health care delivery systems.

The Ryan White CARE Act Amendments of 2000 has preserved and improved upon the best aspects of the original CARE Act. At the same time, in recognition of the changes that have taken place over the last 5 years, the committee has also made some necessary alterations. To address the geographic expansion of this epidemic, this reauthorization continues the efforts made during the last reauthorization to direct resources and services to areas that are particularly underserved, including rural areas and metropolitan areas with significant AIDS cases that are not eligible for title I funding. There is also a new focus on strengthening the capacity of rural and minority communities to address the epidemic. Furthermore, the ADAP program has been strengthened 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.

III. LEGISLATIVE HISTORY AND COMMITTEE ACTION

S. 2311 was introduced on March 29, 2000, by Senators Jeffords, Kennedy, Frist, Hatch, Dodd, Enzi, Harkin, Mikulski, Bingaman, Wellstone, Reed, Biden, and Durbin. The bill was referred to the Committee on Health, Education, Labor, and Pensions. In the executive session of the committee, held on Wednesday, April 12, 2000, S. 2311 was brought up for consideration. The bill was unanimously adopted and favorably reported to the full Senate.

IV. COMMITTEE VIEWS

PART A

Through part A of S. 2311, the committee intends that emergency relief continue to Eligible Metropolitan Areas (EMA's) that have been severely impacted by the HIV epidemic. Financial relief to EMA's will ensure that health care institutions and providers of

essential, health-related, supportive services will be able to provide services to uninsured and underinsured, low-income individuals affected by the AIDS epidemic. The committee recognizes that the impact of HIV/AIDS is often exacerbated by other medical and social factors such as tuberculosis, sexually transmitted diseases, substance abuse, homelessness, and severe mental illness, which pose serious obstacles in the treatment of HIV/AIDS. The committee also recognizes and affirms in S. 2311 that local planning, priority setting, and funding allocation processes are effective mechanisms to address the variations in the impact of the AIDS epidemic among different communities and populations, and that shifting trends in the local epidemic, disparities in health care access and outcomes, and the need for capacity development within the HIV health care infrastructures can best be addressed through a local process.

The committee acknowledges the need to enhance further planning and priority-setting processes within the title I program. The committee supports the implementation of quality management programs that can assist grantees to better document the impact of CARE Act programs and lead to improvements in the quality of care and services provided through Ryan White funding. Similarly, the committee believes that requiring CARE Act providers to develop appropriate and meaningful relationships with key points of entry for HIV-positive individuals into the health care system will increase the numbers of people in care. The committee also 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 not receiving services. The guidance provided by the committee is intended to support and strengthen the advisory capacity of planning councils, the ability of grantees to administer CARE Act funds to ensure quality care, and the coordination of resources with other payers. The committee reaffirms the Secretary's responsibility in providing needed guidance and tools to assist EMA's in carrying out their mandate.

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 coordination 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.

These modifications will support closing the gap in disparities of access to HIV services and HIV-related health outcomes and improve planning, allocation, coordination, and quality management activities. Furthermore, these changes support capacity development to reach underserved populations and provide EMA's with the skills and resources to address the challenges of a shifting HIV/AIDS epidemic.

I. Section 2602. Administration and Planning Council

Housing and homeless service providers

The committee endorses the planning council mechanism, including its advisory structure and duties, in its effectiveness in carrying out the responsibilities of reflecting and representing the local HIV/AIDS epidemic. The committee provides for the inclusion of housing and homeless service providers within the category of “social service providers” to acknowledge the importance of housing and homeless support services to treatment adherence and quality of health care, as these impact effective care for HIV disease. It is the intent of the committee that the category of housing and homeless service providers include grantees receiving Federal, State, or local housing and/or homeless funds, including U.S. Department of Housing and Urban Development (HUD) McKinney Homeless Assistance grant and Housing Opportunities for Persons With AIDS (HOPWA) funds. Such participation acknowledges the importance of coordination of these processes in meeting funders’ principal mission of addressing the multiple and complex needs of persons with HIV disease.

The committee recognizes that homeless persons comprise a medically underserved population that experiences disparities in health services. The prevalence of HIV/AIDS is considerably higher among homeless people than in the general population. Limited access to medical care severely restricts the access of homeless people to HIV/AIDS prevention, risk reduction, treatment, and care. Accordingly, the committee construes terms used throughout the act, such as “special population,” “traditionally underserved,” “historically underserved,” “disproportionately affected,” and “affected subgroup experiencing disparities in health services” to include the homeless population.

Membership considerations

The committee places importance on the inclusion of representation from historically underserved, low-income, urban and rural areas and populations within the EMA. Planning councils should continue to identify and include in council activities specific groups within underserved communities that are experiencing increased infections, as documented in State and local HIV/AIDS surveillance and needs assessment data. By recruiting consumers and organizations that reflect the special needs of these populations, such as women, people of color, Native Americans, youth, homeless persons, rural residents, and uninsured/underinsured persons, the committee believes that the planning council will improve its ability to plan, prioritize, and allocate funds in a more reflective and informed manner. Other populations, such as persons with co-occurring conditions—defined as other coexisting diseases or environmental factors—should have representation on planning councils to ensure that planning council processes address the difficulties related to health disparities and access to and adherence with HIV treatment. Where applicable, such membership should include representatives from other titles of the CARE Act in order to ensure that the membership processes adequately reflect the demographics of the local epidemic.

Funding allocations based on HIV/AIDS demographics

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 bill further requests that the Secretary work with title I grant recipients and providers to establish epidemiologic measures and tools for use by EMA's in identifying the number of individuals with HIV infection, especially those who are not in care. The committee recognizes the difficulty grantees may experience in identifying persons with HIV infection not in care. The committee does not require EMA's to establish priorities for the allocation of funds for persons not in care, until the Secretary is able to provide such advice and technical assistance. EMA's should continue such efforts as they have developed in this area for establishing priorities of funds for this population. The committee is aware that many EMA's do not have HIV reporting in place and may be further disadvantaged in implementing the requirements under this section, even with the additional tools and measures provided by the Secretary. The committee strongly encourages that the means to report the incidence of HIV be in place as soon as possible, and the Secretary should take these differences into account in implementing these requirements. The committee expects that those grantees already considering people not in care should continue to do so, adopting where relevant the methods developed by the Secretary.

Capacity development

The committee recognizes the need for capacity development planning, in order to assist local communities in developing HIV primary care services and effective provider networks. Such capacity development should target the structural, administrative, and financial management systems that enhance the ability of underserved communities to respond to the need for HIV primary health care, particularly in those underserved and minority communities where infrastructure for the provision of HIV services is inadequate. Capacity development includes: (1) activities that establish and enhance core management functions (for example, accounting and information systems, planning, and evaluation); (2) establishment and enhancement of program development functions (for example, personnel and staff competencies and HIV primary care network development); and (3) addition of new services (for example, the purchase of equipment and minor upgrading of facilities). The committee does not intend funds to be used for construction or significant remodeling of facilities.

The committee intends that these capacity development services meet the criteria of expanding the capacity, preparedness, and expertise of grantees to deliver HIV-related primary care and health-related supportive services to underserved populations. Planning councils should prioritize HIV primary care services and network infrastructure development through their needs assessment and

planning process. The committee recognizes that strengthening capacity must be done in a local context.

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 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 also realizes that, in the planning process, planning councils may not currently utilize information regarding the types of specialized services needed to bring vulnerable subpopulations into care and to retain them in care. The specific needs of populations or subgroups identified—such as communities of color, persons who are underinsured or uninsured, women, persons with co-occurring conditions, youth, homeless persons, or persons who live in rural areas within the eligible area—should be specifically addressed. To the extent that these populations are underserved in the eligible area, the Secretary should assist the planning councils in identifying the information needed to plan and prioritize resources for these populations.

II. Section 2603. Types and distribution of grants

Formula funding allocation—hold harmless

The committee intends to continue to extend the hold harmless provision to ensure that the amount of a formula grant will not be less than 98 percent of the amount the eligible area received for the previous fiscal year. An eligible area will be allowed to lose no more than 2 percent annually of its formula grant, for a maximum of 10 percent over the 5-year reauthorization period. The hold harmless provision reflects the committee's concern that essential primary care and support services are not compromised by short-term fluctuations in AIDS case counts.

III. Section 2604. Use of amounts

Support service required to be health care related

The committee wishes to stress the primary importance of CARE Act funds in meeting the health care needs of persons and families with HIV disease. The reauthorization language requires support services provided through CARE Act funds to be health care related. EMA's should ensure that support services meet the objective of increasing access to health care and ongoing adherence with primary care needs. The committee reaffirms the critical relationship between support service provision and positive health outcomes. The committee does not establish the level of documentation required to meet this objective and expects the Secretary to provide

additional guidance to EMA's regarding the assessment of relationships between health and related supportive services in achieving improved access to and stability in health care access.

Early intervention services

The reauthorization language authorizes early intervention services as eligible services under part A under certain limited circumstances. 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 planning council priority setting and funding allocation processes. The language references the specified early intervention services under part C, section 2651(b)(2), and the provision of certain counseling services under section 2662 of the CARE Act. In addition, the language describes the types of organizations that may provide early intervention services as those that provide other HIV-related services through parts A or C, or are key points of access to the health care system for individuals at high risk for HIV.

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 direct 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 for HIV surveillance functions or primary prevention, including those activities that are supported through the Centers for Disease Control and Prevention (CDC). 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 bill would allow use of funds for such early intervention services only if no other Federal, State, or local funds are available for those purposes. The committee recognizes that other funding sources exist for these services and expects all grantees to seek out and use these funds to the extent they are reasonably available.

Women, infants, and children set-aside

The committee wishes to clarify that the set-aside for infants, children, and women with HIV disease be allocated proportionally, based on the percentage of the local HIV-infected population that each group represents. The committee is aware of the rising incidence of HIV in youth and in women of color, and it recognizes the unique challenges facing these groups regarding access and sustaining primary care and support services for HIV and AIDS. The intent of this legislation is to increase the availability of primary care and health-related supportive services for each of these

groups. The committee wishes to emphasize the importance of these increasing trends and requests the Secretary to provide guidance to planning councils and grantees in planning and providing services to these unique populations.

Quality management program

The committee recognizes the importance of having CARE Act grantees assure that quality services are provided to people with HIV and that quality management activities are conducted on an ongoing basis. Quality management programs are intended to serve grantees in evaluating and improving the quality of primary care and health-related supportive services provided under this act. The quality management program should accomplish a threefold purpose: (1) assist direct service medical providers funded through the CARE Act in assuring that funded services adhere to established HIV clinical practices and Public Health Service (PHS) guidelines; (2) ensure that strategies for improvements to quality medical care include vital health-related supportive services in achieving appropriate access to and adherence with HIV medical care; and (3) ensure that available demographic, clinical, and health care utilization information is used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

The committee expects the Secretary to provide EMA's with guidance and technical assistance to establish quality management programs with direct medical services providers funded through the CARE Act. Such programs are generally available and implemented in clinical practice environments. The additional guidance and technical assistance provided should assist grantees to develop performance measures on specific client health outcomes desired, cost-effectiveness of services provided by the CARE Act, and health care status indicators of overall improvement in the delivery of appropriate health care services to individuals with HIV disease. The committee expects that EMA's will communicate and coordinate CARE Act requirements with other payers to the extent possible to ensure consistency in quality management activities.

The Secretary may consider the need for guidance to EMA's on what mechanisms should be in place to ensure that medical services provided through Ryan White funds, whether directly or through contractual agreement, have established procedures and protocols in place to monitor and assess quality of care based on established PHS guidelines. Where services are provided through contractual agreements, the EMA should incorporate into the contract the requirement that subcontractors have a quality measurement program in place.

The committee places responsibility on the Secretary to ensure that PHS guidelines, as well as broader measures of the population characteristics and trends in use in HIV services, are communicated to all CARE Act grantees and subgrantees. 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 or program support costs. It is not the in-

tent of the committee to reassign current program support costs or clinical quality programs to new cost areas, if they are an integral part of an EMA's current quality management efforts. Program support costs are described as any expenditure related to the delivering or receiving of 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.

Medicaid and SCHIP coordination with CARE Act

The reauthorization language recognizes the availability of other health benefit programs, such as the State Medicaid and Children's Health Insurance Program (SCHIP). Planning councils should consider and coordinate these alternative funding sources in planning for Ryan White CARE Act services. Furthermore, the committee expects planning councils and grantees to account for the needs of all persons with HIV in assessing the types and levels of services to be provided within a given jurisdiction.

The committee also recognizes the importance of the Statewide Coordinated Statement of Need (SCSN) process in coordinating HIV/AIDS care and support activities across the State, including areas that fall within EMA's. The SCSN should inform and support the activities of the planning council, especially in the coordination of funding sources for HIV primary care and support services. CARE Act funds should not be used to provide items or services for which payment has already been made or reasonably can be expected to be made by third-party payers, including Medicaid, Medicare, SCHIP, and or other State or local entitlement programs, prepaid health plans, or private insurance. Funds allocated by this Act shall be available to supplement services to patients who are Medicaid beneficiaries for services not covered by Medicaid. CARE Act grantees should ensure that eligible individuals are expeditiously enrolled in Medicaid and that CARE Act funds are not used to pay for any Medicaid- or SCHIP-covered services for Medicaid or SCHIP enrollees. Both the comprehensive plan and the statewide coordinated statement of need can assist the planning council in coordinating the various Federal, State and local funding sources.

Clarification on use of planning council administrative costs

The committee also wishes to clarify what activities are allowable under planning council administrative costs. Planning council administration funds can be used for training and technical assistance activities for planning council members regarding internal and external governing and planning processes. In addition, planning council administration funds can be used to support consumer-related transportation and other related expenses that will

enable persons with HIV to participate fully and contribute as planning council members.

Grantee health care relationships

The committee recognizes that many individuals with HIV/AIDS will pass through key points of entry into the medical system without receiving referral to HIV care services. In order to identify and refer those individuals to HIV primary care and health-related supportive services, and thus improve access to care for persons not currently in the system, the committee expects grantees to establish relationships with entities that often serve as these key points of entry into the medical system for populations at high risk for HIV infection. Such key points of entry can include, but are not limited to, emergency rooms, community health centers, substance treatment programs, detoxification centers, mental health treatment programs, adult and juvenile detention centers, correctional facilities, soup kitchens, sexually transmitted disease clinics, HIV counseling and testing sites, homeless shelters, and transitional housing and homeless outreach programs.

In encouraging the development of key points of entry relationships, the EMA should: (1) evaluate what beneficial relationships are in place and those that are needed to strengthen referral of individuals from key points of entry into HIV primary care sites; and (2) assist subgrantees in the development of these relationships. The committee allows for the use of CARE Act funds to support early intervention services within such sites to facilitate the identification, counseling, and referral of individuals with HIV/AIDS into the HIV care system, as defined elsewhere in the report.

PART B

The committee believes that the current structure of part B has enabled States to develop HIV- and AIDS-related primary care infrastructure in areas of greatest need and increasingly in areas where the epidemic is growing. Part B provides an effective means for ensuring that CARE Act funds reach all populations in need of HIV/AIDS health care services. Changes made in the reauthorization language are not intended to restrict States' efforts to direct needed resources to specific areas. Rather, it is the intent of the committee to provide to States that lack sufficient resources an opportunity to reduce restrictions on ADAP benefits while holding States responsible for an expected level of effort in utilizing available local and State resources to meet local needs. In addition, changes in the reauthorization address the fact that a number of States have emerging communities in need of targeted assistance. These communities have significant HIV/AIDS caseloads which, nevertheless, do not qualify for emergency assistance under part A of the CARE Act. The issue of geographic equity within the State was one that the committee aimed to address in reauthorization. The committee recognizes that States without EMA's often have less funding to support the provision of a full array of HIV care services than States with a part A grant.

In establishing the legislative changes for part B, the committee also intended to assist States in developing planning, priority setting, and funding allocation tools. The reauthorization allows

States to fund capacity development activities to assist areas with extremely limited HIV care infrastructure. Additional flexibility is given to States to develop quality management programs for the monitoring and improvement of CARE Act-funded activities. The committee intends that States have adequate time, resources, and guidance in implementing these activities. The committee believes that an increase in the minimum grants for services available to States will help to improve the foundation of care services. Specific United States territories were given title II eligibility in order to correct oversights in the previous CARE Act reauthorization which omitted them from lists of eligible entities. It is the committee's belief that these changes will enhance States' and territories' ability to distribute CARE Act funds to those areas where a disproportionate need exists.

The committee expects that States funded under Ryan White 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 coordination 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.

I. Section 2612. General use of funds

Primary purpose of CARE Act services in achieving health care access

The committee stresses that the primary purpose of CARE Act funds is to address the health care needs of persons and families with HIV disease. To support this goal, the reauthorization language requires support services funded through the CARE Act to be health care related. States should assure that eligible supportive services meet the objective of increasing access to health care and ongoing adherence with primary care needs. The legislation requires States to have a mechanism in place to ensure that supportive services provided through Ryan White funds, whether directly or through contractual agreement, accomplish the objective of increasing access to health care and ongoing adherence with primary care needs. The committee reaffirms the relationship between support service provision and positive health outcomes. The committee does not establish the level of documentation required to meet this objective and expects the Secretary to provide additional guidance to States regarding the assessment of relationships between health and related supportive services in achieving improved access to and stability in health care access.

Early intervention services

The reauthorization language authorizes early intervention services as eligible services under part B under certain limited circumstances. 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. The language references the specified early inter-

vention services under part C, section 2651(b)(2) and the provision of certain counseling services under section 2662 of the CARE Act. In addition, the language describes the types of organizations that may provide early intervention services as those that provide other HIV-related services through parts B or C, or are points of access to the health care system for individuals at high risk for HIV.

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 direct 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 for HIV surveillance functions or primary prevention, including those activities which are supported through the Centers for Disease Control and Prevention (CDC). 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 bill would allow use of funds for such early intervention services only if no other Federal, State, or local funds are available for those purposes. The committee intends that grantees should demonstrate that CARE Act funds will not be used to supplant other funds supporting 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 the extent they are reasonably available.

II. Section 2616. Provision of treatments

Expansion of ADAP to include medical monitoring services

The primary purpose of medical monitoring services is to ensure that individuals with HIV/AIDS gain access to and utilize life-saving therapeutics. The committee expands eligible services and expenses under ADAP to include those services that support increased access to and adherence with antiretroviral therapy, such as treatment adherence counseling, medical monitoring, and laboratory testing. Medical monitoring activities are essential components of the provision of treatments, and States are encouraged to expand their ADAP's to include these activities, as they directly relate to appropriate use of medications. However, the committee explicitly intends that States should not fund these services where such funding will reduce the availability of ADAP medications on the State formulary or force the State to establish more exclusive financial and medical eligibility.

In order for States to utilize ADAP funds for medical monitoring of HIV treatment, the Secretary must ensure that eligibility restrictions have been resolved within a given State and that the

State's formulary covers all essential HIV-related treatments. The committee expects the Secretary to determine the criteria for eligibility, based on the characteristics of the ADAP program within the applicant State, including the State's ability to maintain current levels of effort in its ADAP funding, as well as its ability to continue current medical eligibility and poverty level standards in the program. A maximum of 10 percent of the ADAP budget can be spent on medical monitoring activities under this section. However, the committee wishes to emphasize that the primary purpose of ADAP funds is in providing antiretroviral medications and medications for treatment of diseases associated with AIDS to people living with HIV. The Secretary must ensure that States do not supplant funded services supported with other Federal and State resources. In addition, the committee believes that States should administer funds under this section in a manner that is consistent with other ADAP services funded through this section, including consistent eligibility criteria, quality management activities, and administrative procedures.

ADAP supplemental fund

The committee establishes a new supplemental award, funded through a 3 percent set aside of the existing authorization for the ADAP program, to assist States in expanding access to appropriate HIV/AIDS therapeutics to low-income individuals with HIV/AIDS. The committee intends for the Secretary to limit the use of this new supplemental fund to the purchase of HIV/AIDS therapeutics. In addition, the committee intends for the Secretary to determine the criteria for eligibility, based on the characteristics of the ADAP program within the applicant State, including the State's ability to remove restrictions on eligibility based on current medical conditions or income restrictions, specifically limiting eligibility to less than 200 percent of the Federal poverty level.

The committee expects the State to continue to maintain current levels of effort in its ADAP funding. In addition, the committee believes that States should administer supplemental awards under this section in a manner that is consistent with other ADAP services funded through this section, including maintaining existing eligibility criteria, quality management activities, and administrative procedures.

III. Section 2617. State application

Funding allocations based on HIV/AIDS demographics

The reauthorization bill reflects the committee's opinion that priority setting and funding allocation decisions should be based on the size and demographic characteristics of the populations with HIV disease within the State. Planning, priority setting, and funding allocation processes must take into account shifts in the local HIV/AIDS epidemic, existing HIV-related health disparities, and resulting negative health outcomes. The committee intends for "demographic characteristics" to include housing status, and requests the Secretary to encourage and assist States to ascertain the housing status of participants in Ryan White-funded programs for serv-

ice delivery, planning, reporting, and quality management purposes.

The reauthorization legislation requires the Secretary to work with title II grant recipients and providers to establish epidemiologic measures and tools for use by States in identifying persons with HIV infection who are not in care. The committee recognizes the difficulty States may experience in identifying persons with HIV infection who are not in care and who may be unknown to any health or social support system. The committee does not intend to require States to establish priorities for the allocation of funds for persons not in care, until the Secretary is able to provide such advice and technical assistance. States should continue such efforts as they have developed in this area for establishing priorities of funds for this population. The committee is aware that many States do not have HIV reporting in place and may be further disadvantaged in implementing the requirements under this section, even with the additional tools and measures provided by the Secretary. The committee strongly encourages that the means to report the incidence of HIV be in place as soon as possible, and that the Secretary should take these differences into account in implementing these requirements.

Capacity development

The committee recognizes the need for capacity development planning, in order to assist States and communities in establishing HIV primary care services and effective provider networks. Such capacity development should target the structural, administrative, and financial management activities that can improve the ability of States and underserved communities to address the need for HIV primary health care, particularly in those underserved and minority communities where infrastructure for the provision of HIV services is inadequate. Capacity development includes: (1) activities that establish and enhance core management functions (for example, accounting and information systems, planning, and evaluation); (2) establishment and enhancement of program development functions (for example, personnel and staff competencies and HIV primary care network development); and (3) addition of new services (for example, the purchase of equipment and minor upgrading of facilities).

The committee intends that these capacity development services meet the criteria of expanding the capacity, preparedness, and expertise of grantees to deliver primary care and health-related supportive services to individuals with HIV in underserved, low-income communities. States should prioritize HIV primary care services and network infrastructure development based on their needs assessment and planning process. The committee recognizes that building capacity must be done in a local context.

Comprehensive plan requirements for CARE Act grant funds

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 additional factors be reflected in the plan such as: disparities in access

to medical and health-related support services by specific sub-populations; capacity development activities; and quality of HIV primary care and health-related supportive services. Upon the development of measures by the Secretary, 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 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 co-occurring conditions within the State need to be specifically addressed. The committee realizes that States, in the planning process, may not currently utilize information on the types of specialized services needed to bring vulnerable subpopulations into care and to retain them in care. To the extent that these populations are underserved in the State, the Secretary should assist States in planning and prioritizing resources for these populations. The committee also asks that the Secretary continue to work with planning councils to identify positive health outcomes achieved by local planning, priority setting, and funding allocation processes in meeting the needs of CARE Act-eligible persons.

Medicaid and SCHIP coordination with the CARE Act

The reauthorization language also recognizes the availability of other health benefit programs, such as the State Medicaid and Children's Health Insurance Program (SCHIP). The committee is aware of the wide variation between State Medicaid programs and the impact of these variations on the variability and scope of services for persons with HIV/AIDS. The committee expects that all States will have in place strong coordinating mechanisms between Ryan White and the State Medicaid programs to assure optimal health care for persons living with HIV disease. States should ensure the coordination of benefits from the Medicaid and SCHIP programs with those funded under the CARE Act. The committee intends for grantees to take into account the needs of all persons with HIV and all payers when assessing the types and levels of services to be provided within a given jurisdiction.

The committee also recognizes the importance of the Statewide Coordinated Statement of Need (SCSN) process in coordinating HIV/AIDS care and support activities across the State, including areas that fall within EMAs. The SCSN should inform and support the State's annual comprehensive plan. States should seek the broadest participation of providers, Federal and State grant recipients, and consumers through such methods as public notices, hearings, or meetings. The committee directs the Secretary to instruct States to consult with the full range of public and nonprofit entities providing health and support services to persons with HIV/AIDS and affected communities and populations.

CARE Act funds should not be used to provide items or services for which payment has already been made or reasonably can be expected to be made by third-party payers, including Medicaid, Medicare, SCHIP, and or other State or local entitlement programs, pre-paid health plans, or private insurance. Funds allocated by this Act

shall be available to supplement services to patients who are Medicaid beneficiaries for services not covered by Medicaid. CARE Act grantees should ensure that eligible individuals are expeditiously enrolled in Medicaid and that CARE Act funds are not used to pay for any Medicaid- or SCHIP-covered services for Medicaid or SCHIP enrollees. Both the comprehensive plan and the statewide coordinated statement of need can assist the State in coordinating the various Federal, State, and local funding sources.

Quality management program

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. The quality management program is intended to serve grantees in evaluating and improving the quality of primary care and health-related supportive services received by persons under this act. The quality management program should accomplish a threefold purpose: (1) assist direct service medical providers funded through the CARE Act in ensuring that funded services adhere to established HIV clinical practices and PHS guidelines; (2) ensure that strategies for improvements to quality medical care include vital health-related supportive services in achieving appropriate access to and adherence with HIV medical care; and (3) ensure that available demographic, clinical, and health care utilization information is used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

The committee expects the Secretary to provide States with guidance and technical assistance for establishing quality management programs. Such programs are generally available and implemented in clinical practice environments. The additional guidance and technical assistance provided should assist grantees to develop performance measures of specific health outcomes, service cost-effectiveness, and indicators of health care status improvement. 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 Secretary may consider the need for guidance to States on the types of mechanisms used to ensure that medical service providers, whether directly or through contractual agreement, have procedures and protocols in place to monitor and assess the quality of care based on established PHS guidelines. Where services are provided through contractual agreements, the States should incorporate within the contract the expectation that subcontractors have a quality assurance program in place. 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 subgrantees. 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. It is not the intent of the committee to reassign current program support costs or clinical quality programs to new cost areas, if they are an integral part of a State's current quality management efforts. 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.

Grantee health care relationships

The committee recognizes that many individuals with HIV/AIDS will pass through key points of entry into the medical system without being referred to HIV care services. In order to identify and refer those individuals to HIV primary care and health-related supportive services, and thus improve access to appropriate care for persons not currently in the system, the committee expects States to establish relationships with entities that serve as key points of entry into the medical system for populations at high risk of HIV infection. Such key points of entry can include, but are not limited to, emergency rooms, community health centers, substance treatment programs, detoxification centers, mental health treatment programs, adult and juvenile detention centers, correctional facilities, soup kitchens, sexually transmitted disease clinics, HIV counseling and testing sites, homeless shelters, and transitional housing and homeless outreach programs.

In encouraging the development of key points of entry relationships, the State should: (1) evaluate those beneficial relationships which are in place and those which are needed to strengthen referral of individuals from key points of entry into HIV primary care sites; and (2) provide mechanisms through funding, contractual, and other types of agreements to strengthen these relationships. In order to ensure the effectiveness of the key point of entry process, the committee allows for the use of CARE Act funds to support early intervention services within such sites to facilitate the identification, counseling, and referral of individuals with HIV/AIDS into the HIV care system.

IV. Section 2618. Distribution of funds

Increase in minimum allotment

The reauthorization bill doubles the existing level for the minimum title II base award to \$200,000 for States with fewer than 90 living cases of AIDS. For States with 90 or more living cases

of AIDS, the language increases the minimum allotment to \$500,000. A minimum funding level of \$50,000 is also established for territories eligible for Title II funding. In doubling the minimum, the committee recognizes that territories and States that typically receive the minimum grant lack health care infrastructure with which to support people with HIV or AIDS. By increasing the minimum base awards for states and territories, the committee intends to provide Part B grantees, that often do not have other available sources for HIV care services, with the ability to develop and improve their local HIV care infrastructure. These minimum grants will improve the level of services available and provide greater balance in allocation among affected areas throughout the Nation.

V. Section 2622. Supplemental grants to emerging communities

The committee intends in this section to acknowledge the challenges faced by many communities with a high burden of HIV and AIDS. The reauthorization language establishes a new supplemental grant award under part B to assist States in providing comprehensive services in areas of the State not eligible for grants under part A. The Secretary shall reserve 50 percent of new appropriations, in excess of appropriations in the previous fiscal year, to fund these supplemental grants. From these funds, the Secretary shall reserve the greater of \$5 million or 50% fund for use in emerging communities, defined as metropolitan areas with an AIDS case count between 1,000 and 1,999 over the most recent 5 calendar years. The remaining supplemental funds shall be awarded to States with demonstrated severity of need. The committee expects the Secretary to develop criteria that measure severity of need for additional assistance in the State (i.e., the overall population size of the eligible area and the number of cumulative AIDS cases in the area).

States should facilitate the development of a local planning structure in the emerging community to establish program priorities and determine funding allocation for the eligible area. It is expected that the State will conduct its role in a manner that is consistent with consortia role and responsibilities, as well as State oversight responsibilities relative to these structures.

The committee intends to supplement the resources available to emerging communities to improve services available to the population living with AIDS in these areas. Thus, the committee believes that the provision of supplemental funds to emerging communities and areas with demonstrated need should be met by a State's commitment to continue to provide the current level of Federal and State funds to the eligible area. Otherwise, the efforts to enhance support to these areas would not be accomplished.

VI. Section 2611. Set-aside for infants, children, and women

Women, infants, and children set-aside

The committee wishes to clarify that the set-aside for infants, children, and women with HIV disease be allocated proportionally based on the percentage of the local HIV-infected population that each group represents. The committee is aware of the rising inci-

dence of HIV in youth and in women of color, and it recognizes the unique challenges facing these groups with respect to access and sustaining primary care and support services for HIV and AIDS. The intent of this legislation is to increase the availability of primary care and health-related supportive services for each of these groups. The committee emphasizes the importance of these increasing trends and requests the Secretary to provide guidance to planning councils and grantees in planning and providing services to these unique populations.

PART C

The committee acknowledges the success of part C grants in providing community-based primary care settings with direct access to vital CARE Act funds. The part C targeted funding allows the CARE Act to respond directly to local needs and shifts in the HIV/AIDS epidemic. It assists local primary care organizations to build or enhance their capacity to deliver HIV care in settings that are community based and regularly utilized by persons with HIV/AIDS. Part C is also recognized by the committee as an optimal mechanism for developing potential primary care networks with its ability to award planning grants to low-income urban and rural areas in need of developing an HIV primary care infrastructure.

I. Section 2651. Establishment of program

Preference for certain areas

It is the committee's view that the shift in the HIV/AIDS epidemic away from the traditional epicenters has not resulted in a commensurate shift in CARE Act resources to address the needs of rural and underserved communities and populations. The reauthorization language establishes a preference in awarding title III grants to areas that are rural and underserved. The committee intends that this preference be applied by the Secretary with new funds. This preference should not be construed to deny funding to qualified applicants in historically underserved urban communities or new applicants that receive assistance under parts A, B, C, or D under planning or minority AIDS initiative grants.

II. Section 2654. Miscellaneous provisions

Planning and development grants

The committee recognizes the need for planning for capacity development in order to assist local communities in establishing HIV primary care services and effective provider networks. Such capacity development focuses on the structural, administrative, and financial management systems activities that can improve the ability of underserved communities to respond to the HIV primary health care needs, particularly in those underserved, low income communities where infrastructure for the provision of HIV services is inadequate. Capacity development includes: (1) activities that establish and enhance core management functions (for example, accounting and information systems, planning and evaluation); (2) establishment and enhancement of program development functions (for example, personnel and staff competencies and HIV primary care network development); and (3) addition of new services (for ex-

ample, the purchase of equipment and minor upgrading of facilities).

The committee intends that these capacity development services meet the criteria of expanding the capacity, preparedness, and expertise of grantees to deliver primary care and health-related supportive services to individuals with HIV in underserved, low-income communities. Capacity development grants, up to a total of \$150,000, may be made for a period not exceeding 3 years. The Secretary also redesignates the percentage available for grants under this section to 5 percent of appropriations.

III. Section 2664. Additional required agreements

Quality management program

The committee recognizes the importance of requiring CARE Act grantees to ensure that quality services are provided to people with HIV and that quality management activities are conducted on an ongoing basis. The quality management program is intended to serve grantees in evaluating and improving the quality of primary care and health-related supportive services received by persons under this act. The quality management program should accomplish a threefold purpose: (1) assist direct service medical providers funded through the CARE Act in ensuring that funded services adhere to established HIV clinical practices and PHS guidelines; (2) ensure that strategies for improvements to quality medical care include vital, health-related supportive services in achieving appropriate access to and adherence with HIV medical care; and (3) ensure that available demographic, clinical, and health care utilization information is used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

The committee expects the Secretary to provide grantees with guidance and technical assistance to establish quality management programs. Such programs are generally available and implemented in clinical practice environments. The guidance and technical assistance provided should assist grantees to develop performance measures on specific client health outcomes, cost-effectiveness of services, and indicators of health care status of the overall delivery of appropriate health care services to individuals with HIV disease. The committee hopes that grantees will communicate and coordinate CARE Act requirements with other payers to the extent possible to ensure consistency in quality management activities.

The Secretary should also consider the need for guidance to grantees on what mechanisms should be used to ensure that medical service providers, whether directly or through contractual agreement, have established procedures and protocols in place to monitor and assess quality of care based on established PHS guidelines. Where services are provided through contractual agreements, the grantee should incorporate within the contract the expectation that subcontractors have a quality measurement program in place.

The committee places responsibility on the Secretary to ensure that PHS guidelines, as well as broader measures of the population characteristics and trends in use in HIV services, are communicated to all CARE Act grantees and subgrantees. This informa-

tion, the committee believes, will assist grantees in ensuring the highest quality of HIV care among CARE Act providers.

The committee also recognizes that the current act provides reference and funding limitations on quality management activities and asks the Secretary to 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. It is not the intent of the committee to reassign current program support costs or clinical quality programs to new cost areas, if they are an integral part of a grantee's current quality management efforts.

Administrative expenses ceiling

The reauthorization language increases the administrative cap for title III grantees from 7.5 to 10 percent to reflect consistency with similar caps established in other sections of the act.

PART D

The committee reaffirms its commitment to the provision of innovative comprehensive HIV care systems for children, youth, and families with or affected by HIV. Grantees funded through this section provide or arrange for coordinated HIV services for the purpose of supporting or coordinating comprehensive, community-based, culturally competent, family- or youth-centered HIV care systems. The committee acknowledges the importance of facilitating the voluntary participation of children, youth, and women with HIV disease in qualified research clinical protocols. The committee understands the lack of access in clinical research activities in many areas of the country. The reauthorization language requires that the Secretary, acting through the Director of NIH, examine the distribution and availability of ongoing and appropriate clinical research projects for the purposes of enhancing and expanding voluntary access to such projects.

I. Section 2671. Grants for coordinated services and access to research for women, infants, children, and youth

Removal of significant enrollment requirement

The committee reemphasizes the importance of providing access to and opportunities for participation in clinical research for women, infants, children, and youth. At the same time, the committee acknowledges that the primary purpose of programs under this section is intended to be increased enrollment in and access to health care services. Clinical research programs are not available in all areas, and yet the clinical services provided under the CARE Act provide significant benefit to women, infants, children, and youth. The committee is concerned that the requirement of significant enrollment in clinical research creates an undue pressure on grantees to involve clients in research that may not be appropriate or beneficial for clients of title IV programs. The committee intends that women, infants, and youth have access to clinical care and HIV-related support services and that they be connected to and enrolled in clinical research where appropriate, with no undue influence or pressure from the grantee.

Requirement for an NIH study of clinical research access

The reauthorization language requires an examination of the distribution and availability of ongoing and appropriate clinical research projects. While the “significant enrollment” language is removed, the committee emphasizes that the maintenance of the current level of effort to include women, infants, youth, and families in research projects is important. To the extent that such projects are available, and that title IV clients served by grantees meet the research/trial protocol, these title IV grantees should educate clients on the benefits and risks of research and facilitate their entry into trials where appropriate. In order to maintain coordination of title IV programs with research activities, NIH-funded projects should include title IV projects on community advisory boards. The Secretary shall direct NIH to work with title IV to evaluate current clinical research activities available in areas where title IV programs are operating. Furthermore, the Secretary shall evaluate access issues related to available clinical trials in situations where distance to the closest trial is a barrier to participation. The committee requires that a report be available for its review within 12 months of enactment of the CARE Act reauthorization bill.

Quality management program

The committee recognizes the importance of having CARE Act grantees ensure that quality services are provided to people with HIV and that quality management activities are conducted on an ongoing basis. The quality management program is intended to serve grantees in evaluating and improving the quality of primary care and health-related supportive services received by persons under this act. The quality management program should accomplish a threefold purpose: (1) assist direct service medical providers funded through the CARE Act in ensuring that funded services adhere to established HIV clinical practices and PHS guidelines; (2) ensure that strategies for improvements to quality medical care include vital health-related supportive services in achieving appropriate access to and adherence with HIV medical care; and (3) ensure that available demographic, clinical, and health care utilization information is used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

The committee expects the Secretary to provide grantees with guidance and technical assistance to establish quality management programs with direct medical services providers funded through the CARE Act. Such programs are generally available and implemented in clinical practice environments. The guidance and technical assistance provided should assist grantees to develop performance measures on specific client health outcomes, cost-effectiveness of services, and indicators of health care status indicators in the overall delivery of appropriate health care services to individuals with HIV disease. The committee expects that grantees will communicate and coordinate CARE Act requirements with other payers, to the extent possible, to ensure consistency in quality management activities.

The Secretary may consider the need for guidance to grantees on what mechanisms should be in place to ensure that medical service providers, whether directly or through contractual agreement, have

established procedures and protocols in place to monitor and assess quality of care based on established PHS guidelines. Where services are provided through contractual agreements, the grantee should incorporate within the contract the expectation that sub-contractors have a quality management program in place.

The committee places responsibility on the Secretary to ensure that PHS guidelines, as well as broader measures of population characteristics and trends in the use of HIV services, are communicated to all CARE Act grantees and subgrantees. This information, the committee believes, will assist grantees in ensuring the highest quality of HIV care among CARE Act providers.

Clarification of title IV services

The committee believes that the primary purpose of title IV should be the following: to provide comprehensive family- and youth-centered HIV-related care; to support early intervention services and linkages to care; to prevent HIV transmission; and to facilitate voluntary access to HIV-related research. Grantees are to provide, directly or through referral, appropriate HIV prevention services in the context of comprehensive care for HIV-infected patients, including prevention of perinatal HIV transmission; primary HIV prevention for HIV-infected clients and their families; information or training about universal precautions for settings that serve HIV-infected women, infants, children, and youth; and early intervention services, including outreach and HIV counseling and testing. Funds may not be used for general HIV education and primary prevention activities outside the context of comprehensive care for HIV-infected patients and their families. Furthermore, the committee intends that providers of such services should be guided by CDC guidelines.

Perinatal HIV prevention services may include case finding of HIV-positive and high-risk women; voluntary prenatal testing; treatment to reduce perinatal transmission; support services to help pregnant women adhere to treatment regimens; and creation of linkages between HIV care providers and women's health providers to ensure that both have state-of-the-art knowledge. As appropriate, these services should be carried out in conjunction with and supported by the CDC and state perinatal prevention programs funded through the CARE Act.

It is not the intent of the committee to require that each grantee under this section provide services to women, infants, children, and youth. Rather, based on local epidemiology, demographics, and service needs, grantees have the flexibility to focus services on one or more of these populations, if appropriate. However, if a grantee does not provide services to each of these populations, it must provide referrals to other appropriate programs.

Consumer involvement in title IV programs

The committee expects the Secretary to assist grantees in establishing a process to formalize and increase consumer involvement in title IV, including consumer involvement in title IV program planning, implementation, and evaluation. Applicants should plan, implement, and evaluate activities to promote meaningful consumer involvement.

Limitations on administrative expenses

The reauthorization language also acknowledges the need of the Secretary to conduct a review of the administrative, program support, and direct service-related activities of grantees. The committee intends that this review be conducted in consultation with grantees and permit the Secretary to determine allowable expenses under these categories and implement requirements as necessary.

PART F

*I. Section 2692. HIV/AIDS communities, schools, and centers**Addition of schools of dental hygiene as eligible grantees*

The committee acknowledges that, due to the lack of a dental school in their locality, a significant percentage of States do not receive reimbursement for dental services provided to people with HIV and AIDS. The reauthorization language expands the category of entities eligible to receive dental reimbursement grants to include schools of dental hygiene programs accredited by the Commission on Dental Accreditation.

II. Section 201. Institute of Medicine study

The Secretary is required to contract with the Institute of Medicine (IOM) to complete a study that examines changing trends in the HIV/AIDS epidemic and the financing and delivery of primary care and support services for low-income, uninsured, and underinsured individuals with HIV disease. The IOM shall provide the Secretary with recommendations regarding the most effective use of all Federal resources for HIV/AIDS care and support services.

The purpose of the study would be to examine key factors associated with the effective and efficient financing and delivery of HIV services (including access, the quality of services, health outcomes, and cost-effectiveness). The committee expects that the study would include examination of CARE Act financing of services as well as existing public sector financing (e.g., Medicaid, Medicare, and State programs) and private health coverage; general demographics (race/ethnicity, socioeconomic status, age, gender, geographic location) and comorbidities (e.g., substance use, mental health issues, homelessness) of individuals with HIV disease; regional variations in the financing and costs of HIV service delivery; and available epidemiological tools and data sets necessary for local and national resource planning and allocation decisions, including an assessment of implementation of HIV infection reporting as it impacts these factors.

As the epidemiology and medical science surrounding the HIV and AIDS epidemic evolve, many significant changes may be in store for the financing and provision of HIV/AIDS care and support programs. The Secretary is instructed to evaluate the availability and utility of health outcomes measures and data for measuring quality and effectiveness of Ryan White-funded service; the effectiveness and efficiency of service delivery through public and private programs, including Medicaid and Medicare; the impact of replacing AIDS case counts with HIV surveillance data in funding formulas on funding allocation; and existing and needed epidemio-

logical data and other analytical tools for resource planning and allocation decisions. The study will be conducted by the National Academy of Sciences/Institute of Medicine to be completed within 21 months of the reauthorization of the CARE Act.

V. COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 10, 2000.

Hon. JAMES M. JEFFORDS,
*Chairman, Committee on Health, Education, Labor, and Pensions,
U.S. Senate, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 2311, 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 Cyndi Dudzinski.

Sincerely,

BARRY B. ANDERSON
(For Dan L. Crippen, Director).

Enclosure.

CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE

S. 2311—Ryan White CARE Act Amendments of 2000

Summary: S. 2311 would extend expiring provisions and authorizations for appropriations in title XXVI of the Public Health Services Act, which was created by the Ryan White CARE Act (Public Law 101-381). It would amend the provisions under that title to increase access to care and require that care to be consistent with the guidelines of the Public Health Service. It also would create two new grant programs to pay for health care services for individuals with HIV or AIDS.

The Ryan White CARE Act is almost all administered through the Health Resources and Services Administration (HRSA); small portions are implemented through the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH). Assuming appropriations of the necessary amounts, CBO estimates that implementing S. 2311 would cost \$326 million in 2001 and a total of \$6.4 billion from 2001 through 2005, without adjusting for inflation, and \$332 million in 2001 and a total of \$6.6 billion from 2001 through 2005 if adjustments for inflation are included. The legislation would not affect direct spending or receipts; therefore, pay-as-you-go procedures would not apply.

S. 2311 contains no private-sector or intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). It would authorize funding for local and state governments as well as for other public entities that either fund or provide services to individuals with HIV or AIDS.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 2311 is shown in Table 1. The costs of this legislation fall within budget function 550 (health).

TABLE 1.—BUDGETARY IMPACT OF S. 2311

	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	(²)	0
Without Adjustments for Inflation						
Proposed Changes:						
Estimated Authorization Level	0	1,620	1,620	1,620	1,620	1,620
Estimated Outlays	0	326	1,329	1,523	1,588	1,588
Spending Under S. 2311:						
Estimated Authorization Level ¹	1,605	1,620	1,620	1,620	1,620	1,620
Estimated Outlays	1,376	1,534	1,577	1,588	1,588	1,588
With Adjustments for Inflation						
Proposed Changes:						
Estimated Authorization Level	0	1,649	1,675	1,706	1,736	1,767
Estimated Outlays	0	322	1,357	1,578	1,672	1,702
Spending Under S. 2311:						
Estimated Authorization Level ¹	1,605	1,649	1,675	1,706	1,736	1,767
Estimated Outlays	1,376	1,540	1,606	1,642	1,672	1,702

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

²Less than \$500,000

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

The authorizations for appropriations for most of the programs under the Ryan White CARE Act expire after fiscal year 2000. S. 2311 reauthorizes those programs for fiscal year 2001 through 2005. For those provisions, Table 2 show the amount appropriated in fiscal year 2000, and the estimated appropriation authorized in the bill for fiscal years 2001 through 2005, with adjustments for inflation.

In addition to reauthorizing current programs, the bill would provide authorizations for three new provisions in the Ryan White CARE Act. The estimated appropriation authorized in the bill for those provisions with adjustments for inflation is also shown in Table 2. A description of the current programs that would be reauthorized and the estimate of the new provisions in the bill are provided below.

Part A of title XXVI, (also known as title I of the Ryan White CARE Act), provides grants to eligible metropolitan areas with substantial levels of individuals with HIV. 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), provides grants to states and territories for medical and other health and social support services delivered primarily through consortia of pro-

viders of HIV services. States must provide matching funds and use a certain amount of the funds for services to infants, children, women, and families. Part C (title III of the act), awards funds to nonprofit community-based programs that provide comprehensive primary health care services aimed at preventing and or reducing HIV-related morbidity. Part D, (title IV of the act), provides funding to improve and expand the primary care and support services for children, youth, women, and families. It is intended to increase access to comprehensive, coordinated, community-based family-centered systems of care for infected individuals and their families. part F¹ funds a net work of regional centers that conduct HIV/AIDS education and training programs for health care providers, special projects of national significance, and reimbursement assistance to dental schools for oral health care.

Section 106 of S. 2311 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. Section 107 would require that each metropolitan area that received a formula grant in 2000 also receive formula grants in 2001 through 2005 that could not decrease by more than 2 percent a year, subject to the amounts appropriated for each year. Section 107 would affect the distribution of annual appropriations and both sections may affect the rate at which such appropriations are spent by increasing the amounts disbursed within 60 days of appropriation, but neither would increase total federal spending.

TABLE 2.—TITLE XXVI PROGRAMS: APPROPRIATIONS FOR FISCAL YEAR 2000 AND AMOUNTS AUTHORIZED IN S. 2311, WITH ADJUSTMENTS FOR INFLATION

	By fiscal year, in millions of dollars—					
	2000	2001	2002	2003	2004	2005
Programs Administered by HRSA						
Reauthorization: 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	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 F:						
AIDS education and training centers	27	27	28	28	29	29
Dental reimbursements	8	8	8	8	9	9
Evaluations and reports	0	1	1	1	1	1
New provisions:						
Supplemental grants to States for non-eligible metropolitan areas	0	5	5	5	5	5
Planning and capacity development grants	0	6	6	6	6	6
Studies and reports	0	1	0	0	0	0
Subtotal	1,595	1,639	1,665	1,696	1,726	1,757
Programs Administered by CDC						
HIV-related services for pregnant women and newborns	10	10	10	10	10	10

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.

TABLE 2.—TITLE XXVI PROGRAMS: APPROPRIATIONS FOR FISCAL YEAR 2000 AND AMOUNTS AUTHORIZED IN S. 2311, WITH ADJUSTMENTS FOR INFLATION—Continued

	By fiscal year, in millions of dollars—					
	2000	2001	2002	2003	2004	2005
Provisions Administered by NIH						
New report	0	(²)	0	0	0	0
Total Proposed Changes	1,605	1,649	1,675	1,706	1,736	1,767

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

²Less than \$500,000.

Under section 128, S. 2311 would create a new supplemental grant to meet HIV care and support needs in metropolitan areas that are not eligible for Part A grants. The Secretary of the Department of Health and Human Services would be required to reserve the greater of \$5 million per year or 25 percent of the increase in funding for Part B grants (other than that earmarked for state AIDS drug assistance programs) for these supplemental grants. CBO estimates that would increase spending by \$5 million per year for a total of \$25 million over the 2001–2005 period.

Section 130 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. As that provision does not create a new program or provide additional funding, CBO estimates that it would reallocate some of the appropriated money but would not change federal spending.

Under section 142, S. 2311 would create a program of capacity development grants to assist public and nonprofit private entities in expanding their ability to provide primary care services to individuals with HIV disease in underserved low-income communities. Under current law, a maximum of 1 percent of the amount appropriated for Part C can be used for planning grants. S. 2311 would increase to 5 percent the proportion that could be earmarked for the new capacity development grants and the planning grants. CBO estimates that provision would increase federal costs by \$6 million in fiscal year 2001 and by a total of \$29 million through 2005.

S. 2311 would require several studies and reports. The Secretary, through the Administrator of HRSA and in consultation with grant recipients, would be required to conduct a review of administrative and program support costs for grants provided under Part D. The results of the study would be used to determine the limitations on allowable amounts for administrative and program support expenses for fiscal year 2002. The Secretary would also request that the Institute of Medicine complete a study within two years after the enactment of this act regarding the appropriate epidemiological measures and their relationship to health-related support services for certain individuals with HIV. The Secretary would report to the appropriate committee of the Congress within 90 days of completion. CBO estimates those reports would increase federal spending by a total of \$1 million over fiscal years 2001 through 2002.

The Secretary, through the Director of NIH, would examine the distribution and availability of HIV-related clinical research programs for women, infants, children, and youth, and submit a report to the Congress within 12 months of enactment. CBO estimates that completing the report would cost less than \$500,000.

Pay-as-you-go considerations: None.

Estimated impact on state, local, and tribal governments: The bill contains no intergovernmental mandates as defined in UMRA. Some provisions of the bill would place additional conditions of assistance on recipients of funding for HIV and AIDS programs, but those requirements would not be intergovernmental mandates. The bill would extend authorizations of funding for a variety of HIV and AIDS programs, and in a few cases would authorize amounts for new grant programs. These authorizations total between \$1.6 billion and \$1.8 billion annually over the 2001–2005 period. Over half of those amounts would be for HIV care grants to states, and about a third would be for emergency relief grants to local governments that qualify as eligible metropolitan areas with substantial levels of individuals with HIV. Both nonprofit and public entities could qualify for grants under the remaining authorizations of funding for a variety of services ranging from education and training to pediatric and women’s services.

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

Estimate prepared by: Federal Costs: Cyndi Dudzinski; Impact on State, Local, and Tribal Governments: Leo Lex; and Impact on the Private Sector: Jennifer Bullard.

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

VI. REGULATORY IMPACT STATEMENT

The committee has determined that there will be only a negative increase in the regulatory burden of paperwork as a result of this legislation.

VII. APPLICATION OF LAW TO LEGISLATIVE BRANCH

Section 102(b)(3) of Public Law 104–1, the Congressional Accountability Act (CAA), requires a description of the application of this bill to the legislative branch. S. 2311 would amend the Ryan White CARE Act of 1990 as amended by the Ryan White Care Act Amendments of 1996, which provides grants to States, cities, and organizations to make primary care and support services available to people living with HIV and AIDS. This requirement would not apply to the legislative branch.

VIII. SECTION-BY-SECTION ANALYSIS

Section 1. Short title

The short title is the “Ryan White CARE Act Amendments of 2000”.

Section 2. References

Specifies that amendments are being made to section XXVI of the Public Health Service Act.

Section 3. General amendments

TITLE I—AMENDMENTS TO HIV HEALTH CARE PROGRAM

Subtitle A—Amendments to Part A (Emergency Relief Grants)

Sec. 101. Amends section 2602. Adds homeless service providers to planning councils and clarifies responsibilities of the planning council, including: the phased in requirement of planning for individuals with HIV disease not currently in care; the development of priorities for resource allocation including the availability of other funding sources such as Medicaid and State Children's Health Insurance Program (SCHIP); and the consideration of capacity developments needs.

Sec. 102. Amends sections 2604 and 2605(a). Establishes funding limits for quality management programs of the lesser of 5% of grant or \$3 million. Grantee is required to provide for a quality management program to ensure that medical services provided to patients are consistent with the most recent PHS 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.

Sec. 103. Amends sections 2604(e)(1) and 2605(a). Includes the State Children's Health Insurance Program in the existing requirement that grantees be eligible Medicaid providers in order to receive grants under the CARE Act. Requires organizations receiving subgrants to maintain referral relationships with points of entry to the health care system for the purpose of facilitating early intervention services for persons newly diagnosed with HIV disease and persons knowledgeable of their HIV status but not in care.

Sec. 104. Amends section 2604(b)(1) and 2605(a). Requires that support services funded through the Act facilitate or enhance the delivery, continuity, or benefits of health services. Defines the appropriate types of services to be funded by the EMA.

Sec. 105. Amends sections 2604(b)(1) and 2605(a)(1). Allows grantees to include HIV early intervention activities to support early diagnosis and provide linkages to care among populations at high risk from HIV. Funding to be limited to only those provider sites serving as key points of entry or current Ryan White funded medical sites. Sites must demonstrate that funds for these services supplement but do not supplant existing funds and that other funds are unavailable.

Sec. 106. Amends sections 2603(a)(2). Replaces the specified fiscal years (1996 through 2000) regarding the expedited distribution requirement for grants under Title I with language allowing the expedited distribution of funds to continue into the next reauthorization period.

Sec. 107. Amends section 2603(a)(4). Updates the hold harmless provision by providing that current Title I EMAs grants be adjusted by no more than an annual 2% per year reduction from FY2000 funding, for a maximum of 10% over 5 years.

Sec. 108. Amends section 2604(b)(3). Continues existing set-aside for infants, children and women but requires that funds be allocated proportionately according to the percentage that each group represents in the eligible area.

Subtitle B—Amendments to Part B (Care Grant Program)

Sec. 121. Amends section 2612 and 2617(b). Continues States' priority setting and funding allocation requirements and adds new factors, including: the size and demographics of the population with HIV disease; capacity development needs; and individuals with HIV disease not currently in care (phased in during FY 2003).

Sec. 122. Amends sections 2617(b)(4) and 2618(c)(3). States are required to provide for a quality management program to ensure that medical services are consistent with the PHS 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. Requires Grantees to coordinate Medicaid and SCHIP program funding with CARE Act funds to assure optimal use of financial resources. Funding limits are established for quality management services, with an exception for smaller States that receive \$1,500,000 or less.

Sec. 123. Amends section 2617(b)(4). Requires organizations receiving subgrants to maintain referral relationships with points of entry to the health care system for the purpose of facilitating early intervention services for persons newly diagnosed with HIV disease and persons knowledgeable of their HIV status but not in care.

Sec. 124. Amends section 3 of Public law 104-146, and PHS Act section 2612(a)(1) and 2617(b)(2). Requires that support services funded under Title II facilitate or enhance the delivery, continuity, or benefits of health services. Defines the appropriate types of services to be funded by the States.

Sec. 125. Amends section 2612(a). Allows grantees to include HIV early intervention activities to support early diagnosis and provide linkages to care among populations at high risk from HIV. Funding to be limited to only those provider sites serving as key points of entry or current Ryan White funded medical sites. Sites must demonstrate that funds for these services supplement but do not supplant existing funds and that other funds are unavailable.

Sec. 126. Amends section 2625(c)(2). Authorization for appropriations for these services is amended for FY 2001-2005.

Sec. 127. Repeals section 2628. Repeals completed IOM study.

Sec. 128. Creates section 2622. Creates a supplemental grant to meet HIV care and support needs in non-EMA areas. Emerging communities defined as cities with between 1,000 and 1,999 reported AIDS cases in the most recent five year period, receive half of the supplemental assistance. States demonstrating needs for assistance receive the remaining funds. Funds for this supplemental grant shall be equal to 50% of newly appropriated funding for each fiscal year under Part B.

Sec. 129. Amends section 2616(c). Clarifies the intent of funding for treatments and services related to treatments. Creates 10% cap for services that encourage, support and enhance adherence with treatment regimens, including medical monitoring. Creates a supplemental grant to enable States to provide assistance to individ-

uals living at or below 200% of the FPL. Supplemental funds shall be available to States who are unable to provide access to HIV therapeutic regimens to all eligible individuals due to the high cost of and severe need for these therapeutic regimens within the State. States shall match the Federal supplement at a rate of 1:4. The Secretary is authorized to reserve 3 percent of ADAP appropriations, which shall be used only for the purchase of therapeutics. Adds language regarding the use of these funds to supplement and not supplant other funding available to provide treatments of the type that may be provided under this section.

Sec. 130. Amends section 2618(b)(1)(A)(i) and 2618(b)(3)(B). Doubles existing minimum Title II base award to \$200,000 for States with less than 90 living cases of AIDS and to \$500,000 for States with 90 or more living cases of AIDS. Adds the Federated States of Micronesia and the Republic of Palau as entities eligible to receive Title II funds. Establishes a minimum funding level of \$50,000 for territories eligible for Title II funding.

Sec. 131. Amends section 2611(b). Continues existing set-aside for infants, children and women but requires that funds be allocated proportionately according to the percentage that each group represents in the State.

Subtitle C—Amendments to Part C (Early Intervention Services)

Sec. 141. Repeals part C of title XXVI and amends section 2661(a) and 2664. Repeals formula grant program that has never been funded.

Sec. 142. Amends section 2654(c). Creates new capacity development grants for underserved low income urban and low income rural areas for the purposes of expanding capacity, preparedness, and expertise to deliver primary care, up to a maximum of \$150,000 over a three year period. Increases the percentage of appropriations under this section that can be used for planning and capacity development grants from 1% to 5%.

Sec. 143. Amends section 2655. Amends language to update authorization for FY 2001–2005 appropriations.

Sec. 144. Amends section 2664(g). Increases the administrative cap for the directly funded Title III programs to 10% from their current level of 7.5% to correspond to the similar 10% cap on individual contractors in Title I. Requires grantees to implement a quality management program.

Sec. 145. Amends section 2651. Provision will require HRSA to consider preferentially Title III grant-funding applications from rural and underserved areas.

Subtitle D—Amendments to Part D (General Provisions)

Sec. 151. Amends section 2671 (b), (d), (f), (g), and (j). Removes the requirement that Title IV grantees enroll a “significant number” of women and children in research projects. Requires better information and education for patients concerning the linkages between care and research. Requires grantees to implement a quality management program. Requires Secretary, through NIH, to examine the distribution and availability of HIV-related clinical pro-

grams for purposes of enhancing and expanding access. Updates authorization for FY 2001–2005 appropriations.

Sec. 152. Amends section 2671. Requires the Secretary to conduct a review of administrative and program support, in consultation with grantees, to determine FY 2002 limitations on allowable amounts for administrative and program support expenses.

Sec. 153. Amends section 2674(c). Amends language to update authorization for FY 2001–2005 appropriations for evaluation and reports under this part.

Sec. 154. Amends section 2677. Amends language to update authorization for FY 2001–2005 appropriations for Part A and Part B.

Subtitle E—Amendments to Part F (Demonstration and Training)

Sec. 161. Amends section 2692(c) (1) and (2). Amends language to update authorization for FY 2001–2005 appropriations for this part. Allows for dental hygiene programs certified by the Commission on Dental Accreditation to receive reimbursement for services provided to people with HIV and AIDS.

Section 4. Institute of Medicine study

TITLE II—MISCELLANEOUS PROVISIONS

Sec. 201. Authorizes the Secretary to request that the Institute of Medicine complete a study of the financing and delivery of primary care and support services for low income, uninsured, and under-insured individuals with HIV disease, within 21 months after the enactment of this Act.

IX. CHANGES IN EXISTING LAW

In compliance with rule XXVI, paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (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

* * * * *

SEC. 2602. ADMINISTRATION AND PLANNING COUNCIL.

(a) ADMINISTRATION.—

(1) IN GENERAL.—* * *

* * * * *

(b) HIV HEALTH SERVICES PLANNING COUNCIL.—

(1) ESTABLISHMENT.—* * *

(2) REPRESENTATION.—* * *

(A) * * *

* * * * *

(C) social service providers, *including providers of housing and homeless services;*

* * * * *

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

[(A) 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 (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;

[(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;

[(C) 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) 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) establish methods for obtaining input on community needs and priorities which may include public meetings, conducting focus groups, and convening ad-hoc panels.] *shall have the responsibilities specified in subsection (d).*

(d) DUTIES OF PLANNING COUNCIL.—The planning council established under subsection (b) shall have the following duties:

(1) PRIORITIES FOR ALLOCATION OF FUNDS.—The council shall 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 following factors:

(A) The size and demographic characteristics of the population with HIV disease to be served, including, subject to subsection (e), the needs of individuals living with HIV infection who are not receiving HIV-related health services.

(B) The documented needs of the population with HIV disease with particular attention being given to disparities in health services among affected subgroups within the eligible area.

(C) The demonstrated or probable cost and outcome effectiveness of proposed strategies and interventions, to the extent that data are reasonably available.

(D) *Priorities of the communities with HIV disease for whom the services are intended.*

(E) *The availability of other governmental and non-governmental resources, including the State medicaid plan under title XIX of the Social Security Act and the State Children's Health Insurance Program under title XXI of such Act to cover health care costs of eligible individuals and families with HIV disease.*

(F) *Capacity development needs resulting from gaps in the availability of HIV services in historically underserved low-income communities.*

(2) *COMPREHENSIVE SERVICE DELIVERY PLAN.—The council shall develop a comprehensive plan for the organization and delivery of health and support services described in section 2604. Such plan shall be compatible with any existing State or local plans regarding the provision of such services to individuals with HIV disease.*

(3) *ASSESSMENT OF FUND ALLOCATION EFFICIENCY.—The council shall assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area.*

(4) *STATEWIDE STATEMENT OF NEED.—The council shall participate in the development of the Statewide coordinated statement of need as initiated by the State public health agency responsible for administering grants under part B.*

(5) *COORDINATION WITH OTHER FEDERAL GRANTEES.—The council shall coordinate with Federal grantees providing HIV-related services within the eligible area.*

(6) *COMMUNITY PARTICIPATION.—The council shall establish methods for obtaining input on community needs and priorities which may include public meetings, conducting focus groups, and convening ad-hoc panels.*

(e) *PROCESS FOR ESTABLISHING ALLOCATION PRIORITIES.—*

(1) *IN GENERAL.—Not later than 24 months after the date of enactment of the Ryan White CARE Act Amendments of 2000, the Secretary shall—*

(A) *consult with eligible metropolitan areas, affected communities, experts, and other appropriate individuals and entities, to develop epidemiologic measures for establishing the number of individuals living with HIV disease who are not receiving HIV-related health services; and*

(B) *provide advice and technical assistance to planning councils with respect to the process for establishing priorities for the allocation of funds under subsection (d)(1).*

(2) *EXCEPTION.—Grantees under this part shall not be required to establish priorities for individuals not in care until epidemiologic measures are developed under paragraph (1).*

* * * * *

SEC. 2603. TYPE AND DISTRIBUTION OF GRANTS.

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

(1) **IN GENERAL.—*** * *

(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).

* * * * *

[(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) LIMITATION.—With respect to each of fiscal years 2001 through 2005, the Secretary shall ensure that the amount of a grant made to an eligible area under paragraph (2) for such a fiscal year is not less than an amount equal to 98 percent of the amount the eligible area received for the fiscal year preceding the year for which the determination is being made.

SEC. 2604. USE OF AMOUNTS.

(a) REQUIREMENTS.—* * *

* * * * *

(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] OUTPATIENT HEALTH SERVICES.—Outpatient and ambulatory health services, including substance abuse treatment, and 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 SUPPORT SERVICES.—Outpatient and ambulatory support services (including case management), to the extent that such services facilitate, enhance, support, or sustain the delivery, continuity, benefits of health services for individuals and families with HIV disease.

[(B) inpatient case management] (C) INPATIENT CASE MANAGEMENT SERVICES.—Inpatient case management services that prevent unnecessary hospitalization or that expe-

dite discharge, as medically appropriate, from inpatient facilities.

* * * * *

(D) *EARLY INTERVENTION SERVICES.*—*Early intervention services as described in section 2651(b)(2), with follow-through referral, provided for the purpose of facilitating the access of individuals receiving the services to HIV-related health services, but only if the entity providing such services—*

(i)(I) is receiving funds under subparagraph (A) or (C); or

(II) is an entity constituting a point of access to services, as described in section 2605(a)(4), that maintains a relationship with an entity described in subclause (I) and that is serving individuals at elevated risk of HIV disease;

(ii) demonstrates to the satisfaction of the chief elected official that Federal, State, or local funds are inadequate for the early intervention services the entity will provide with funds received under this subparagraph; and

(iii) demonstrates to the satisfaction of the chief elected official that funds will be utilized under this subparagraph to supplement not supplant other funds available for such services in the year for which such funds are being utilized.

* * * * *

(3) *PRIORITY FOR WOMEN, INFANTS AND CHILDREN.*—*For the purpose of providing health and support services to infants, children, 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 for each population under this subsection, 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] ratio of each population in such area of infants, children, 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 the receives a grant under this part shall provide for the establishment of a quality management program to assess the extent to which medical 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 to develop strategies for improvements in the access to and quality of medical services.*

(2) *USE OF FUNDS.*—*From amounts received under a grant awarded under this part, the chief elected official of an eligible area may use, for activities associated with its quality management program, 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.—

* * * * *

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

(1) PROVISION OF SERVICE.—Subject to paragraph (2), the Secretary may not make a grant under section 2601(a) for the provision of services under this section in a State unless, in the case of any such service that is available pursuant to the State plan approved under title XIX of the Social Security Act and the State Children’s Health Insurance Program under title XXI of such Act for the State—

* * * * *

[(e)] (f) ADMINISTRATION.—

* * * * *

[(f)] (g) CONSTRUCTION.—* * *

SEC. 2605. APPLICATION.

(a) IN GENERAL.—* * *

(1)(A) that funds received under a grant awarded under this part will be utilized to supplement not supplant State funds made available in the year for which the grant is awarded to provide HIV-related [services to individuals with HIV disease] services as described in section 2604(b)(1);

(B) that the political subdivisions within the eligible area will maintain the level of expenditures by such political subdivisions for HIV-related [services for individuals with HIV disease] services as described in section 2604(b)(1) at a level that is equal to the level of such expenditures by such political subdivisions for the preceding fiscal year; and

* * * * *

(3) that the chief elected official of the eligible area will satisfy all requirements under section 2604(c);

(4) that funded entities within the eligible area that receive funds under a grant under section 2601(a) shall maintain appropriate relationships with entities in the area served that constitute key points of access to the health care system for individuals with HIV disease (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV counseling and testing sites, mental health programs, and homeless shelters) and other entities under section 2652(a) for the purpose of facilitating early intervention for individuals newly diagnosed with HIV disease and individuals knowledgeable of their status but not in care;

[(3)] (5) 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)] (6) 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—

* * * * *
[(5)] (7) to the maximum extent practicable, that—
 (A) * * *

* * * * *
 (C) a program of outreach will be provided to low-income individuals with HIV-disease to inform such individuals of such services; **[and]**

[(6)] (8) 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**[.]**; *and*

(9) that the eligible area has procedures in place to ensure that services provided with funds received under this part meet the criteria specified in section 2604(b)(1).

* * * * *

PART B—CARE GRANT PROGRAM

Subpart I—General Grant Provisions

SEC. 2611. [300ff-21] GRANTS.

(a) **IN GENERAL.**—* * *

* * * * *

(b) **PRIORITY FOR WOMEN, INFANTS AND CHILDREN.**—For the purpose of providing health and support services to infants, children, and women with HIV disease, including treatment measures to prevent the perinatal transmission of HIV, a State shall use *for each population under this subsection*, 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]** *ratio of each population in the State of infants, children, 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 State] (a) **IN GENERAL.**—A State may use amounts provided under grants made under this part—

(1) to provide the services described in section 2604(b)(1) **[for individuals with HIV disease]**, *subject to the conditions and limitations that apply under such section;*

* * * * *

(4) to provide assistance to assure the continuity of health insurance coverage for individuals with HIV disease in accordance with section 2615; **[and]**

(5) to provide therapeutics to treat HIV disease to individuals with HIV disease in accordance with section 2616**[.]**; *and*

(6) to provide, through systems of HIV-related health services provided under paragraphs (1), (2), and (3), early intervention services, as described in section 2651(b)(2), with follow-up referral, provided for the purpose of facilitating the access of individuals receiving the services to HIV-related health services, but only if the entity providing such services—

(A)(i) is receiving funds under section 2612(a)(1); or

(ii) is an entity constituting a point of access to services, as described in section 2617(b)(4), that maintains a referral relationship with an entity described in clause (i) and that is serving individuals at elevated risk of HIV disease;

(B) demonstrates to the State's satisfaction that other Federal, State, or local funds are inadequate for the early intervention services the entity will provide with funds received under this paragraph; and

(C) demonstrates to the satisfaction of the State that funds will be utilized under this paragraph to supplement not supplant other funds available for such services in the year for which such funds are being utilized.

Services (b) DELIVERY OF SERVICES.—Services described in **paragraph (1)** subsection (a)(1) shall be delivered through consortia designed as described in **paragraph (2)** subsection (a)(2) and section 2613, where such consortia exist, unless the State demonstrates to the Secretary that delivery of such services would be more effective when other delivery mechanisms are used. In making a determination regarding the delivery of services, the State shall consult with appropriate representatives of service providers and recipients of services who would be affected by such determination, and shall include in its demonstration to the Secretary the findings of the State regarding such consultation.

SEC. 2616. [300ff-26] PROVISION OF TREATMENTS.

(a) IN GENERAL.—* * *

* * * * *

(c) STATE DUTIES.—**In carrying (1) IN GENERAL.**—*In carrying out this section the State [shall—] shall use funds made available under this section to—*

(1) (A) determine, in accordance with guidelines issued by the Secretary, which treatments are eligible to be included under the program established under this section;

(2) (B) provide assistance for the purchase of treatments determined to be eligible under paragraph (1), and the provision of such ancillary devices that are essential to administer such treatments;

(3) (C) provide outreach to individuals with HIV disease, and as appropriate to the families of such individuals;

(4) (D) facilitate access to treatments for such individuals;
and

(5) (E) document the progress made in making therapeutics described in subsection (a) available to individuals eligible for assistance under this section~~].~~; and

(F) encourage, support, and enhance adherence to and compliance with treatment regimens, including related medical monitoring.

(2) LIMITATIONS.—

(A) *IN GENERAL.*—No State shall use funds under paragraph (1)(F) unless the limitations on access to HIV/AIDS therapeutic regimens as defined in subsection (e)(2) are eliminated.

(B) *AMOUNT OF FUNDING.*—No State shall use in excess of 10 percent of the amount set-aside for use under this section in any fiscal year to carry out activities under paragraph (1)(F) unless the State demonstrates to the Secretary that such additional services are essential and in no way diminish access to therapeutics.

* * * * *

(e) SUPPLEMENTAL GRANTS FOR THE PROVISION OF TREATMENTS.—

(1) *IN GENERAL.*—From amounts made available under paragraph (5), the Secretary shall award supplemental grants to States determined to be eligible under paragraph (2) to enable such States to increase access to therapeutics to treat HIV disease as provided by the State under subsection (c)(1)(B) for individuals at or below 200 percent of the Federal poverty line.

(2) *CRITERIA.*—The Secretary shall develop criteria for the awarding of grants under paragraph (1) to States that demonstrate a severe need. In determining the criteria for demonstrating State severity of need, the Secretary shall consider eligibility standards and formulary composition.

(3) *STATE REQUIREMENT.*—The Secretary may not make a grant to a State under this subsection unless the State agrees that—

(A) the State will make available (directly or through donations from public or private entities) non-Federal contributions toward the activities to be carried out under the grant in an amount equal to \$1 for each \$4 of Federal funds provided in the grant; and

(B) the State will not impose eligibility requirements for services or scope of benefits limitations under subsection (a) that are more restrictive than such requirements in effect as of January 1, 2000.

(4) *USE AND COORDINATION.*—Amounts made available under a grant under this subsection shall only be used by the State to provide HIV/AIDS-related medications. The State shall coordinate the use of such amounts with the amounts otherwise provided under this section in order to maximize drug coverage.

(5) FUNDING.—

(A) *RESERVATION OF AMOUNT.*—The Secretary shall reserve 3 percent of any amount referred to in section 2618(b)(2)(H) that is appropriated for a fiscal year, to carry out this subsection.

(B) *MINIMUM AMOUNT.*—In providing grants under this subsection, the Secretary shall ensure that the amount of a grant to a State under this part is not less than the amount the State received under this part in the previous fiscal year, as a result of grants provided under this subsection.

(f) *SUPPLEMENT NOT SUPPLANT.*—Notwithstanding any other provision of law, amounts made available under this section shall be used to supplement and not supplant other funding available to

provide treatments of the type that may be provided under this section.

* * * * *

SEC. 2617. STATE APPLICATION.

(a) IN GENERAL.—* * *

(b) * * *

(1) * * *

* * * * *

(C) * * *

[(i) the number of individuals to be served with assistance provided under the grant;]

(i) the size and demographic characteristics of the population with HIV disease to be served, except that by not later than October 1, 2002, the State shall take into account the needs of individuals not in care, based on epidemiologic measures developed by the Secretary in consultation with the State, affected communities, experts, and other appropriate individuals (such State shall not be required to establish priorities for individuals not in care until such epidemiologic measures are developed);

* * * * *

(iii) the average cost of providing each category of HIV-related health services and the extent to which such cost is paid by third-party payors; [and]

* * * * *

(v) the availability of other governmental and non-governmental resources;

(vi) the capacity development needs resulting in gaps in the provision of HIV services in historically underserved low-income and rural low-income communities; and

(vii) the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the State;

(2) * * *

* * * * *

(B) 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) an assurance that capacity development needs resulting from gaps in the provision of services in underserved low-income and rural low-income communities will be addressed; and

(D) with respect to fiscal year 2003 and subsequent fiscal years, assurances that, in the planning and allocation of resources, the State, through systems of HIV-related health services provided under paragraphs (1), (2), and (3) of section 2612(a), will make appropriate provision for the HIV-related health and support service needs of individuals who

have been diagnosed with HIV disease but who are not currently receiving such services, based on the epidemiologic measures developed under paragraph (1)(C)(i);

(E) an assurance that the State has procedures in place to ensure that services provided with funds received under this section meet the criteria specified in section 2604(b)(1)(B); and

[(C)] (F) 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

* * * * *
(4) * * *

* * * * *
[(C)] the State will provide for periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the State under this part; **]**

(C) the State will provide for—

(i) the establishment of a quality management program to assess the extent to which medical 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 infections and to develop strategies for improvements in the access to and quality of medical services; and

(ii) a periodic review (such as through an independent peer review) to assess the quality and appropriateness of HIV-related health and support services provided by entities that receive funds from the State under this part;

* * * * *
(E) an assurance that the State, through systems of HIV-related health services provided under paragraphs (1), (2), and (3) of section 2612(a), has considered strategies for working with providers to make optimal use of financial assistance under the State medicaid plan under title XIX of the Social Security Act, the State Children’s Health Insurance Program under title XXI of such Act, and other Federal grantees that provide HIV-related services, to maximize access to quality HIV-related health and support services;

[(E)] (F) the State will maintain HIV-related activities at a level that is equal to not less than 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)] (G) 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) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

(ii) by an entity that provides health services on a prepaid basis~~...~~; and

(H) that funded entities maintain appropriate relationships with entities in the area served that constitute key points of access to the health care system for individuals with HIV disease (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV counseling and testing sites, mental health programs, and homeless shelters), and other entities under section 2652(a), for the purpose of facilitating early intervention for individuals newly diagnosed with HIV disease and individuals knowledgeable of their status but not in care.

* * * * *

SEC. 2618. [300ff-28] DISTRIBUTION OF FUNDS.

(b) AMOUNT OF GRANT TO STATE.—

(1) MINIMUM ALLOTMENT.—* * *

* * * * *

(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]~~ \$250,000;

* * * * *

(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.*

* * * * *

(c) ALLOCATION OF ASSISTANCE BY STATES.—

* * * * *

(3) PLANNING AND EVALUATIONS.—Subject to paragraph (5) and except as provided in paragraph (6), a State may not use more than 10 percent of amounts received under a grant awarded under this part for planning and evaluation activities,

including not more than \$3,000,000 for all activities associated with its quality management program.

* * * * *

[(6) EXCEPTION.—With respect to a State that received the minimum allotment under subsection (a)(1) for a fiscal year such State, from the amounts received under a grant awarded under this part for such fiscal year for the activities described in paragraphs (3) and (4), may, notwithstanding paragraphs (3), (4), and (5), use not more than that amount required to support one full-time-equivalent employee.]

(6) EXCEPTION FOR QUALITY MANAGEMENT.—Notwithstanding paragraph (5), a State whose grant under this part for a fiscal year does not exceed \$1,500,000 may use not to exceed 20 percent of the amount of the grant for the purposes described in paragraphs (3) and (4) if—

(A) that portion of the amount that may be used for such purposes in excess of 15 percent of the grant is used for its quality management program; and

(B) the State submits and the Secretary approves a plan (in such form and containing such information as the Secretary may prescribe) for use of funds for its quality management program.

* * * * *

SEC. 2622. SUPPLEMENTAL GRANTS.

(a) IN GENERAL.—The Secretary shall award supplemental grants to States determined to be eligible under subsection (b) to enable such States to provide comprehensive services of the type described in section 2612(a) to supplement the services otherwise provided by the State under a grant under this subpart in emerging communities within the State that are not eligible to receive grants under part A.

(b) ELIGIBILITY.—To be eligible to receive a supplemental grant under subsection (a) a State shall—

(1) be eligible to receive a grant under this subpart; and

(2) demonstrate the existence in the State of an emerging community as defined in subsection (d)(1).

(c) REPORTING REQUIREMENTS.—A State that desires a grant under this section shall, as part of the State application submitted under section 2617, submit a detailed description of the manner in which the State will use amounts received under the grant and of the severity of need. Such description shall include—

(1) a report concerning the dissemination of supplemental funds under this section and the plan for the utilization of such funds in the emerging community;

(2) a demonstration of the existing commitment of local resources, both financial and in-kind;

(3) a demonstration that the State will maintain HIV-related activities at a level that is equal to not less than the level of such activities in the State for the 1-year period preceding the fiscal year for which the State is applying to receive a grant under this part;

(4) a demonstration of the ability of the State to utilize such supplemental financial resources in a manner that is immediately responsive and cost effective;

(5) a demonstration that the resources will be allocated in accordance with the local demographic incidence of AIDS including appropriate allocations for services for infants, children, women, and families with HIV disease;

(6) a demonstration of the inclusiveness of the planning process, with particular emphasis on affected communities and individuals with HIV disease; and

(7) a demonstration of the manner in which the proposed services are consistent with local needs assessments and the statewide coordinated statement of need.

(d) **DEFINITION OF EMERGING COMMUNITY.**—In this section, the term “emerging community” means a metropolitan area—

(1) that is not eligible for a grant under part A; and

(2) for which there has been reported to the Director of the Centers for Disease Control and Prevention a cumulative total of between 500 and 1999 cases of acquired immune deficiency syndrome for the most recent period of 5 calendar years for which such data are available.

(e) **FUNDING.**—

(1) **IN GENERAL.**—Subject to paragraph (2), with respect to each fiscal year beginning with fiscal year 2001, the Secretary, to carry out this section, shall utilize—

(A) the greater of—

(i) 25 percent of the amount appropriated under 2677 to carry out part B, excluding the amount appropriated under section 2618(b)(2)(H), for such fiscal year that is in excess of the amount appropriated to carry out such part in fiscal year preceding the fiscal year involved; or

(ii) \$5,000,000;

to provide funds to States for use in emerging communities with at least 1000, but less than 2000, cases of AIDS as reported to and confirmed by the Director of the Centers for Disease Control and Prevention for the five year period preceding the year for which the grant is being awarded; and

(B) the greater of—

(i) 25 percent of the amount appropriated under 2677 to carry out part B, excluding the amount appropriated under section 2618(b)(2)(H), for such fiscal year that is in excess of the amount appropriated to carry out such part in fiscal year preceding the fiscal year involved; or

(ii) \$5,000,000;

to provide funds to States for use in emerging communities with at least 500, but less than 1000, cases of AIDS reported to and confirmed by the Director of the Centers for Disease Control and Prevention for the five year period preceding the year for which the grant is being awarded.

(2) **TRIGGER OF FUNDING.**—This section shall be effective only for fiscal years beginning in the first fiscal year in which the amount appropriated under 2677 to carry out part B, excluding the amount appropriated under section 2618(b)(2)(H), exceeds by at least \$20,000,000 the amount appropriated under 2677 to

carry out part B in fiscal year 2000, excluding the amount appropriated under section 2618(b)(2)(H).

(3) *MINIMUM AMOUNT IN FUTURE YEARS.*—Beginning with the first fiscal year in which amounts provided for emerging communities under paragraph (1)(A) equals \$5,000,000 and under paragraph (1)(B) equals \$5,000,000, the Secretary shall ensure that amounts made available under this section for the types of emerging communities described in each such paragraph in subsequent fiscal years is at least \$5,000,000.

SEC. 2625. CDC GUIDELINES FOR PREGNANT WOMEN.

(a) **REQUIREMENT.**—* * *

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(c) **ADDITIONAL FUNDS REGARDING WOMEN AND INFANTS.**—

(1) **IN GENERAL.**—* * *

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(2) **FUNDING.**—For purposes of carrying out this sub-section, there are authorized to be appropriated \$10,000,000 for each of the **[fiscal years 1996 through 2000]** *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.

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[SEC. 2628. REPORT BY THE INSTITUTE OF MEDICINE.

[(a) IN GENERAL.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct an evaluation of the extent to which State efforts have been effective in reducing the perinatal transmission of the human immuno deficiency, virus, and an analysis of the existing barriers to the further reduction in such transmission.

[(b) REPORT TO CONGRESS.—The Secretary shall ensure that, not later than 2 years after the date of enactment of this section, the evaluation and analysis described in subsection (a) is completed and a report summarizing the results of such evaluation and analysis is prepared by the Institute of Medicine and submitted to the appropriate committees of Congress together with the recommendations of the Institute.]

TITLE XXVI—HIV HEALTH CARE SERVICES PROGRAM

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

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**[PART C—EARLY INTERVENTION SERVICES] PART C—
EARLY INTERVENTION AND PRIMARY CARE SERVICES**

[Subpart I—Formula Grants for States

[SEC. 2641. [300ff-41] 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 speci-

fied 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. [300ff-42] 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 accepts voluntary donations for the purpose of providing services to the public.

[SEC. 2643. [300ff-43] 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. [300ff-44] 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. [300ff-45] 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. [300ff-46] REPORTING AND PARTNER NOTIFICATION.

[(a) REPORTING.—The Secretary may not take 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. [300ff-47] 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 intends, 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 sub-

section (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. [300ff-48] 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. [300ff-49] 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 pay-

ments, 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. [300ff-49a] 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. [300ff-50] 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.】

Subpart [II] I—Categorical Grants

SEC. 2651. [300ff-51] ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—* * *

* * * * *

(d) *PREFERENCE IN AWARDING GRANTS.*—*In awarding new grants under this section, the Secretary shall give preference to applicants that will use amounts received under the grant to serve areas that are determined to be rural and underserved for the purposes of providing health care to individuals infected with HIV or diagnosed with AIDS.*

SEC. 2652. [300ff-52] MINIMUM QUALIFICATIONS OF GRANTEES.

(a) IN GENERAL.—The entities referred to in section 2651(a) are public entities and nonprofit private entities that are—

- 【(1) migrant health centers under section 329 or community health centers under section 330;
- 【(2) grantees under section 340 (regarding health services for the homeless);】
 - (1) *health centers under section 330;*
- 【(3)】 (2) *grantees under section 1001 (regarding family planning) other than states;*
- 【(4)】 (3) *comprehensive hemophilia diagnostic and treatment centers;*
- 【(5)】 (4) *Federally-qualified health centers under section 1905(1)(2)(B) of the Social Security Act; or*
- 【(6)】 (5) *nonprofit private entities that provide comprehensive primary care services to populations at risk of HIV disease.*

* * * * *

SEC. 2654. [300ff-54] MISCELLANEOUS PROVISIONS.

(a) SERVICES FOR INDIVIDUALS WITH HEMOPHILIA.—* * *

* * * * *

(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.]

(1) *IN GENERAL.*—*The Secretary may provide planning and development grants to public and nonprofit private entities for the purpose of—*

(A) *enabling such entities to provide HIV early intervention services; or*

(B) *assisting such entities to expand the capacity, preparedness, and expertise to deliver primary care services to individuals with HIV disease in underserved low-income communities on the condition that the funds are not used to purchase or improve land or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility.*

(2) REQUIREMENT.—The Secretary may only award a grant to an entity under [(paragraph (1))] *paragraph (1)(A)* if the Secretary determines that the entity will use such grant to assist the entity in qualifying for a grant under section 2651.

(3) PREFERENCE.—In awarding grants under [(paragraph (1))] *paragraph (1)(A)*, the Secretary shall give preference to entities that provide primary care services in rural or underserved communities.

(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 percent] *5 percent* of the amount appropriated for a fiscal year under section 2655 may be used to carry out this section.

SEC. 2655. [300ff-55] 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] *2001 through 2005*.

Subpart [III] II—General Provisions**SEC. 2661. [300ff-61] CONFIDENTIALITY AND INFORMED CONSENT.**

(a) CONFIDENTIALITY.—The Secretary may not make a grant under this part [unless—

[(1) in the case of any State applying for a grant under section 2641, the State agrees to ensure that information regarding the receipt of early intervention services is maintained confidentially pursuant to law or regulations in a manner not inconsistent with applicable law; and

[(2) in the case] *unless, in the case* of any entity applying for a grant under section 2651, the entity agrees to ensure that information regarding the receipt of early intervention services pursuant to the grant is maintained confidentially in a manner not inconsistent with applicable law.

* * * * *

SEC. 2664. [300ff-64] ADDITIONAL REQUIRED AGREEMENTS.

(a) REPORTS TO SECRETARY.—* * *

* * * * *

(e) REQUIREMENTS REGARDING IMPOSITION OF CHARGES FOR SERVICES.—

(1) IN GENERAL.—* * *

* * * * *

(5) WAIVER REGARDING CERTAIN SECONDARY AGREEMENTS.—
The requirement established in paragraph (1)(B)(i) shall be waived by the Secretary in the case of any entity for whom the Secretary has granted a waiver under section [2642(b) or] 2652(b)(2).

(f) RELATIONSHIP TO ITEMS AND SERVICES UNDER OTHER PROGRAMS.—

(1) IN GENERAL.—* * *

* * * * *

(2) APPLICABILITY TO CERTAIN SECONDARY AGREEMENTS FOR PROVISION OF SERVICES.—An agreement made under paragraph (1) shall not apply in the case of an entity through which a grantee under this part provides early intervention services if the Secretary has provided a waiver under section [2642(b) or] 2652(b)(2) regarding the entity.

(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 percent including planning and evaluation of the grant for administrative expenses with respect to the grant; and]

(3) the applicant will not expend more than 10 percent of the grant for costs of administrative activities with respect to the grant;

(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.

[(h) CONSTRUCTION.—A State may not use amounts received under a grant awarded under section 2641 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.]

* * * * *

PART D—GENERAL PROVISIONS

SEC. 2671. [300ff-71] GRANTS FOR COORDINATED SERVICES AND ACCESS TO RESEARCH FOR WOMEN, INFANTS, CHILDREN, AND YOUTH.

(a) IN GENERAL.—* * *

* * * * *

[(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.]

* * * * *

[(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.】

* * * * *

(d) ADDITIONAL SERVICES FOR PATIENTS AND FAMILIES.—A grant under subsection (a) may be made only if the applicant for the grant agrees as follows:

(1) * * *

* * * * *

(4) *The applicant will provide individuals with information and education on opportunities to participate in HIV/AIDS-related clinical research.*

* * * * *

【(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 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. *The Secretary acting through the Director of NIH, shall examine the distribution and availability of ongoing and appropriate HIV/AIDS-related research projects to existing sites under this section for purposes of enhancing and expanding voluntary access to HIV-related research, especially within communities that are not reasonably served by such projects. Not later than 12 months after the date of enactment of the Ryan White CARE Act Amendments of 2000, the Secretary shall prepare and submit to the appropriate committees of Congress a report that describes the findings made by the Director and the manner in which the conclusions based on those findings can be addressed.*

* * * * *

(i) LIMITATION ON ADMINISTRATION EXPENSES.—

(1) DETERMINATION BY SECRETARY.—*Not later than 12 months after the date of enactment of the Ryan White CARE Act Amendments of 2000, the Secretary, in consultation with grantees under this part, shall conduct a review of the administrative, program support, and direct service-related activities that are carried out under this part to ensure that eligible individuals have access to quality, HIV-related health and support*

services and research opportunities under this part, and to support the provision of such services.

(2) REQUIREMENTS.—

(A) IN GENERAL.—Not later than 180 days after the expiration of the 12-month period referred to in paragraph (1) the Secretary, in consultation with grantees under this part, shall determine the relationship between the costs of the activities referred to in paragraph (1) and the access of eligible individuals to the services and research opportunities described in such paragraph.

(B) LIMITATION.—After a final determination under subparagraph (A), the Secretary may not make a grant under this part unless the grantee complies with such requirements as may be included in such determination.

[(i)] (j) TRAINING AND TECHNICAL ASSISTANCE.—Of the amounts appropriated under subsection (j) for a fiscal year, the Secretary may use not more than five percent to provide, directly or through contracts with public and private entities (which may include grantees under subsection (a)), training and technical assistance to assist applicants and grantees under subsection (a) in complying with the requirements of this section.

[(j)] (k) 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]** *fiscal years 2001 through 2005.*

SEC. 2674. [300ff-74] EVALUATIONS AND REPORTS.

(a) EVALUATIONS.—* * *

* * * * *

(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. 2677. [300ff-77] 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.

There are authorized to be appropriated—

(1) such sums as may be necessary to carry out part A for each of the fiscal years 2001 through 2005; and

(2) such sums as may be necessary to carry out part B for each of the fiscal years 2001 through 2005.

* * * * *

Subpart II—AIDS Education and Training Centers

SEC. 2692. [300ff-11] HIV/AIDS COMMUNITIES, SCHOOLS, AND CENTERS.

(a) SCHOOLS; CENTERS.—

* * * * *

(b) DENTAL SCHOOLS.—

(1) IN GENERAL.—The Secretary may make grants to assist dental schools and programs described in section [777(b)(4)(B)] 777(b)(4)(B) (as such section existed on the day before the date of enactment of the Health Professions Education Partnerships Act of 1998 (Public Law 105-392)) and dental hygiene programs that are accredited by the Commission on Dental Accreditation with respect to oral health care to patients with HIV disease.

(2) APPLICATION.—Each dental school or program described in section [777(b)(4)(B)] 777(b)(4)(B) (as such section existed on the day before the date of enactment of the Health Professions Education Partnerships Act of 1998 (Public Law 105-392)) 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.

* * * * *

(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] *fiscal years 2001 through 2005.*

* * * * *

RYAN WHITE CARE ACT AMENDMENTS OF 1996

Public Law 104-146

* * * * *

SEC. 3. GENERAL AMENDMENTS.

(a) PROGRAM OF GRANTS.—

(1) NUMBER OF CASES.—* * *

* * * * *

(iii) by inserting *before paragraph (2) as so redesignated* the following new paragraph:

* * * * *

