

The legislation, as you know, reauthorizes the Children's Hospital Graduate Medical Education program until 2011 to fund residency programs in Children's Hospitals. This program is designed to help Children's teaching hospitals that do not receive significant Federal support for their resident and intern training programs through the Medicare program because of their low volume of Medicare patients.

Full-service teaching hospitals receive funds for graduate medical education through Medicare payments, but prior to the enactment of this program, independent Children's teaching hospitals did not have a similar program to fund their resident training programs for physicians.

Thankfully, Congress recognized this inequity and the financial disadvantage it placed on Children's Hospital. Now, Mr. Speaker, money from this program helps to support the broad teaching goals of Children's teaching hospitals, including training health care professionals, providing rare and specialized clinical services, and innovative clinical care, providing care to the poor and underserved, and conducting biomedical research.

Teaching hospitals have higher costs than other hospitals because of the special services they provide. This legislation seeks to alleviate that burden. On June 21, 2005, the House overwhelmingly passed legislation authorizing \$100 million a year for fiscal years 2007 through 2011, to offset direct medical education costs of graduate medical education in Children's Hospitals.

The Senate amended this legislation and increased that authorization to direct costs to \$110 million a year for fiscal years 2007 through 2011.

The Senate also increased the funds authorized for the indirect medical education costs of graduate medical by \$20 million, providing \$220 million for fiscal years 2007 through 2011.

These commendable changes will provide needed funds to the Children's Hospital Graduate Medical Education program. Again, I want to thank the chairman who is here on the floor, our Republican chairman, Mr. DEAL, because this did end up being a bipartisan effort. I know you played a major role in making it a consensus bill. I urge all of my colleagues to support the legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. DEAL of Georgia. Mr. Speaker, I yield 4 minutes to the gentlewoman from Connecticut (Mrs. JOHNSON), a long-time supporter of this program.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman from Georgia for yielding me time.

I rise in enthusiastic support of H.R. 5574, legislation that reauthorizes the Children's Hospital Graduate Medical Education program.

It is a little recognized fact that we support medical education through Medicare payments. And since there are not a lot of Medicare patients in

Children's Hospitals, we found that we were providing inadequate support for the training of pediatricians, and especially as pediatrics became a specialty with the same spectrum of subspecialties as are common in the rest of medicine.

So in 1998 Congresswoman PRYCE from Ohio and I authored this program, and I really appreciate the good work of Chairman NATHAN DEAL from Georgia in bringing it to the floor with bipartisan support to reauthorize it for another 5 years.

When we first started this program, Federal GME support for Children's Hospitals was at .5 percent of what Medicare was providing for other teaching hospitals. Thanks to the legislation and the support over the years that Congress has given it, today Federal GME supports 80 percent of the cost of residencies in Children's Hospitals.

That is a wonderful thing, because as a result of that, Children's Hospitals have been able to increase the number of residents they train, including both general pediatricians and pediatric specialists, increase the number of training programs, improve the quality of the training programs, and strengthen the caliber of the residents they train.

The program works. It is improving the care available to our children across the country. The Children's GME Hospitals accounted for more than 80 percent of the growth in pediatric subspecialty training programs in the country, and more than 65 percent of the growth in the number of pediatric subspecialists trained. That has been critical at the time when many regions of the country, including major metropolitan areas, have experienced shortages of pediatric subspecialists: pediatric cardiologists, pediatric oncologists, and so it goes.

In Connecticut, the pediatric residency program at the University of Connecticut School of Medicine is currently training 57 residents at Connecticut's Children's Medical Center. These residents provide care to children in all hospital settings, including primary care, emergency care, inpatient care, critical care and subspecialty clinics.

Mr. Speaker, I want to thank my colleagues for authorizing this program for the full 5 years and recognize my colleague from Ohio, Congresswoman PRYCE, for her leadership in this work over the last 7 years. It has been a huge success for children across America, and we salute those hospitals that specialize in the complex care of children with very serious illnesses as we pass this legislation today.

Mr. PALLONE. Mr. Speaker, I have no additional speakers and yield back the balance of my time.

Mr. DEAL of Georgia. Mr. Speaker, I have no other requests for time.

In closing, I would like to express my appreciation to Mr. PALLONE, who was an original cosponsor of this legislation. And it is true that we have made

a bipartisan effort. I think that is the way we should do more things around here. I appreciate the cooperative spirit with which this bill has now moved through both bodies.

Ms. PRYCE of Ohio. Mr. Speaker, I rise today in support of H.R. 5574, legislation that will reauthorize and strengthen the children's hospital graduate medical education program.

I want to thank Chairman BARTON and Chairman DEAL for their commitment to prioritizing this important measure this year—it's been a great team effort and I appreciate the Committee's support for children's health.

I also want to extend a special thanks to Congresswoman NANCY JOHNSON of Connecticut. We've been strong partners over the years on children's health issues—enactment of Children's Hospital GME back in 1999 is one of my proudest moments working together.

We've had great success increasing the Federal investment in this program ever since—from Members on both sides of the aisle.

The Ohio delegation has helped lead the charge—in no small part thanks to the efforts of our esteemed Chairman of the Labor HHS Appropriations Subcommittee, RALPH REGULA.

I am extremely fortunate to have an extraordinary children's hospital in my hometown of Columbus, OH. Strong leadership, a clear vision, and a compassionate team of medical professionals has made Columbus Children's one of the best hospitals in the nation caring for sick children.

The CHGME program has helped the hospital—and hospitals all across America—do what they do best—provide the best training to doctors to deliver the best patient care possible. And we can all agree that our children deserve nothing short of the very best.

A vote in favor of H.R. 5574 will send it to the President's desk and reauthorize this important program for another 5 years. I urge my colleagues to support this measure.

Mr. DEAL of Georgia. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Georgia (Mr. DEAL) that the House suspend the rules and concur in the Senate amendment to the bill, H.R. 5574.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the Senate amendment was concurred in.

A motion to reconsider was laid on the table.

RYAN WHITE HIV/AIDS TREATMENT MODERNIZATION ACT OF 2006

Mr. DEAL of Georgia. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 6143) to amend title XXVI of the Public Health Service Act to revise and extend the program for providing life-saving care for those with HIV/AIDS, as amended.

The Clerk read as follows:

H.R. 6143

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Ryan White HIV/AIDS Treatment Modernization Act of 2006”.

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

Sec. 1. Short title; table of contents.

TITLE I—EMERGENCY RELIEF FOR ELIGIBLE AREAS

Sec. 101. Establishment of program; general eligibility for grants.

Sec. 102. Type and distribution of grants; formula grants.

Sec. 103. Type and distribution of grants; supplemental grants.

Sec. 104. Timeframe for obligation and expenditure of grant funds.

Sec. 105. Use of amounts.

Sec. 106. Additional amendments to part A.

Sec. 107. New program in part A; transitional grants for certain areas ineligible under section 2601.

Sec. 108. Authorization of appropriations for part A.

TITLE II—CARE GRANTS

Sec. 201. General use of grants.

Sec. 202. AIDS Drug Assistance Program.

Sec. 203. Distribution of funds.

Sec. 204. Additional amendments to subpart I of part B.

Sec. 205. Supplemental grants on basis of demonstrated need.

Sec. 206. Emerging communities.

Sec. 207. Timeframe for obligation and expenditure of grant funds.

Sec. 208. Authorization of appropriations for subpart I of part B.

Sec. 209. Early diagnosis grant program.

Sec. 210. Certain partner notification programs; authorization of appropriations.

TITLE III—EARLY INTERVENTION SERVICES

Sec. 301. Establishment of program; core medical services.

Sec. 302. Eligible entities; preferences; planning and development grants.

Sec. 303. Authorization of appropriations.

Sec. 304. Confidentiality and informed consent.

Sec. 305. Provision of certain counseling services.

Sec. 306. General provisions.

TITLE IV—WOMEN, INFANTS, CHILDREN, AND YOUTH

Sec. 401. Women, infants, children, and youth.

Sec. 402. GAO Report.

TITLE V—GENERAL PROVISIONS

Sec. 501. General provisions.

TITLE VI—DEMONSTRATION AND TRAINING

Sec. 601. Demonstration and training.

Sec. 602. AIDS education and training centers.

Sec. 603. Codification of minority AIDS initiative.

TITLE VII—MISCELLANEOUS PROVISIONS

Sec. 701. Hepatitis; use of funds.

Sec. 702. Certain references.

TITLE I—EMERGENCY RELIEF FOR ELIGIBLE AREAS**SEC. 101. ESTABLISHMENT OF PROGRAM; GENERAL ELIGIBILITY FOR GRANTS.**

(a) **IN GENERAL.**—Section 2601 of the Public Health Service Act (42 U.S.C. 300ff-11) is amended by striking subsections (b) through (d) and inserting the following:

“(b) **CONTINUED STATUS AS ELIGIBLE AREA.**—Notwithstanding any other provision of this section, a metropolitan area that is an eligible area for a fiscal year continues to

be an eligible area until the metropolitan area fails, for three consecutive fiscal years—

“(1) to meet the requirements of subsection (a); and

“(2) to have a cumulative total of 3,000 or more living cases of AIDS (reported to and confirmed by the Director of the Centers for Disease Control and Prevention) as of December 31 of the most recent calendar year for which such data is available.

“(c) **BOUNDARIES.**—For purposes of determining eligibility under this part—

“(1) with respect to a metropolitan area that received funding under this part in fiscal year 2006, the boundaries of such metropolitan area shall be the boundaries that were in effect for such area for fiscal year 1994; or

“(2) with respect to a metropolitan area that becomes eligible to receive funding under this part in any fiscal year after fiscal year 2006, the boundaries of such metropolitan area shall be the boundaries that are in effect for such area when such area initially receives funding under this part.”.

(b) **TECHNICAL AND CONFORMING AMENDMENTS.**—Section 2601(a) of the Public Health Service Act (42 U.S.C. 300ff-11(a)) is amended—

(1) by striking “through (d)” and inserting “through (c)”;

(2) by inserting “and confirmed by” after “reported to”.

(c) **DEFINITION OF METROPOLITAN AREA.**—Section 2607(2) of the Public Health Service Act (42 U.S.C. 300ff-17(2)) is amended—

(1) by striking “area referred” and inserting “area that is referred”; and

(2) by inserting before the period the following: “, and that has a population of 50,000 or more individuals”.

SEC. 102. TYPE AND DISTRIBUTION OF GRANTS; FORMULA GRANTS.

(a) **DISTRIBUTION PERCENTAGES.**—Section 2603(a)(2) of the Public Health Service Act (42 U.S.C. 300ff-13(a)(2)) is amended—

(1) in the first sentence—

(A) by striking “50 percent of the amount appropriated under section 2677” and inserting “66½ percent of the amount made available under section 2610(b) for carrying out this subpart”; and

(B) by striking “paragraph (3)” and inserting “paragraphs (3) and (4)”.

(2) by striking the last sentence.

(b) **DISTRIBUTION BASED ON LIVING CASES OF HIV/AIDS.**—Section 2603(a)(3) of the Public Health Service Act (42 U.S.C. 300ff-13(a)(3)) is amended—

(1) in subparagraph (B), by striking “estimated living cases of acquired immune deficiency syndrome” and inserting “living cases of HIV/AIDS (reported to and confirmed by the Director of the Centers for Disease Control and Prevention)”;

(2) by striking subparagraphs (C) through (E) and inserting the following:

“(C) **LIVING CASES OF HIV/AIDS.**—

“(i) **REQUIREMENT OF NAMES-BASED REPORTING.**—Except as provided in clause (ii), the number determined under this subparagraph for an eligible area for a fiscal year for purposes of subparagraph (B) is the number of living names-based cases of HIV/AIDS that, as of December 31 of the most recent calendar year for which such data is available, have been reported to and confirmed by the Director of the Centers for Disease Control and Prevention.

“(ii) **TRANSITION PERIOD; EXEMPTION REGARDING NON-AIDS CASES.**—For each of the fiscal years 2007 through 2010, an eligible area is, subject to clauses (iii) through (v), exempt from the requirement under clause (i) that living names-based non-AIDS cases of HIV be reported unless—

“(I) a system was in operation as of December 31, 2005, that provides sufficiently accurate and reliable names-based reporting of such cases throughout the State in which the area is located, subject to clause (viii); or

“(II) no later than the beginning of fiscal year 2008, 2009, or 2010, the Secretary, in consultation with the chief executive of the State in which the area is located, determines that a system has become operational in the State that provides sufficiently accurate and reliable names-based reporting of such cases throughout the State.

“(iii) **REQUIREMENTS FOR EXEMPTION FOR FISCAL YEAR 2007.**—For fiscal year 2007, an exemption under clause (ii) for an eligible area applies only if, by October 1, 2006—

“(I)(aa) the State in which the area is located had submitted to the Secretary a plan for making the transition to sufficiently accurate and reliable names-based reporting of living non-AIDS cases of HIV; or

“(bb) all statutory changes necessary to provide for sufficiently accurate and reliable reporting of such cases had been made; and

“(II) the State had agreed that, by April 1, 2008, the State will begin accurate and reliable names-based reporting of such cases, except that such agreement is not required to provide that, as of such date, the system for such reporting be fully sufficient with respect to accuracy and reliability throughout the area.

“(iv) **REQUIREMENT FOR EXEMPTION AS OF FISCAL YEAR 2008.**—For each of the fiscal years 2008 through 2010, an exemption under clause (ii) for an eligible area applies only if, as of April 1, 2008, the State in which the area is located is substantially in compliance with the agreement under clause (iii)(II).

“(v) **PROGRESS TOWARD NAMES-BASED REPORTING.**—For fiscal year 2009 or 2010, the Secretary may terminate an exemption under clause (i) for an eligible area if the State in which the area is located submitted a plan under clause (iii)(I)(aa) and the Secretary determines that the State is not substantially following the plan.

“(vi) **COUNTING OF CASES IN AREAS WITH EXEMPTIONS.**—

“(I) **IN GENERAL.**—With respect to an eligible area that is under a reporting system for living non-AIDS cases of HIV that is not names-based (referred to in this subparagraph as “code-based reporting”), the Secretary shall, for purposes of this subparagraph, modify the number of such cases reported for the eligible area in order to adjust for duplicative reporting in and among systems that use code-based reporting.

“(II) **ADJUSTMENT RATE.**—The adjustment rate under subclause (I) for an eligible area shall be a reduction of 5 percent in the number of living non-AIDS cases of HIV reported for the area.

“(vii) **MULTIPLE POLITICAL JURISDICTIONS.**—With respect to living non-AIDS cases of HIV, if an eligible area is not entirely within one political jurisdiction and as a result is subject to more than one reporting system for purposes of this subparagraph:

“(I) Names-based reporting under clause (i) applies in a jurisdictional portion of the area, or an exemption under clause (ii) applies in such portion (subject to applicable provisions of this subparagraph), according to whether names-based reporting or code-based reporting is used in such portion.

“(II) If under subclause (I) both names-based reporting and code-based reporting apply in the area, the number of code-based cases shall be reduced under clause (vi).

“(viii) **LIST OF ELIGIBLE AREAS MEETING STANDARD REGARDING DECEMBER 31, 2005.**—

“(I) **IN GENERAL.**—If an eligible area or portion thereof is in a State specified in subclause (II), the eligible area or portion shall

be considered to meet the standard described in clause (i)(I). No other eligible area or portion thereof may be considered to meet such standard.

“(II) RELEVANT STATES.—For purposes of subclause (I), the States specified in this subclause are the following: Alaska, Alabama, Arkansas, Arizona, Colorado, Florida, Indiana, Iowa, Idaho, Kansas, Louisiana, Michigan, Minnesota, Missouri, Mississippi, North Carolina, North Dakota, Nebraska, New Jersey, New Mexico, New York, Nevada, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, West Virginia, Wyoming, Guam, and the Virgin Islands.

“(ix) RULES OF CONSTRUCTION REGARDING ACCEPTANCE OF REPORTS.—

“(I) CASES OF AIDS.—With respect to an eligible area that is subject to the requirement under clause (i) and is not in compliance with the requirement for names-based reporting of living non-AIDS cases of HIV, the Secretary shall, notwithstanding such non-compliance, accept reports of living cases of AIDS that are in accordance with such clause.

“(II) APPLICABILITY OF EXEMPTION REQUIREMENTS.—The provisions of clauses (i) through (viii) may not be construed as having any legal effect for fiscal year 2011 or any subsequent fiscal year, and accordingly, the status of a State for purposes of such clauses may not be considered after fiscal year 2010.

“(x) PROGRAM FOR DETECTING INACCURATE OR FRAUDULENT COUNTING.—The Secretary shall carry out a program to monitor the reporting of names-based cases for purposes of this subparagraph and to detect instances of inaccurate reporting, including fraudulent reporting.”

(c) CODE-BASED AREAS; LIMITATION ON INCREASE IN GRANT.—Section 2603(a)(3) of the Public Health Service Act (42 U.S.C. 300ff-13(a)), as amended by subsection (b)(2) of this section, is amended by adding at the end the following subparagraph:

“(D) CODE-BASED AREAS; LIMITATION ON INCREASE IN GRANT.—

“(i) IN GENERAL.—For each of the fiscal years 2007 through 2010, if code-based reporting (within the meaning of subparagraph (C)(vi)) applies in an eligible area or any portion thereof as of the beginning of the fiscal year involved, then notwithstanding any other provision of this paragraph, the amount of the grant pursuant to this paragraph for such area for such fiscal year may not—

“(I) for fiscal year 2007, exceed by more than 5 percent the amount of the grant for the area that would have been made pursuant to this paragraph and paragraph (4) for fiscal year 2006 (as such paragraphs were in effect for such fiscal year) if paragraph (2) (as so in effect) had been applied by substituting ‘66% percent’ for ‘50 percent’; and

“(II) for each of the fiscal years 2008 and 2009, exceed by more than 5 percent the amount of the grant pursuant to this paragraph and paragraph (4) for the area for the preceding fiscal year.

“(ii) USE OF AMOUNTS INVOLVED.—For each of the fiscal years 2007 through 2010, amounts available as a result of the limitation under clause (i) shall be made available by the Secretary as additional amounts for grants pursuant to subsection (b) for the fiscal year involved, subject to paragraph (4) and section 2610(d)(2).”

(d) HOLD HARMLESS.—Section 2603(a) of the Public Health Service Act (42 U.S.C. 300ff-13(a)) is amended—

(1) in paragraph (3)(A)—

(A) in clause (ii), by striking the period at the end and inserting a semicolon; and

(B) by inserting after and below clause (ii) the following:

“which product shall then, as applicable, be increased under paragraph (4).”

(2) by amending paragraph (4) to read as follows:

“(4) INCREASES IN GRANT.—

“(A) IN GENERAL.—For each eligible area that received a grant pursuant to this subsection for fiscal year 2006, the Secretary shall, for each of the fiscal years 2007 through 2009, increase the amount of the grant made pursuant to paragraph (3) for the area to ensure that the amount of the grant for the fiscal year involved is not less than the following amount, as applicable to such fiscal year:

“(i) For fiscal year 2007, an amount equal to 95 percent of the amount of the grant that would have been made pursuant to paragraph (3) and this paragraph for fiscal year 2006 (as such paragraphs were in effect for such fiscal year) if paragraph (2) (as so in effect) had been applied by substituting ‘66% percent’ for ‘50 percent’.

“(ii) For each of the fiscal years 2008 and 2009, an amount equal to 95 percent of the amount of the grant made pursuant to paragraph (3) and this paragraph for the preceding fiscal year.

“(B) SOURCE OF FUNDS FOR INCREASE.—

“(i) IN GENERAL.—From the amounts available for carrying out the single program referred to in section 2609(d)(2)(C) for a fiscal year (relating to supplemental grants), the Secretary shall make available such amounts as may be necessary to comply with subparagraph (A), subject to section 2610(d)(2).

“(ii) PRO RATA REDUCTION.—If the amounts referred to in clause (i) for a fiscal year are insufficient to fully comply with subparagraph (A) for the year, the Secretary, in order to provide the additional funds necessary for such compliance, shall reduce on a pro rata basis the amount of each grant pursuant to this subsection for the fiscal year, other than grants for eligible areas for which increases under subparagraph (A) apply. A reduction under the preceding sentence may not be made in an amount that would result in the eligible area involved becoming eligible for such an increase.

“(C) LIMITATION.—This paragraph may not be construed as having any applicability after fiscal year 2009.”

SEC. 103. TYPE AND DISTRIBUTION OF GRANTS; SUPPLEMENTAL GRANTS.

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

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by striking “Not later than” and all that follows through “the Secretary shall” and inserting the following: “Subject to subsection (a)(4)(B)(i) and section 2610(d), the Secretary shall”;

(B) in subparagraph (B), by striking “demonstrates the severe need in such area” and inserting “demonstrates the need in such area, on an objective and quantified basis,”;

(C) by striking subparagraph (F) and inserting the following:

“(F) demonstrates the inclusiveness of affected communities and individuals with HIV/AIDS;”

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

(E) by adding at the end the following:

“(H) demonstrates the ability of the applicant to expend funds efficiently by not having had, for the most recent grant year under subsection (a) for which data is available, more than 2 percent of grant funds under such subsection canceled or covered by any waivers under subsection (c)(3).”; and

(2) in paragraph (2)—

(A) in subparagraph (A), by striking “severe need” and inserting “demonstrated need”;

(B) by striking subparagraph (B) and inserting the following:

“(B) DEMONSTRATED NEED.—The factors considered by the Secretary in determining whether an eligible area has a demonstrated need for purposes of paragraph (1)(B) may include any or all of the following:

“(i) The unmet need for such services, as determined under section 2602(b)(4) or other community input process as defined under section 2609(d)(1)(A).

“(ii) An increasing need for HIV/AIDS-related services, including relative rates of increase in the number of cases of HIV/AIDS.

“(iii) The relative rates of increase in the number of cases of HIV/AIDS within new or emerging subpopulations.

“(iv) The current prevalence of HIV/AIDS.

“(v) Relevant factors related to the cost and complexity of delivering health care to individuals with HIV/AIDS in the eligible area.

“(vi) The impact of co-morbid factors, including co-occurring conditions, determined relevant by the Secretary.

“(vii) The prevalence of homelessness.

“(viii) The prevalence of individuals described under section 2602(b)(2)(M).

“(ix) The relevant factors that limit access to health care, including geographic variation, adequacy of health insurance coverage, and language barriers.

“(x) The impact of a decline in the amount received pursuant to subsection (a) on services available to all individuals with HIV/AIDS identified and eligible under this title.”; and

(C) by striking subparagraphs (C) and (D) and inserting the following:

“(C) PRIORITY IN MAKING GRANTS.—The Secretary shall provide funds under this subsection to an eligible area to address the decline in services related to the decline in the amounts received pursuant to subsection (a) consistent with the grant award for the eligible area for fiscal year 2006, to the extent that the factor under subparagraph (B)(x) (relating to a decline in funding) applies to the eligible area.”

SEC. 104. TIMEFRAME FOR OBLIGATION AND EXPENDITURE OF GRANT FUNDS.

Section 2603 of the Public Health Service Act (42 U.S.C. 300ff-13) is amended—

(1) by redesignating subsection (c) as subsection (d); and

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

“(c) TIMEFRAME FOR OBLIGATION AND EXPENDITURE OF GRANT FUNDS.—

“(1) OBLIGATION BY END OF GRANT YEAR.—Effective for fiscal year 2007 and subsequent fiscal years, funds from a grant award made pursuant to subsection (a) or (b) for a fiscal year are available for obligation by the eligible area involved through the end of the one-year period beginning on the date in such fiscal year on which funds from the award first become available to the area (referred to in this subsection as the ‘grant year for the award’), except as provided in paragraph (3)(A).

“(2) SUPPLEMENTAL GRANTS; CANCELLATION OF UNOBLIGATED BALANCE OF GRANT AWARD.—Effective for fiscal year 2007 and subsequent fiscal years, if a grant award made pursuant to subsection (b) for an eligible area for a fiscal year has an unobligated balance as of the end of the grant year for the award—

“(A) the Secretary shall cancel that unobligated balance of the award, and shall require the eligible area to return any amounts from such balance that have been disbursed to the area; and

“(B) the funds involved shall be made available by the Secretary as additional amounts for grants pursuant to subsection (b) for the first fiscal year beginning after

the fiscal year in which the Secretary obtains the information necessary for determining that the balance is required under subparagraph (A) to be canceled, except that the availability of the funds for such grants is subject to subsection (a)(4) and section 2610(d)(2) as applied for such year.

“(3) FORMULA GRANTS; CANCELLATION OF UNOBLIGATED BALANCE OF GRANT AWARD; WAIVER PERMITTING CARRYOVER.—

“(A) IN GENERAL.—Effective for fiscal year 2007 and subsequent fiscal years, if a grant award made pursuant to subsection (a) for an eligible area for a fiscal year has an unobligated balance as of the end of the grant year for the award, the Secretary shall cancel that unobligated balance of the award, and shall require the eligible area to return any amounts from such balance that have been disbursed to the area, unless—

“(i) before the end of the grant year, the chief elected official of the area submits to the Secretary a written application for a waiver of the cancellation, which application includes a description of the purposes for which the area intends to expend the funds involved; and

“(ii) the Secretary approves the waiver.

“(B) EXPENDITURE BY END OF CARRYOVER YEAR.—With respect to a waiver under subparagraph (A) that is approved for a balance that is unobligated as of the end of a grant year for an award:

“(i) The unobligated funds are available for expenditure by the eligible area involved for the one-year period beginning upon the expiration of the grant year (referred to in this subsection as the ‘carryover year’).

“(ii) If the funds are not expended by the end of the carryover year, the Secretary shall cancel that unexpended balance of the award, and shall require the eligible area to return any amounts from such balance that have been disbursed to the area.

“(C) USE OF CANCELLED BALANCES.—In the case of any balance of a grant award that is cancelled under subparagraph (A) or (B)(ii), the grant funds involved shall be made available by the Secretary as additional amounts for grants pursuant to subsection (b) for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that the balance is required under such subparagraph to be canceled, except that the availability of the funds for such grants is subject to subsection (a)(4) and section 2610(d)(2) as applied for such year.

“(D) CORRESPONDING REDUCTION IN FUTURE GRANT.—

“(i) IN GENERAL.—In the case of an eligible area for which a balance from a grant award under subsection (a) is unobligated as of the end of the grant year for the award—

“(I) the Secretary shall reduce, by the same amount as such unobligated balance, the amount of the grant under such subsection for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that such balance was unobligated as of the end of the grant year (which requirement for a reduction applies without regard to whether a waiver under subparagraph (A) has been approved with respect to such balance); and

“(II) the grant funds involved in such reduction shall be made available by the Secretary as additional funds for grants pursuant to subsection (b) for such first fiscal year, subject to subsection (a)(4) and section 2610(d)(2);

except that this clause does not apply to the eligible area if the amount of the unobligated balance was 2 percent or less.

“(ii) RELATION TO INCREASES IN GRANT.—A reduction under clause (i) for an eligible area

for a fiscal year may not be taken into account in applying subsection (a)(4) with respect to the area for the subsequent fiscal year.”

SEC. 105. USE OF AMOUNTS.

Section 2604 of the Public Health Service Act (42 U.S.C. 300ff-14) is amended to read as follows:

“SEC. 2604. USE OF AMOUNTS.

“(a) REQUIREMENTS.—The Secretary may not make a grant under section 2601(a) to the chief elected official of an eligible area unless such political subdivision agrees that—

“(1) subject to paragraph (2), the allocation of funds and services within the eligible area will be made in accordance with the priorities established, pursuant to section 2602(b)(4)(C), by the HIV health services planning council that serves such eligible area;

“(2) funds provided under section 2601 will be expended only for—

“(A) core medical services described in subsection (c);

“(B) support services described in subsection (d); and

“(C) administrative expenses described in subsection (h); and

“(3) the use of such funds will comply with the requirements of this section.

“(b) DIRECT FINANCIAL ASSISTANCE TO APPROPRIATE ENTITIES.—

“(1) IN GENERAL.—The chief elected official of an eligible area shall use amounts from a grant under section 2601 to provide direct financial assistance to entities described in paragraph (2) for the purpose of providing core medical services and support services.

“(2) APPROPRIATE ENTITIES.—Direct financial assistance may be provided under paragraph (1) to public or nonprofit private entities, or private for-profit entities if such entities are the only available provider of quality HIV care in the area.

“(c) REQUIRED FUNDING FOR CORE MEDICAL SERVICES.—

“(1) IN GENERAL.—With respect to a grant under section 2601 for an eligible area for a grant year, the chief elected official of the area shall, of the portion of the grant remaining after reserving amounts for purposes of paragraphs (1) and (5)(B)(i) of subsection (h), use not less than 75 percent to provide core medical services that are needed in the eligible area for individuals with HIV/AIDS who are identified and eligible under this title (including services regarding the co-occurring conditions of the individuals).

“(2) WAIVER.—

“(A) IN GENERAL.—The Secretary shall waive the application of paragraph (1) with respect to a chief elected official for a grant year if the Secretary determines that, within the eligible area involved—

“(i) there are no waiting lists for AIDS Drug Assistance Program services under section 2616; and

“(ii) core medical services are available to all individuals with HIV/AIDS identified and eligible under this title.

“(B) NOTIFICATION OF WAIVER STATUS.—When informing the chief elected official of an eligible area that a grant under section 2601 is being made for the area for a grant year, the Secretary shall inform the official whether a waiver under subparagraph (A) is in effect for such year.

“(3) CORE MEDICAL SERVICES.—For purposes of this subsection, the term ‘core medical services’, with respect to an individual with HIV/AIDS (including the co-occurring conditions of the individual), means the following services:

“(A) Outpatient and ambulatory health services.

“(B) AIDS Drug Assistance Program treatments in accordance with section 2616.

“(C) AIDS pharmaceutical assistance.

“(D) Oral health care.

“(E) Early intervention services described in subsection (e).

“(F) Health insurance premium and cost sharing assistance for low-income individuals in accordance with section 2615.

“(G) Home health care.

“(H) Medical nutrition therapy.

“(I) Hospice services.

“(J) Home and community-based health services as defined under section 2614(c).

“(K) Mental health services.

“(L) Substance abuse outpatient care.

“(M) Medical case management, including treatment adherence services.

“(d) SUPPORT SERVICES.—

“(1) IN GENERAL.—For purposes of this section, the term ‘support services’ means services, subject to the approval of the Secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services).

“(2) MEDICAL OUTCOMES.—In this subsection, the term ‘medical outcomes’ means those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

“(e) EARLY INTERVENTION SERVICES.—

“(1) IN GENERAL.—For purposes of this section, the term ‘early intervention services’ means HIV/AIDS early intervention services described in section 2651(e), with follow-up referral provided for the purpose of facilitating the access of individuals receiving the services to HIV-related health services. The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV/AIDS counseling and testing sites, health care points of entry specified by eligible areas, federally qualified health centers, and entities described in section 2652(a) that constitute a point of access to services by maintaining referral relationships.

“(2) CONDITIONS.—With respect to an entity that proposes to provide early intervention services under paragraph (1), such paragraph shall apply only if the entity demonstrates to the satisfaction of the chief elected official for the eligible area involved that—

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

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

“(f) PRIORITY FOR WOMEN, INFANTS, CHILDREN, AND YOUTH.—

“(1) IN GENERAL.—For the purpose of providing health and support services to infants, children, youth, and women with HIV/AIDS, including treatment measures to prevent the perinatal transmission of HIV, the chief elected official of an eligible area, in accordance with the established priorities of the planning council, shall for each of such populations in the eligible area use, from the grants made for the area under section 2601(a) for a fiscal year, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS.

“(2) WAIVER.—With respect to the population involved, the Secretary may provide to the chief elected official of an eligible

area a waiver of the requirement of paragraph (1) if such official demonstrates to the satisfaction of the Secretary that the population is receiving HIV-related health services through the State Medicaid program under title XIX of the Social Security Act, the State children's health insurance program under title XXI of such Act, or other Federal or State programs.

“(g) 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 for the State—

“(A) the political subdivision involved will provide the service directly, and the political subdivision has entered into a participation agreement under the State plan and is qualified to receive payments under such plan; or

“(B) the political subdivision 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.

“(2) WAIVER.—

“(A) IN GENERAL.—In the case of an entity making an agreement pursuant to paragraph (1)(B) regarding the provision of services, the requirement established in such paragraph shall be waived by the HIV health services planning council for the eligible area 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.

“(B) DETERMINATION.—A determination by the HIV health services planning council of whether an entity referred to in subparagraph (A) 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.

“(h) ADMINISTRATION.—

“(1) LIMITATION.—The chief elected official of an eligible area shall not use in excess of 10 percent of amounts received under a grant under this part for administrative expenses.

“(2) ALLOCATIONS BY CHIEF ELECTED OFFICIAL.—In the case of entities and subcontractors to which the chief elected official of an eligible area allocates amounts received by the official under a grant under this part, the official shall ensure that, of the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not exceed 10 percent (without regard to whether particular entities expend more than 10 percent for such expenses).

“(3) ADMINISTRATIVE ACTIVITIES.—For purposes of paragraph (1), amounts may be used for administrative activities that include—

“(A) routine grant administration and monitoring activities, including the development of applications for part A funds, the receipt and disbursement of program funds, the development and establishment of reimbursement and accounting systems, the development of a clinical quality management program as described in paragraph (5), the preparation of routine programmatic and financial reports, and compliance with grant conditions and audit requirements; and

“(B) all activities associated with the grantee's contract award procedures, including the activities carried out by the HIV health services planning council as established under section 2602(b), the development of requests for proposals, contract proposal

review activities, negotiation and awarding of contracts, monitoring of contracts through telephone consultation, written documentation or onsite visits, reporting on contracts, and funding reallocation activities.

“(4) SUBCONTRACTOR ADMINISTRATIVE ACTIVITIES.—For the purposes of this subsection, subcontractor administrative activities include—

“(A) usual and recognized overhead activities, including established indirect rates for agencies;

“(B) management oversight of specific programs funded under this title; and

“(C) other types of program support such as quality assurance, quality control, and related activities.

“(5) CLINICAL QUALITY MANAGEMENT.—

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

“(B) USE OF FUNDS.—

“(i) IN GENERAL.—From amounts received under a grant awarded under this subpart for a fiscal year, the chief elected official of an eligible area may use for activities associated with the clinical quality management program required in subparagraph (A) not to exceed the lesser of—

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

“(II) \$3,000,000.

“(ii) RELATION TO LIMITATION ON ADMINISTRATIVE EXPENSES.—The costs of a clinical quality management program under subparagraph (A) may not be considered administrative expenses for purposes of the limitation established in paragraph (1).

“(i) CONSTRUCTION.—A chief elected official may not use amounts received under a grant awarded under this part to purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or to make cash payments to intended recipients of services.”

SEC. 106. ADDITIONAL AMENDMENTS TO PART A.

(a) REPORTING OF CASES.—Section 2601(a) of the Public Health Service Act (42 U.S.C. 300ff-11(a)) is amended by striking “for the most recent period” and inserting “during the most recent period”.

(b) PLANNING COUNCIL REPRESENTATION.—Section 2602(b)(2)(G) of the Public Health Service Act (42 U.S.C. 300ff-12(b)(2)(G)) is amended by inserting “, members of a Federally recognized Indian tribe as represented in the population, individuals co-infected with hepatitis B or C” after “disease”.

(c) APPLICATION FOR GRANT.—

(1) PAYER OF LAST RESORT.—Section 2605(a)(6)(A) of the Public Health Service Act (42 U.S.C. 300ff-15(a)(6)(A)) is amended by inserting “(except for a program administered by or providing the services of the Indian Health Service)” before the semicolon.

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

(A) in paragraph (8), by striking “and” at the end;

(B) in paragraph (9), by striking the period and inserting “; and”; and

(C) by adding at the end the following:

“(10) that the chief elected official will submit to the lead State agency under sec-

tion 2617(b)(4), audits, consistent with Office of Management and Budget circular A133, regarding funds expended in accordance with this part every 2 years and shall include necessary client-based data to compile unmet need calculations and Statewide coordinated statements of need process.”.

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

(A) in paragraph (3), by striking “and” at the end;

(B) in paragraph (4), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

“(5) the manner in which the expected expenditures are related to the planning process for States that receive funding under part B (including the planning process described in section 2617(b)); and

“(6) the expected expenditures and how those expenditures will improve overall client outcomes, as described under the State plan under section 2617(b), and through additional outcomes measures as identified by the HIV health services planning council under section 2602(b).”.

SEC. 107. NEW PROGRAM IN PART A; TRANSITIONAL GRANTS FOR CERTAIN AREAS INELIGIBLE UNDER SECTION 2601.

(a) IN GENERAL.—Part A of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-11) is amended—

(1) by inserting after the part heading the following:

“**Subpart I—General Grant Provisions**”; and

(2) by adding at the end the following:

“**Subpart II—Transitional Grants**

“**SEC. 2609. ESTABLISHMENT OF PROGRAM.**

“(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall make grants for the purpose of providing services described in section 2604 in transitional areas, subject to the same provisions regarding the allocation of grant funds as apply under subsection (c) of such section.

“(b) TRANSITIONAL AREAS.—For purposes of this section, the term ‘transitional area’ means, subject to subsection (c), a metropolitan area for which there has been reported to and confirmed by the Director of the Centers for Disease Control and Prevention a cumulative total of at least 1,000, but fewer than 2,000, cases of AIDS during the most recent period of 5 calendar years for which such data are available.

“(c) CERTAIN ELIGIBILITY RULES.—

“(1) FISCAL YEAR 2007.—With respect to grants under subsection (a) for fiscal year 2007, a metropolitan area that received funding under subpart I for fiscal year 2006 but does not for fiscal year 2007 qualify under such subpart as an eligible area and does not qualify under subsection (b) as a transitional area shall, notwithstanding subsection (b), be considered a transitional area.

“(2) CONTINUED STATUS AS TRANSITIONAL AREA.—

“(A) IN GENERAL.—Notwithstanding subsection (b), a metropolitan area that is a transitional area for a fiscal year continues, except as provided in subparagraph (B), to be a transitional area until the metropolitan area fails, for three consecutive fiscal years—

“(i) to qualify under such subsection as a transitional area; and

“(ii) to have a cumulative total of 1,500 or more living cases of AIDS (reported to and confirmed by the Director of the Centers for Disease Control and Prevention) as of December 31 of the most recent calendar year for which such data are available.

“(B) EXCEPTION REGARDING STATUS AS ELIGIBLE AREA.—Subparagraph (A) does not

apply for a fiscal year if the metropolitan area involved qualifies under subpart I as an eligible area.

“(d) APPLICATION OF CERTAIN PROVISIONS OF SUBPART I.—

“(1) ADMINISTRATION; PLANNING COUNCIL.—

“(A) IN GENERAL.—The provisions of section 2602 apply with respect to a grant under subsection (a) for a transitional area to the same extent and in the same manner as such provisions apply with respect to a grant under subpart I for an eligible area, except that, subject to subparagraph (B), the chief elected official of the transitional area may elect not to comply with the provisions of section 2602(b) if the official provides documentation to the Secretary that details the process used to obtain community input (particularly from those with HIV) in the transitional area for formulating the overall plan for priority setting and allocating funds from the grant under subsection (a).

“(B) EXCEPTION.—For each of the fiscal years 2007 through 2009, the exception described in subparagraph (A) does not apply if the transitional area involved received funding under subpart I for fiscal year 2006.

“(2) TYPE AND DISTRIBUTION OF GRANTS; TIMEFRAME FOR OBLIGATION AND EXPENDITURE OF GRANT FUNDS.—

“(A) FORMULA GRANTS; SUPPLEMENTAL GRANTS.—The provisions of section 2603 apply with respect to grants under subsection (a) to the same extent and in the same manner as such provisions apply with respect to grants under subpart I, subject to subparagraphs (B) and (C).

“(B) FORMULA GRANTS; INCREASE IN GRANT.—For purposes of subparagraph (A), section 2603(a)(4) does not apply.

“(C) SUPPLEMENTAL GRANTS; SINGLE PROGRAM WITH SUBPART I PROGRAM.—With respect to section 2603(b) as applied for purposes of subparagraph (A):

“(i) The Secretary shall combine amounts available pursuant to such subparagraph with amounts available for carrying out section 2603(b) and shall administer the two programs as a single program.

“(ii) In the single program, the Secretary has discretion in allocating amounts between eligible areas under subpart I and transitional areas under this section, subject to the eligibility criteria that apply under such section, and subject to section 2603(b)(2)(C) (relating to priority in making grants).

“(iii) Pursuant to section 2603(b)(1), amounts for the single program are subject to use under sections 2603(a)(4) and 2610(d)(1).

“(3) APPLICATION; TECHNICAL ASSISTANCE; DEFINITIONS.—The provisions of sections 2605, 2606, and 2607 apply with respect to grants under subsection (a) to the same extent and in the same manner as such provisions apply with respect to grants under subpart I.”

(b) CONFORMING AMENDMENTS.—Subpart I of part A of title XXVI of the Public Health Service Act, as designated by subsection (a)(1) of this section, is amended by striking “this part” each place such term appears and inserting “this subpart”.

SEC. 108. AUTHORIZATION OF APPROPRIATIONS FOR PART A.

Part A of title XXVI of the Public Health Service Act, as amended by section 106(a), is amended by adding at the end the following:

“Subpart III—General Provisions

“SEC. 2610. AUTHORIZATION OF APPROPRIATIONS.

“(a) IN GENERAL.—For the purpose of carrying out this part, there are authorized to be appropriated \$604,000,000 for fiscal year 2007, \$626,300,000 for fiscal year 2008, \$649,500,000 for fiscal year 2009, \$673,600,000 for fiscal year 2010, and \$698,500,000 for fiscal year 2011. Amounts appropriated under the

preceding sentence for a fiscal year are available for obligation by the Secretary until the end of the second succeeding fiscal year.

“(b) RESERVATION OF AMOUNTS.—

“(1) FISCAL YEAR 2007.—Of the amount appropriated under subsection (a) for fiscal year 2007, the Secretary shall reserve—

“(A) \$458,310,000 for grants under subpart I; and

“(B) \$145,690,000 for grants under section 2609.

“(2) SUBSEQUENT FISCAL YEARS.—Of the amount appropriated under subsection (a) for fiscal year 2008 and each subsequent fiscal year—

“(A) the Secretary shall reserve an amount for grants under subpart I; and

“(B) the Secretary shall reserve an amount for grants under section 2609.

“(c) TRANSFER OF CERTAIN AMOUNTS; CHANGE IN STATUS AS ELIGIBLE AREA OR TRANSITIONAL AREA.—Notwithstanding subsection (b):

“(1) If a metropolitan area is an eligible area under subpart I for a fiscal year, but for a subsequent fiscal year ceases to be an eligible area by reason of section 2601(b)—

“(A)(i) the amount reserved under paragraph (1)(A) or (2)(A) of subsection (b) of this section for the first such subsequent year of not being an eligible area is deemed to be reduced by an amount equal to the amount of the grant made pursuant to section 2603(a) for the metropolitan area for the preceding fiscal year; and

“(ii)(I) if the metropolitan area qualifies for such first subsequent fiscal year as a transitional area under 2609, the amount reserved under paragraph (1)(B) or (2)(B) of subsection (b) for such fiscal year is deemed to be increased by an amount equal to the amount of the reduction under subparagraph (A) for such year; or

“(II) if the metropolitan area does not qualify for such first subsequent fiscal year as a transitional area under 2609, an amount equal to the amount of such reduction is, notwithstanding subsection (a), transferred and made available for grants pursuant to section 2618(a)(1), in addition to amounts available for such grants under section 2623; and

“(B) if a transfer under subparagraph (A)(ii)(II) is made with respect to the metropolitan area for such first subsequent fiscal year, then—

“(i) the amount reserved under paragraph (1)(A) or (2)(A) of subsection (b) of this section for such year is deemed to be reduced by an additional \$500,000; and

“(ii) an amount equal to the amount of such additional reduction is, notwithstanding subsection (a), transferred and made available for grants pursuant to section 2618(a)(1), in addition to amounts available for such grants under section 2623.

“(2) If a metropolitan area is a transitional area under section 2609 for a fiscal year, but for a subsequent fiscal year ceases to be a transitional area by reason of section 2609(c)(2) (and does not qualify for such subsequent fiscal year as an eligible area under subpart I)—

“(A) the amount reserved under subsection (b)(2)(B) of this section for the first such subsequent fiscal year of not being a transitional area is deemed to be reduced by an amount equal to the total of—

“(i) the amount of the grant that, pursuant to section 2603(a), was made under section 2609(d)(2)(A) for the metropolitan area for the preceding fiscal year; and

“(ii) \$500,000; and

“(B) an amount equal to the amount of the reduction under subparagraph (A) for such year is, notwithstanding subsection (a), transferred and made available for grants

pursuant to section 2618(a)(1), in addition to amounts available for such grants under section 2623.

“(3) If a metropolitan area is a transitional area under section 2609 for a fiscal year, but for a subsequent fiscal year qualifies as an eligible area under subpart I—

“(A) the amount reserved under subsection (b)(2)(B) of this section for the first such subsequent fiscal year of becoming an eligible area is deemed to be reduced by an amount equal to the amount of the grant that, pursuant to section 2603(a), was made under section 2609(d)(2)(A) for the metropolitan area for the preceding fiscal year; and

“(B) the amount reserved under subsection (b)(2)(A) for such fiscal year is deemed to be increased by an amount equal to the amount of the reduction under subparagraph (A) for such year.

“(d) CERTAIN TRANSFERS; ALLOCATIONS BETWEEN PROGRAMS UNDER SUBPART I.—With respect to paragraphs (1)(B)(i) and (2)(A)(ii) of subsection (c), the Secretary shall administer any reductions under such paragraphs for a fiscal year in accordance with the following:

“(1) The reductions shall be made from amounts available for the single program referred to in section 2609(d)(2)(C) (relating to supplemental grants).

“(2) The reductions shall be made before the amounts referred to in paragraph (1) are used for purposes of section 2603(a)(4).

“(3) If the amounts referred to in paragraph (1) are not sufficient for making all the reductions, the reductions shall be reduced until the total amount of the reductions equals the total of the amounts referred to in such paragraph.

“(e) RULES OF CONSTRUCTION REGARDING FIRST SUBSEQUENT FISCAL YEAR.—Paragraphs (1) and (2) of subsection (c) apply with respect to each series of fiscal years during which a metropolitan area is an eligible area under subpart I or a transitional area under section 2609 for a fiscal year and then for a subsequent fiscal year ceases to be such an area by reason of section 2601(b) or 2609(c)(2), respectively, rather than applying to a single such series. Paragraph (3) of subsection (c) applies with respect to each series of fiscal years during which a metropolitan area is a transitional area under section 2609 for a fiscal year and then for a subsequent fiscal year becomes an eligible area under subpart I, rather than applying to a single such series.”

TITLE II—CARE GRANTS

SEC. 201. GENERAL USE OF GRANTS.

(a) IN GENERAL.—Section 2612 of the Public Health Service Act (42 U.S.C. 300ff-22) is amended to read as follows:

“SEC. 2612. GENERAL USE OF GRANTS.

“(a) IN GENERAL.—A State may use amounts provided under grants made under section 2611 for—

“(1) core medical services described in subsection (b);

“(2) support services described in subsection (c); and

“(3) administrative expenses described in section 2618(b)(3).

“(b) REQUIRED FUNDING FOR CORE MEDICAL SERVICES.—

“(1) IN GENERAL.—With respect to a grant under section 2611 for a State for a grant year, the State shall, of the portion of the grant remaining after reserving amounts for purposes of subparagraphs (A) and (E)(ii)(I) of section 2618(b)(3), use not less than 75 percent to provide core medical services that are needed in the State for individuals with HIV/AIDS who are identified and eligible under this title (including services regarding the co-occurring conditions of the individuals).

“(2) WAIVER.—

“(A) IN GENERAL.—The Secretary shall waive the application of paragraph (1) with respect to a State for a grant year if the Secretary determines that, within the State—

“(i) there are no waiting lists for AIDS Drug Assistance Program services under section 2616; and

“(ii) core medical services are available to all individuals with HIV/AIDS identified and eligible under this title.

“(B) NOTIFICATION OF WAIVER STATUS.—When informing a State that a grant under section 2611 is being made to the State for a fiscal year, the Secretary shall inform the State whether a waiver under subparagraph (A) is in effect for the fiscal year.

“(3) CORE MEDICAL SERVICES.—For purposes of this subsection, the term ‘core medical services’, with respect to an individual infected with HIV/AIDS (including the co-occurring conditions of the individual) means the following services:

“(A) Outpatient and ambulatory health services.

“(B) AIDS Drug Assistance Program treatments in accordance with section 2616.

“(C) AIDS pharmaceutical assistance.

“(D) Oral health care.

“(E) Early intervention services described in subsection (d).

“(F) Health insurance premium and cost sharing assistance for low-income individuals in accordance with section 2615.

“(G) Home health care.

“(H) Medical nutrition therapy.

“(I) Hospice services.

“(J) Home and community-based health services as defined under section 2614(c).

“(K) Mental health services.

“(L) Substance abuse outpatient care.

“(M) Medical case management, including treatment adherence services.

“(c) SUPPORT SERVICES.—

“(1) IN GENERAL.—For purposes of this subsection, the term ‘support services’ means services, subject to the approval of the Secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services).

“(2) DEFINITION OF MEDICAL OUTCOMES.—In this subsection, the term ‘medical outcomes’ means those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

“(d) EARLY INTERVENTION SERVICES.—

“(1) IN GENERAL.—For purposes of this section, the term ‘early intervention services’ means HIV/AIDS early intervention services described in section 2651(e), with follow-up referral provided for the purpose of facilitating the access of individuals receiving the services to HIV-related health services. The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV/AIDS counseling and testing sites, health care points of entry specified by States, federally qualified health centers, and entities described in section 2652(a) that constitute a point of access to services by maintaining referral relationships.

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

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

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

“(e) PRIORITY FOR WOMEN, INFANTS, CHILDREN, AND YOUTH.—

“(1) IN GENERAL.—For the purpose of providing health and support services to infants, children, youth, and women with HIV/AIDS, including treatment measures to prevent the perinatal transmission of HIV, a State shall for each of such populations in the eligible area use, from the grants made for the area under section 2601(a) for a fiscal year, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS.

“(2) WAIVER.—With respect to the population involved, the Secretary may provide to a State a waiver of the requirement of paragraph (1) if such State demonstrates to the satisfaction of the Secretary that the population is receiving HIV-related health services through the State Medicaid program under title XIX of the Social Security Act, the State children’s health insurance program under title XXI of such Act, or other Federal or State programs.

“(f) CONSTRUCTION.—A State may not use amounts received under a grant awarded under section 2611 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.”

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

(1) in subsection (a), in the matter preceding paragraph (1)—

(A) by striking “may use” and inserting “may, subject to subsection (f), use”; and

(B) by striking “section 2612(a)(1)” and inserting “section 2612(a)”;

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

“(f) ALLOCATION OF FUNDS; TREATMENT AS SUPPORT SERVICES.—For purposes of the requirement of section 2612(b)(1), expenditures of grants under section 2611 for or through consortia under this section are deemed to be support services, not core medical services. The preceding sentence may not be construed as having any legal effect on the provisions of subsection (a) that relate to authorized expenditures of the grant.”

(c) TECHNICAL AMENDMENTS.—Part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-21 et seq.) is amended—

(1) in section 2611—

(A) in subsection (a), by striking the subsection designation and heading; and

(B) by striking subsection (b);

(2) in section 2614—

(A) in subsection (a), in the matter preceding paragraph (1), by striking “section 2612(a)(2)” and inserting “section 2612(b)(3)(J)”; and

(B) in subsection (c)(2)(B), by striking “homemaker or”;

(3) in section 2615(a) by striking “section 2612(a)(3)” and inserting “section 2612(b)(3)(F)”; and

(4) in section 2616(a) by striking “section 2612(a)(5)” and inserting “section 2612(b)(3)(B)”.

SEC. 202. AIDS DRUG ASSISTANCE PROGRAM.

(a) REQUIREMENT OF MINIMUM DRUG LIST.—Section 2616 of the Public Health Service Act (42 U.S.C. 300ff-26) is amended—

(1) in subsection (c), by striking paragraph (1) and inserting the following:

“(1) ensure that the therapeutics included on the list of classes of core antiretroviral therapeutics established by the Secretary under subsection (e) are, at a minimum, the treatments provided by the State pursuant to this section;”;

(2) by redesignating subsection (e) as subsection (f); and

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

“(e) LIST OF CLASSES OF CORE ANTIRETROVIRAL THERAPEUTICS.—For purposes of subsection (c)(1), the Secretary shall develop and maintain a list of classes of core antiretroviral therapeutics, which list shall be based on the therapeutics included in the guidelines of the Secretary known as the Clinical Practice Guidelines for Use of HIV/AIDS Drugs, relating to drugs needed to manage symptoms associated with HIV. The preceding sentence does not affect the authority of the Secretary to modify such Guidelines.”

(b) DRUG REBATE PROGRAM.—Section 2616 of the Public Health Service Act, as amended by subsection (a)(2) of this section, is amended by adding at the end the following:

“(g) DRUG REBATE PROGRAM.—A State shall ensure that any drug rebates received on drugs purchased from funds provided pursuant to this section are applied to activities supported under this subpart, with priority given to activities described under this section.”

SEC. 203. DISTRIBUTION OF FUNDS.

(a) DISTRIBUTION BASED ON LIVING CASES OF HIV/AIDS.—

(1) STATE DISTRIBUTION FACTOR.—Section 2618(a)(2) of the Public Health Service Act (42 U.S.C. 300ff-28(a)(2)) is amended—

(A) in subparagraph (B), by striking “estimated number of living cases of acquired immune deficiency syndrome in the eligible area involved” and inserting “number of living cases of HIV/AIDS in the State involved”; and

(B) by amending subparagraph (D) to read as follows:

“(D) LIVING CASES OF HIV/AIDS.—

“(i) REQUIREMENT OF NAMES-BASED REPORTING.—Except as provided in clause (ii), the number determined under this subparagraph for a State for a fiscal year for purposes of subparagraph (B) is the number of living names-based cases of HIV/AIDS in the State that, as of December 31 of the most recent calendar year for which such data is available, have been reported to and confirmed by the Director of the Centers for Disease Control and Prevention.

“(ii) TRANSITION PERIOD; EXEMPTION REGARDING NON-AIDS CASES.—For each of the fiscal years 2007 through 2010, a State is, subject to clauses (iii) through (v), exempt from the requirement under clause (i) that living non-AIDS names-based cases of HIV be reported unless—

“(I) a system was in operation as of December 31, 2005, that provides sufficiently accurate and reliable names-based reporting of such cases throughout the State, subject to clause (vii); or

“(II) no later than the beginning of fiscal year 2008, 2009, or 2010, the Secretary, after consultation with the chief executive of the State, determines that a system has become operational in the State that provides sufficiently accurate and reliable names-based reporting of such cases throughout the State.

“(iii) REQUIREMENTS FOR EXEMPTION FOR FISCAL YEAR 2007.—For fiscal year 2007, an exemption under clause (ii) for a State applies only if, by October 1, 2006—

“(I)(aa) the State had submitted to the Secretary a plan for making the transition

to sufficiently accurate and reliable names-based reporting of living non-AIDS cases of HIV; or

“(bb) all statutory changes necessary to provide for sufficiently accurate and reliable reporting of such cases had been made; and

“(II) the State had agreed that, by April 1, 2008, the State will begin accurate and reliable names-based reporting of such cases, except that such agreement is not required to provide that, as of such date, the system for such reporting be fully sufficient with respect to accuracy and reliability throughout the area.

“(iv) REQUIREMENT FOR EXEMPTION AS OF FISCAL YEAR 2008.—For each of the fiscal years 2008 through 2010, an exemption under clause (ii) for a State applies only if, as of April 1, 2008, the State is substantially in compliance with the agreement under clause (iii)(II).

“(v) PROGRESS TOWARD NAMES-BASED REPORTING.—For fiscal year 2009 or 2010, the Secretary may terminate an exemption under clause (ii) for a State if the State submitted a plan under clause (iii)(I)(aa) and the Secretary determines that the State is not substantially following the plan.

“(vi) COUNTING OF CASES IN AREAS WITH EXEMPTIONS.—

“(I) IN GENERAL.—With respect to a State that is under a reporting system for living non-AIDS cases of HIV that is not names-based (referred to in this subparagraph as ‘code-based reporting’), the Secretary shall, for purposes of this subparagraph, modify the number of such cases reported for the State in order to adjust for duplicative reporting in and among systems that use code-based reporting.

“(II) ADJUSTMENT RATE.—The adjustment rate under subclause (I) for a State shall be a reduction of 5 percent in the number of living non-AIDS cases of HIV reported for the State.

“(vii) LIST OF STATES MEETING STANDARD REGARDING DECEMBER 31, 2005.—

“(I) IN GENERAL.—If a State is specified in subclause (II), the State shall be considered to meet the standard described in clause (ii)(I). No other State may be considered to meet such standard.

“(II) RELEVANT STATES.—For purposes of subclause (I), the States specified in this subclause are the following: Alaska, Alabama, Arkansas, Arizona, Colorado, Florida, Indiana, Iowa, Idaho, Kansas, Louisiana, Michigan, Minnesota, Missouri, Mississippi, North Carolina, North Dakota, Nebraska, New Jersey, New Mexico, New York, Nevada, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, West Virginia, Wyoming, Guam, and the Virgin Islands.

“(viii) RULES OF CONSTRUCTION REGARDING ACCEPTANCE OF REPORTS.—

“(I) CASES OF AIDS.—With respect to a State that is subject to the requirement under clause (i) and is not in compliance with the requirement for names-based reporting of living non-AIDS cases of HIV, the Secretary shall, notwithstanding such non-compliance, accept reports of living cases of AIDS that are in accordance with such clause.

“(II) APPLICABILITY OF EXEMPTION REQUIREMENTS.—The provisions of clauses (ii) through (vii) may not be construed as having any legal effect for fiscal year 2011 or any subsequent fiscal year, and accordingly, the status of a State for purposes of such clauses may not be considered after fiscal year 2010.

“(ix) PROGRAM FOR DETECTING INACCURATE OR FRAUDULENT COUNTING.—The Secretary shall carry out a program to monitor the reporting of names-based cases for purposes of this subparagraph and to detect instances of

inaccurate reporting, including fraudulent reporting.”.

(2) NON-EMA DISTRIBUTION FACTOR.—Section 2618(a)(2)(C) of the Public Health Service Act (42 U.S.C. 300ff-28(a)(2)(C)) is amended—

(A) in clause (i), by striking “estimated number of living cases of acquired immune deficiency syndrome” each place such term appears and inserting “number of living cases of HIV/AIDS”; and

(B) in clause (ii), by amending such clause to read as follows:

“(ii) a number equal to the sum of—

(I) the total number of living cases of HIV/AIDS that are within areas in such State that are eligible areas under subpart I of part A for the fiscal year involved, which individual number for an area is the number that applies under section 2601 for the area for such fiscal year; and

(II) the total number of such cases that are within areas in such State that are transitional areas under section 2609 for such fiscal year, which individual number for an area is the number that applies under such section for the fiscal year.”.

(b) FORMULA AMENDMENTS GENERALLY.—Section 2618(a)(2) of the Public Health Service Act (42 U.S.C. 300ff-28(a)(2)) is amended—

(1) in subparagraph (A)—

(A) by striking “The amount referred to” in the matter preceding clause (i) and all that follows through the end of clause (i) and inserting the following: “For purposes of paragraph (1), the amount referred to in this paragraph for a State (including a territory) for a fiscal year is, subject to subparagraphs (E) and (F)—

“(i) an amount equal to the amount made available under section 2623 for the fiscal year involved for grants pursuant to paragraph (1), subject to subparagraph (G); and”;

(B) in clause (ii)—

(i) in subclause (I)—

(I) by striking “.80” and inserting “.75”;

and

(II) by striking “and” at the end;

(ii) in subclause (II)—

(I) by inserting “non-EMA” after “respective”; and

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

(iii) by adding at the end the following:

“(III) if the State does not for such fiscal year contain any area that is an eligible area under subpart I of part A or any area that is a transitional area under section 2609 (referred to in this subclause as a ‘no-EMA State’), the product of 0.05 and the ratio of the number of cases that applies for the State under subparagraph (D) to the sum of the respective numbers of cases that so apply for all no-EMA States.”;

(2) by striking subparagraphs (E) through (H);

(3) by inserting after subparagraph (D) the following subparagraphs:

“(E) CODE-BASED STATES; LIMITATION ON INCREASE IN GRANT.—

“(i) IN GENERAL.—For each of the fiscal years 2007 through 2010, if code-based reporting (within the meaning of subparagraph (D)(vi)) applies in a State as of the beginning of the fiscal year involved, then notwithstanding any other provision of this paragraph, the amount of the grant pursuant to paragraph (1) for the State may not for the fiscal year involved exceed by more than 5 percent the amount of the grant pursuant to this paragraph for the State for the preceding fiscal year, except that the limitation under this clause may not result in a grant pursuant to paragraph (1) for a fiscal year that is less than the minimum amount that applies to the State under such paragraph for such fiscal year.

“(ii) USE OF AMOUNTS INVOLVED.—For each of the fiscal years 2007 through 2010, amounts available as a result of the limitation under clause (i) shall be made available by the Secretary as additional amounts for grants pursuant to section 2620, subject to subparagraph (H).

“(F) SEVERITY OF NEED.—

“(i) FISCAL YEARS BEGINNING WITH 2011.—If, by January 1, 2010, the Secretary notifies the appropriate committees of Congress that the Secretary has developed a severity of need index in accordance with clause (v), the provisions of subparagraphs (A) through (E) shall not apply for fiscal year 2011 or any fiscal year thereafter, and the Secretary shall use the severity of need index (as defined in clause (iv)) for the determination of the formula allocations, subject to the Congressional Review Act.

“(ii) SUBSEQUENT FISCAL YEARS.—If, on or before any January 1 that is subsequent to the date referred to in clause (i), the Secretary notifies the appropriate committees of Congress that the Secretary has developed a severity of need index, in accordance with clause (v), for each succeeding fiscal year, the provisions of subparagraphs (A) through (D) shall not apply for the subsequent fiscal year or any fiscal year thereafter, and the Secretary shall use the severity of need index (as defined in clause (iv)) for the determination of the formula allocations, subject to the Congressional Review Act.

“(iii) FISCAL YEAR 2013.—The Secretary shall notify the appropriate committees of Congress that the Secretary has developed a severity of need index by January 1, 2012, in accordance with clause (v), and the provisions of subparagraphs (A) through (D) shall not apply for fiscal year 2013 or any fiscal year thereafter, and the Secretary shall use the severity of need index (as defined in clause (iv)) for the determination of the formula allocations, subject to the Congressional Review Act.

“(iv) DEFINITION OF SEVERITY OF NEED INDEX.—In this subparagraph, the term ‘severity of need index’ means the index of the relative needs of individuals within the State, as identified by a variety of different factors, and is a factor that is multiplied by the number of living HIV/AIDS cases in the State, providing different weights to those cases based on their needs.

“(v) REQUIREMENTS FOR SECRETARIAL NOTIFICATION.—When the Secretary notifies the appropriate committees of Congress that the Secretary has developed a severity of need index, the Secretary shall provide the following:

“(I) Methodology for and rationale behind developing the severity of need index, including information related to the field testing of the severity of need index.

“(II) An independent contractor analysis of activities carried out under subclause (I).

“(III) Expected changes in funding allocations, given the application of the severity of need index and the elimination of the provisions of subparagraphs (A) through (D).

“(IV) Information regarding the process by which the Secretary received community input regarding the application and development of the severity of need index.

“(V) Timeline and process for the implementation of the severity of need index to ensure that it is applied in the following fiscal year.

“(vi) ANNUAL REPORTS.—Not later than 1 year after the date of enactment of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, and annually thereafter until the Secretary notifies Congress that the Secretary has developed a severity of need index in accordance with this subparagraph, the Secretary shall prepare and submit to the

appropriate committees of Congress a report—

“(I) that updates progress toward having client level data;

“(II) that updates the progress toward having a severity of need index, including information related to the methodology and process for obtaining community input; and

“(III) that, as applicable, states whether the Secretary could develop a severity of need index before fiscal year 2010.”; and

(4) by redesignating subparagraph (I) as subparagraph (G).

(c) SEPARATE ADAP GRANTS.—Section 2618(a)(2)(G) of the Public Health Service Act (42 U.S.C. 300ff-28(a)(2)(G)), as redesignated by subsection (b)(4) of this section, is amended—

(1) in clause (i)—

(A) in the matter preceding subclause (I), by striking “section 2677” and inserting “section 2623”;

(B) in subclause (II), by striking the period at the end and inserting a semicolon; and

(C) by adding after and below subclause (II) the following:

“which product shall then, as applicable, be increased under subparagraph (H).”;

(2) in clause (ii)—

(A) by striking subclauses (I) through (III) and inserting the following:

“(I) IN GENERAL.—From amounts made available under subclause (V), the Secretary shall award supplemental grants to States described in subclause (II) to enable such States to purchase and distribute to eligible individuals under section 2616(b) pharmaceutical therapeutics described under subsections (c)(2) and (e) of such section.

“(II) ELIGIBLE STATES.—For purposes of subclause (I), a State shall be an eligible State if the State did not have unobligated funds subject to reallocation under section 2618(d) in the previous fiscal year and, in accordance with criteria established by the Secretary, demonstrates a severe need for a grant under this clause. For purposes of determining severe need, the Secretary shall consider eligibility standards, formulary composition, the number of eligible individuals to whom a State is unable to provide therapeutics described in section 2616(a), and an unanticipated increase of eligible individuals with HIV/AIDS.

“(III) STATE REQUIREMENTS.—The Secretary may not make a grant to a State under this clause unless the State agrees that the State will make available (directly or through donations of 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, except that the Secretary may waive this subclause if the State has otherwise fully complied with section 2617(d) with respect to the grant year involved. The provisions of this subclause shall apply to States that are not required to comply with such section 2617(d).”.

(B) in subclause (IV), by moving the subclause two ems to the left;

(C) in subclause (V), by striking “3 percent” and inserting “5 percent”; and

(D) by striking subclause (VI); and

(3) by adding at the end the following clause:

“(iii) CODE-BASED STATES; LIMITATION ON INCREASE IN FORMULA GRANT.—The limitation under subparagraph (E)(i) applies to grants pursuant to clause (i) of this subparagraph to the same extent and in the same manner as such limitation applies to grants pursuant to paragraph (1), except that the reference to minimum grants does not apply for purposes of this clause. Amounts available as a result of the limitation under the preceding sentence shall be made available by the Sec-

retary as additional amounts for grants under clause (ii) of this subparagraph.”.

(d) HOLD HARMLESS.—Section 2618(a)(2) of the Public Health Service Act (42 U.S.C. 300ff-28(a)(2)), as amended by subsection (b)(4) of this section, is amended by adding at the end the following subparagraph:

“(H) INCREASE IN FORMULA GRANTS.—

“(i) IN GENERAL.—For each of the fiscal years 2007 through 2009, the Secretary shall ensure, subject to clauses (ii) through (iv), that the total for a State of the grant pursuant to paragraph (1) and the grant pursuant to subparagraph (G) is not less than 95 percent of such total for the State for the preceding fiscal year, except that any increase under this clause—

“(I) may not result in a grant pursuant to paragraph (1) that is more than 95 percent of the amount of such grant for the preceding fiscal year; and

“(II) may not result in a grant pursuant to subparagraph (G) that is more than 95 percent of the amount of such grant for such preceding fiscal year.

“(ii) FISCAL YEAR 2007.—For purposes of clause (i) as applied for fiscal year 2007, the references in such clause to subparagraph (G) are deemed to be references to subparagraph (I) as such subparagraph was in effect for fiscal year 2006.

“(iii) SOURCE OF FUNDS FOR INCREASE.—

“(I) IN GENERAL.—From the amount reserved under section 2623(b)(2) for a fiscal year, and from amounts available for such section pursuant to subsection (d) of this section, the Secretary shall make available such amounts as may be necessary to comply with clause (i).

“(II) PRO RATA REDUCTION.—If the amounts referred to in subclause (I) for a fiscal year are insufficient to fully comply with clause (i) for the year, the Secretary, in order to provide the additional funds necessary for such compliance, shall reduce on a pro rata basis the amount of each grant pursuant to paragraph (1) for the fiscal year, other than grants for States for which increases under clause (i) apply and other than States described in paragraph (1)(A)(i)(I). A reduction under the preceding sentence may not be made in an amount that would result in the State involved becoming eligible for such an increase.

“(iv) APPLICABILITY.—This paragraph may not be construed as having any applicability after fiscal year 2009.”.

(e) ADMINISTRATIVE EXPENSES; CLINICAL QUALITY MANAGEMENT.—Section 2618(b) of the Public Health Service Act (42 U.S.C. 300ff-28(b)) is amended—

(1) by redesignating paragraphs (2) through (7) as paragraphs (1) through (6);

(2) in paragraph (2) (as so redesignated)—

(A) by striking “paragraph (5)” and inserting “paragraph (4)”; and

(B) by striking “paragraph (6)” and inserting “paragraph (5)”; and

(3) in paragraph (3) (as so redesignated)—

(A) by amending subparagraph (A) to read as follows:

“(A) IN GENERAL.—Subject to paragraph (4), and except as provided in paragraph (5), a State may not use more than 10 percent of amounts received under a grant awarded under section 2611 for administration.”;

(B) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D), respectively;

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

“(B) ALLOCATIONS.—In the case of entities and subcontractors to which a State allocates amounts received by the State under a grant under section 2611, the State shall ensure that, of the aggregate amount so allocated, the total of the expenditures by such entities for administrative expenses does not

exceed 10 percent (without regard to whether particular entities expend more than 10 percent for such expenses).”;

(D) in subparagraph (C) (as so redesignated), by inserting before the period the following: “, including a clinical quality management program under subparagraph (E)”; and

(E) by adding at the end the following:

“(E) CLINICAL QUALITY MANAGEMENT.—

“(i) REQUIREMENT.—Each State that receives a grant under section 2611 shall provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

“(ii) USE OF FUNDS.—

“(I) IN GENERAL.—From amounts received under a grant awarded under section 2611 for a fiscal year, a State may use for activities associated with the clinical quality management program required in clause (i) not to exceed the lesser of—

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

“(bb) \$3,000,000.

“(II) RELATION TO LIMITATION ON ADMINISTRATIVE EXPENSES.—The costs of a clinical quality management program under clause (i) may not be considered administrative expenses for purposes of the limitation established in subparagraph (A).”;

(4) in paragraph (4) (as so redesignated)—

(A) by striking “paragraph (6)” and inserting “paragraph (5)”; and

(B) by striking “paragraphs (3) and (4)” and inserting “paragraphs (2) and (3)”; and

(5) in paragraph (5) (as so redesignated), by striking “paragraphs (3)” and all that follows through “(5),” and inserting the following: “paragraphs (2) and (3), may, notwithstanding paragraphs (2) through (4),”.

(f) REALLOCATION FOR SUPPLEMENTAL GRANTS.—Section 2618(d) of the Public Health Service Act (42 U.S.C. 300ff-28(d)) is amended to read as follows:

“(d) REALLOCATION.—Any portion of a grant made to a State under section 2611 for a fiscal year that has not been obligated as described in subsection (c) ceases to be available to the State and shall be made available by the Secretary for grants under section 2620, in addition to amounts made available for such grants under section 2623(b)(2).”.

(g) DEFINITIONS; OTHER TECHNICAL AMENDMENTS.—Section 2618(a) of the Public Health Service Act (42 U.S.C. 300ff-28(a)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking “section 2677” and inserting “section 2623”;

(2) in paragraph (1)(A)—

(A) in the matter preceding clause (i), by striking “each of the several States and the District of Columbia” and inserting “each of the 50 States, the District of Columbia, Guam, and the Virgin Islands (referred to in this paragraph as a ‘covered State’)”; and

(B) in clause (i)—

(i) in subclause (I), by striking “State or District” and inserting “covered State”; and

(ii) in subclause (II)—

(I) by striking “State or District” and inserting “covered State”; and

(II) by inserting “and” after the semicolon; and

(3) in paragraph (1)(B), by striking “each territory of the United States, as defined in paragraph (3),” and inserting “each territory other than Guam and the Virgin Islands”;

(4) in paragraph (2)(C)(i), by striking “or territory”; and

(5) by striking paragraph (3).

SEC. 204. ADDITIONAL AMENDMENTS TO SUBPART I OF PART B.

(a) REFERENCES TO PART B.—Subpart I of part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-21 et seq.) is amended by striking “this part” each place such term appears and inserting “section 2611”.

(b) HEPATITIS.—Section 2614(a)(3) of the Public Health Service Act (42 U.S.C. 300ff-24(a)(3)) is amended by inserting “, including specialty care and vaccinations for hepatitis co-infection,” after “health services”.

(c) APPLICATION FOR GRANT.—

(1) COORDINATION.—Section 2617(b) of the Public Health Service Act (42 U.S.C. 300ff-27(b)) is amended—

(A) by redesignating paragraphs (4) through (6) as paragraphs (5) through (7), respectively;

(B) by inserting after paragraph (3), the following:

“(4) the designation of a lead State agency that shall—

“(A) administer all assistance received under this part;

“(B) conduct the needs assessment and prepare the State plan under paragraph (3);

“(C) prepare all applications for assistance under this part;

“(D) receive notices with respect to programs under this title;

“(E) every 2 years, collect and submit to the Secretary all audits, consistent with Office of Management and Budget circular A133, from grantees within the State, including audits regarding funds expended in accordance with this part; and

“(F) carry out any other duties determined appropriate by the Secretary to facilitate the coordination of programs under this title.”;

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

(i) in subparagraph (E), by striking “and” at the end; and

(ii) by inserting after subparagraph (F) the following:

“(G) includes key outcomes to be measured by all entities in the State receiving assistance under this title; and”;

(D) in paragraph (7) (as so redesignated), in subparagraph (A)—

(i) by striking “paragraph (5)” and inserting “paragraph (6)”;

(ii) by striking “paragraph (4)” and inserting “paragraph (5)”.

(2) NATIVE AMERICAN REPRESENTATION.—Section 2617(b)(6) of the Public Health Service Act, as redesignated by paragraph (1)(A) of this subsection, is amended by inserting before “representatives of grantees” the following: “members of a Federally recognized Indian tribe as represented in the State.”.

(3) PAYER OF LAST RESORT.—Section 2617(b)(7)(F)(ii) of the Public Health Service Act, as redesignated by paragraph (1)(A) of this subsection, is amended by inserting before the semicolon the following: “(except for a program administered by or providing the services of the Indian Health Service)”.

(d) MATCHING FUNDS; APPLICABILITY OF REQUIREMENT.—Section 2617(d)(3) of the Public Health Service Act (42 U.S.C. 300ff-27(d)(3)) is amended—

(1) in subparagraph (A), by striking “acquired immune deficiency syndrome” and inserting “HIV/AIDS”; and

(2) in subparagraph (C), by striking “acquired immune deficiency syndrome” and inserting “HIV/AIDS”.

SEC. 205. SUPPLEMENTAL GRANTS ON BASIS OF DEMONSTRATED NEED.

Subpart I of part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-21 et seq.) is amended—

(1) by redesignating section 2620 as section 2621; and

(2) by inserting after section 2619 the following:

“SEC. 2620. SUPPLEMENTAL GRANTS.

“(a) IN GENERAL.—For the purpose of providing services described in section 2612(a), the Secretary shall make grants to States—

“(1) whose applications under section 2617 have demonstrated the need in the State, on an objective and quantified basis, for supplemental financial assistance to provide such services; and

“(2) that did not, for the most recent grant year pursuant to section 2618(a)(1) or 2618(a)(2)(G)(i) for which data is available, have more than 2 percent of grant funds under such sections canceled or covered by any waivers under section 2622(c).

“(b) DEMONSTRATED NEED.—The factors considered by the Secretary in determining whether an eligible area has a demonstrated need for purposes of subsection (a)(1) may include any or all of the following:

“(1) The unmet need for such services, as determined under section 2617(b).

“(2) An increasing need for HIV/AIDS-related services, including relative rates of increase in the number of cases of HIV/AIDS.

“(3) The relative rates of increase in the number of cases of HIV/AIDS within new or emerging subpopulations.

“(4) The current prevalence of HIV/AIDS.

“(5) Relevant factors related to the cost and complexity of delivering health care to individuals with HIV/AIDS in the eligible area.

“(6) The impact of co-morbid factors, including co-occurring conditions, determined relevant by the Secretary.

“(7) The prevalence of homelessness.

“(8) The prevalence of individuals described under section 2602(b)(2)(M).

“(9) The relevant factors that limit access to health care, including geographic variation, adequacy of health insurance coverage, and language barriers.

“(10) The impact of a decline in the amount received pursuant to section 2618 on services available to all individuals with HIV/AIDS identified and eligible under this title.

“(c) PRIORITY IN MAKING GRANTS.—The Secretary shall provide funds under this section to a State to address the decline in services related to the decline in the amounts received pursuant to section 2618 consistent with the grant award to the State for fiscal year 2006, to the extent that the factor under subsection (b)(10) (relating to a decline in funding) applies to the State.

“(d) CORE MEDICAL SERVICES.—The provisions of section 2612(b) apply with respect to a grant under this section to the same extent and in the same manner as such provisions apply with respect to a grant made pursuant to section 2618(a)(1).

“(e) APPLICABILITY OF GRANT AUTHORITY.—The authority to make grants under this section applies beginning with the first fiscal year for which amounts are made available for such grants under section 2623(b)(1).”.

SEC. 206. EMERGING COMMUNITIES.

Section 2621 of the Public Health Service Act, as redesignated by section 205(1) of this Act, is amended—

(1) in the heading for the section, by striking “SUPPLEMENTAL GRANTS” and inserting “EMERGING COMMUNITIES”;

(2) in subsection (b)—

(A) in paragraph (2), by striking “and” at the end;

(B) by redesignating paragraph (3) as paragraph (4); and

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

“(3) agree that the grant will be used to provide funds directly to emerging commu-

nities in the State, separately from other funds under this title that are provided by the State to such communities; and”.

(3) by striking subsections (d) and (e) and inserting the following:

“(d) DEFINITIONS OF EMERGING COMMUNITY.—For purposes of this section, the term ‘emerging community’ means a metropolitan area (as defined in section 2607) for which there has been reported to and confirmed by the Director of the Centers for Disease Control and Prevention a cumulative total of at least 500, but fewer than 1,000, cases of AIDS during the most recent period of 5 calendar years for which such data are available.

“(e) CONTINUED STATUS AS EMERGING COMMUNITY.—Notwithstanding any other provision of this section, a metropolitan area that is an emerging community for a fiscal year continues to be an emerging community until the metropolitan area fails, for three consecutive fiscal years—

“(1) to meet the requirements of subsection (d); and

“(2) to have a cumulative total of 750 or more living cases of AIDS (reported to and confirmed by the Director of the Centers for Disease Control and Prevention) as of December 31 of the most recent calendar year for which such data is available.

“(f) DISTRIBUTION.—The amount of a grant under subsection (a) for a State for a fiscal year shall be an amount equal to the product of—

“(1) the amount available under section 2623(b)(1) for the fiscal year; and

“(2) a percentage equal to the ratio constituted by the number of living cases of HIV/AIDS in emerging communities in the State to the sum of the respective numbers of such cases in such communities for all States.”.

SEC. 207. TIMEFRAME FOR OBLIGATION AND EXPENDITURE OF GRANT FUNDS.

Subpart I of part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-21 et seq.), as amended by section 205, is further amended by adding at the end the following:

“SEC. 2622. TIMEFRAME FOR OBLIGATION AND EXPENDITURE OF GRANT FUNDS.

“(a) OBLIGATION BY END OF GRANT YEAR.—Effective for fiscal year 2007 and subsequent fiscal years, funds from a grant award made to a State for a fiscal year pursuant to section 2618(a)(1) or 2618(a)(2)(G), or under section 2620 or 2621, are available for obligation by the State through the end of the one-year period beginning on the date in such fiscal year on which funds from the award first become available to the State (referred to in this section as the ‘grant year for the award’), except as provided in subsection (c)(1).

“(b) SUPPLEMENTAL GRANTS; CANCELLATION OF UNOBLIGATED BALANCE OF GRANT AWARD.—Effective for fiscal year 2007 and subsequent fiscal years, if a grant award made to a State for a fiscal year pursuant to section 2618(a)(2)(G)(ii), or under section 2620 or 2621, has an unobligated balance as of the end of the grant year for the award—

“(1) the Secretary shall cancel that unobligated balance of the award, and shall require the State to return any amounts from such balance that have been disbursed to the State; and

“(2) the funds involved shall be made available by the Secretary as additional amounts for grants pursuant to section 2620 for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that the balance is required under paragraph (1) to be canceled, except that the availability of the funds for such grants is subject to section 2618(a)(2)(H) as applied for such year.

“(c) FORMULA GRANTS; CANCELLATION OF UNOBLIGATED BALANCE OF GRANT AWARD; WAIVER PERMITTING CARRYOVER.—

“(1) IN GENERAL.—Effective for fiscal year 2007 and subsequent fiscal years, if a grant award made to a State for a fiscal year pursuant to section 2618(a)(1) or 2618(a)(2)(G)(i) has an unobligated balance as of the end of the grant year for the award, the Secretary shall cancel that unobligated balance of the award, and shall require the State to return any amounts from such balance that have been disbursed to the State, unless—

“(A) before the end of the grant year, the State submits to the Secretary a written application for a waiver of the cancellation, which application includes a description of the purposes for which the State intends to expend the funds involved; and

“(B) the Secretary approves the waiver.

“(2) EXPENDITURE BY END OF CARRYOVER YEAR.—With respect to a waiver under paragraph (1) that is approved for a balance that is unobligated as of the end of a grant year for an award:

“(A) The unobligated funds are available for expenditure by the State involved for the one-year period beginning upon the expiration of the grant year (referred to in this section as the ‘carryover year’).

“(B) If the funds are not expended by the end of the carryover year, the Secretary shall cancel that unexpended balance of the award, and shall require the State to return any amounts from such balance that have been disbursed to the State.

“(3) USE OF CANCELLED BALANCES.—In the case of any balance of a grant award that is cancelled under paragraph (1) or (2)(B), the grant funds involved shall be made available by the Secretary as additional amounts for grants under section 2620 for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that the balance is required under such paragraph to be canceled, except that the availability of the funds for such grants is subject to section 2618(a)(2)(H) as applied for such year.

“(4) CORRESPONDING REDUCTION IN FUTURE GRANT.—

“(A) IN GENERAL.—In the case of a State for which a balance from a grant award made pursuant to section 2618(a)(1) or 2618(a)(2)(G)(i) is unobligated as of the end of the grant year for the award—

“(i) the Secretary shall reduce, by the same amount as such unobligated balance, the amount of the grant under such section for the first fiscal year beginning after the fiscal year in which the Secretary obtains the information necessary for determining that such balance was unobligated as of the end of the grant year (which requirement for a reduction applies without regard to whether a waiver under paragraph (1) has been approved with respect to such balance); and

“(ii) the grant funds involved in such reduction shall be made available by the Secretary as additional funds for grants under section 2620 for such first fiscal year, subject to section 2618(a)(2)(H); except that this subparagraph does not apply to the State if the amount of the unobligated balance was 2 percent or less.

“(B) RELATION TO INCREASES IN GRANT.—A reduction under subparagraph (A) for a State for a fiscal year may not be taken into account in applying section 2618(a)(2)(H) with respect to the State for the subsequent fiscal year.

“(d) TREATMENT OF DRUG REBATES.—For purposes of this section, funds that are drug rebates referred to in section 2616(g) may not be considered part of any grant award referred to in subsection (a).”.

SEC. 208. AUTHORIZATION OF APPROPRIATIONS FOR SUBPART I OF PART B.

Subpart I of part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-21

et seq.), as amended by section 207, is further amended by adding at the end the following:

“SEC. 2623. AUTHORIZATION OF APPROPRIATIONS.

“(a) IN GENERAL.—For the purpose of carrying out this subpart, there are authorized to be appropriated \$1,195,500,000 for fiscal year 2007, \$1,239,500,000 for fiscal year 2008, \$1,285,200,000 for fiscal year 2009, \$1,332,600,000 for fiscal year 2010, and \$1,381,700,000 for fiscal year 2011. Amounts appropriated under the preceding sentence for a fiscal year are available for obligation by the Secretary until the end of the second succeeding fiscal year.

“(b) RESERVATION OF AMOUNTS.—

“(1) EMERGING COMMUNITIES.—Of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall reserve \$5,000,000 for grants under section 2621.

“(2) SUPPLEMENTAL GRANTS.—

“(A) IN GENERAL.—Of the amount appropriated under subsection (a) for a fiscal year in excess of the 2006 adjusted amount, the Secretary shall reserve ½ for grants under section 2620, except that the availability of the reserved funds for such grants is subject to section 2618(a)(2)(H) as applied for such year, and except that any amount appropriated exclusively for carrying out section 2616 (and, accordingly, distributed under section 2618(a)(2)(G)) is not subject to this subparagraph.

“(B) 2006 ADJUSTED AMOUNT.—For purposes of subparagraph (A), the term ‘2006 adjusted amount’ means the amount appropriated for fiscal year 2006 under section 2677(b) (as such section was in effect for such fiscal year), excluding any amount appropriated for such year exclusively for carrying out section 2616 (and, accordingly, distributed under section 2618(a)(2)(I), as so in effect).”.

SEC. 209. EARLY DIAGNOSIS GRANT PROGRAM.

Section 2625 of the Public Health Service Act (42 U.S.C. 300ff-33) is amended to read as follows:

“SEC. 2625. EARLY DIAGNOSIS GRANT PROGRAM.

“(a) IN GENERAL.—In the case of States whose laws or regulations are in accordance with subsection (b), the Secretary, acting through the Centers for Disease Control and Prevention, shall make grants to such States for the purposes described in subsection (c).

“(b) DESCRIPTION OF COMPLIANT STATES.—For purposes of subsection (a), the laws or regulations of a State are in accordance with this subsection if, under such laws or regulations (including programs carried out pursuant to the discretion of State officials), both of the policies described in paragraph (1) are in effect, or both of the policies described in paragraph (2) are in effect, as follows:

“(1)(A) Voluntary opt-out testing of pregnant women.

“(B) Universal testing of newborns.

“(2)(A) Voluntary opt-out testing of clients at sexually transmitted disease clinics.

“(B) Voluntary opt-out testing of clients at substance abuse treatment centers.

The Secretary shall periodically ensure that the applicable policies are being carried out and recertify compliance.

“(c) USE OF FUNDS.—A State may use funds provided under subsection (a) for HIV/AIDS testing (including rapid testing), prevention counseling, treatment of newborns exposed to HIV/AIDS, treatment of mothers infected with HIV/AIDS, and costs associated with linking those diagnosed with HIV/AIDS to care and treatment for HIV/AIDS.

“(d) APPLICATION.—A State that is eligible for the grant under subsection (a) shall submit an application to the Secretary, in such form, in such manner, and containing such information as the Secretary may require.

“(e) LIMITATION ON AMOUNT OF GRANT.—A grant under subsection (a) to a State for a

fiscal year may not be made in an amount exceeding \$10,000,000.

“(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to pre-empt State laws regarding HIV/AIDS counseling and testing.

“(g) DEFINITIONS.—In this section:

“(1) The term ‘voluntary opt-out testing’ means HIV/AIDS testing—

“(A) that is administered to an individual seeking other health care services; and

“(B) in which—

“(i) pre-test counseling is not required but the individual is informed that the individual will receive an HIV/AIDS test and the individual may opt out of such testing; and

“(ii) for those individuals with a positive test result, post-test counseling (including referrals for care) is provided and confidentiality is protected.

“(2) The term ‘universal testing of newborns’ means HIV/AIDS testing that is administered within 48 hours of delivery to—

“(A) all infants born in the State; or

“(B) all infants born in the State whose mother’s HIV/AIDS status is unknown at the time of delivery.

“(h) AUTHORIZATION OF APPROPRIATIONS.—Of the funds appropriated annually to the Centers for Disease Control and Prevention for HIV/AIDS prevention activities, \$30,000,000 shall be made available for each of the fiscal years 2007 through 2011 for grants under subsection (a), of which \$20,000,000 shall be made available for grants to States with the policies described in subsection (b)(1), and \$10,000,000 shall be made available for grants to States with the policies described in subsection (b)(2). Funds provided under this section are available until expended.”.

SEC. 210. CERTAIN PARTNER NOTIFICATION PROGRAMS; AUTHORIZATION OF APPROPRIATIONS.

Section 2631(d) of the Public Health Service Act (42 U.S.C. 300ff-38(d)) is amended by striking “there are” and all that follows and inserting the following: “there is authorized to be appropriated \$10,000,000 for each of the fiscal years 2007 through 2011.”.

TITLE III—EARLY INTERVENTION SERVICES

SEC. 301. ESTABLISHMENT OF PROGRAM; CORE MEDICAL SERVICES.

(a) IN GENERAL.—Section 2651 of the Public Health Service Act (42 U.S.C. 300ff-51) is amended to read as follows:

“SEC. 2651. ESTABLISHMENT OF A PROGRAM.

“(a) IN GENERAL.—For the purposes described in subsection (b), the Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to public and nonprofit private entities specified in section 2652(a).

“(b) REQUIREMENTS.—

“(1) IN GENERAL.—The Secretary may not make a grant under subsection (a) unless the applicant for the grant agrees to expend the grant only for—

“(A) core medical services described in subsection (c);

“(B) support services described in subsection (d); and

“(C) administrative expenses as described in section 2664(g)(3).

“(2) EARLY INTERVENTION SERVICES.—An applicant for a grant under subsection (a) shall expend not less than 50 percent of the amount received under the grant for the services described in subparagraphs (B) through (E) of subsection (e)(1) for individuals with HIV/AIDS.

“(c) REQUIRED FUNDING FOR CORE MEDICAL SERVICES.—

“(1) IN GENERAL.—With respect to a grant under subsection (a) to an applicant for a fiscal year, the applicant shall, of the portion

of the grant remaining after reserving amounts for purposes of paragraphs (3) and (5) of section 2664(g), use not less than 75 percent to provide core medical services that are needed in the area involved for individuals with HIV/AIDS who are identified and eligible under this title (including services regarding the co-occurring conditions of the individuals).

“(2) WAIVER.—

“(A) The Secretary shall waive the application of paragraph (1) with respect to an applicant for a grant if the Secretary determines that, within the service area of the applicant—

“(i) there are no waiting lists for AIDS Drug Assistance Program services under section 2616; and

“(ii) core medical services are available to all individuals with HIV/AIDS identified and eligible under this title.

“(B) NOTIFICATION OF WAIVER STATUS.—When informing an applicant that a grant under subsection (a) is being made for a fiscal year, the Secretary shall inform the applicant whether a waiver under subparagraph (A) is in effect for the fiscal year.

“(3) CORE MEDICAL SERVICES.—For purposes of this subsection, the term ‘core medical services’, with respect to an individual with HIV/AIDS (including the co-occurring conditions of the individual) means the following services:

“(A) Outpatient and ambulatory health services.

“(B) AIDS Drug Assistance Program treatments under section 2616.

“(C) AIDS pharmaceutical assistance.

“(D) Oral health care.

“(E) Early intervention services described in subsection (e).

“(F) Health insurance premium and cost sharing assistance for low-income individuals in accordance with section 2615.

“(G) Home health care.

“(H) Medical nutrition therapy.

“(I) Hospice services.

“(J) Home and community-based health services as defined under section 2614(c).

“(K) Mental health services.

“(L) Substance abuse outpatient care.

“(M) Medical case management, including treatment adherence services.

“(d) SUPPORT SERVICES.—

“(1) IN GENERAL.—For purposes of this section, the term ‘support services’ means services, subject to the approval of the Secretary, that are needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services).

“(2) DEFINITION OF MEDICAL OUTCOMES.—In this section, the term ‘medical outcomes’ means those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

“(e) SPECIFICATION OF EARLY INTERVENTION SERVICES.—

“(1) IN GENERAL.—The early intervention services referred to in this section are—

“(A) counseling individuals with respect to HIV/AIDS in accordance with section 2662;

“(B) testing individuals with respect to HIV/AIDS, 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 HIV/AIDS;

“(C) referrals described in paragraph (2);

“(D) other clinical and diagnostic services regarding HIV/AIDS, and periodic medical

evaluations of individuals with HIV/AIDS; and

“(E) providing the therapeutic measures described in subparagraph (B).

“(2) REFERRALS.—The services referred to in paragraph (1)(C) are referrals of individuals with HIV/AIDS 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 a pregnant woman.

“(3) REQUIREMENT OF AVAILABILITY OF ALL EARLY INTERVENTION SERVICES THROUGH EACH GRANTEE.—

“(A) IN GENERAL.—The Secretary may not make a grant under subsection (a) unless the applicant for the grant agrees that each of the early intervention services specified in paragraph (2) will be available through the grantee. With respect to compliance with such agreement, such a grantee may expend the grant to provide the early intervention services directly, and may expend the grant to enter into agreements with public or non-profit private entities, or private for-profit entities if such entities are the only available provider of quality HIV care in the area, under which the entities provide the services.

“(B) OTHER REQUIREMENTS.—Grantees described in—

“(i) subparagraphs (A), (D), (E), and (F) of section 2652(a)(1) shall use not less than 50 percent of the amount of such a grant to provide the services described in subparagraphs (A), (B), (D), and (E) of paragraph (1) directly and on-site or at sites where other primary care services are rendered; and

“(ii) subparagraphs (B) and (C) of section 2652(a)(1) shall ensure the availability of early intervention services through a system of linkages to community-based primary care providers, and to establish mechanisms for the referrals described in paragraph (1)(C), and for follow-up concerning such referrals.”

(b) ADMINISTRATIVE EXPENSES; CLINICAL QUALITY MANAGEMENT PROGRAM.—Section 2664(g) of the Public Health Service Act (42 U.S.C. 300ff-64(g)) is amended—

(1) in paragraph (3), by amending the paragraph to read as follows:

“(3) the applicant will not expend more than 10 percent of the grant for administrative expenses with respect to the grant, including planning and evaluation, except that the costs of a clinical quality management program under paragraph (5) may not be considered administrative expenses for purposes of such limitation;”;

(2) in paragraph (5), by inserting “clinical” before “quality management”.

SEC. 302. ELIGIBLE ENTITIES; PREFERENCES; PLANNING AND DEVELOPMENT GRANTS.

(a) MINIMUM QUALIFICATION OF GRANTEES.—Section 2652(a) of the Public Health Service Act (42 U.S.C. 300ff-52(a)) is amended to read as follows:

“(a) ELIGIBLE ENTITIES.—

“(1) IN GENERAL.—The entities referred to in section 2651(a) are public entities and non-profit private entities that are—

“(A) federally-qualified health centers under section 1905(1)(2)(B) of the Social Security Act;

“(B) grantees under section 1001 (regarding family planning) other than States;

“(C) comprehensive hemophilia diagnostic and treatment centers;

“(D) rural health clinics;

“(E) health facilities operated by or pursuant to a contract with the Indian Health Service;

“(F) community-based organizations, clinics, hospitals and other health facilities that provide early intervention services to those persons infected with HIV/AIDS through intravenous drug use; or

“(G) nonprofit private entities that provide comprehensive primary care services to populations at risk of HIV/AIDS, including faith-based and community-based organizations.

“(2) UNDERSERVED POPULATIONS.—Entities described in paragraph (1) shall serve underserved populations which may include minority populations and Native American populations, ex-offenders, individuals with comorbidities including hepatitis B or C, mental illness, or substance abuse, low-income populations, inner city populations, and rural populations.”

(b) PREFERENCES IN MAKING GRANTS.—Section 2653 of the Public Health Service Act (42 U.S.C. 300ff-53) is amended—

(1) in subsection (b)(1)—

(A) in subparagraph (A), by striking “acquired immune deficiency syndrome” and inserting “HIV/AIDS”; and

(B) in subparagraph (D), by inserting before the semicolon the following: “and the number of cases of individuals co-infected with HIV/AIDS and hepatitis B or C”; and

(2) in subsection (d)(2), by striking “special consideration” and inserting “preference”.

(c) PLANNING AND DEVELOPMENT GRANTS.—Section 2654(c) of the Public Health Service Act (42 U.S.C. 300ff-54(c)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), by striking “HIV”; and

(B) in subparagraph (B), by striking “HIV” and inserting “HIV/AIDS”; and

(2) in paragraph (3), by striking “or underserved communities” and inserting “areas or to underserved populations”.

SEC. 303. AUTHORIZATION OF APPROPRIATIONS.

Section 2655 of the Public Health Service Act (42 U.S.C. 300ff-55) is amended by striking “such sums” and all that follows through “2005” and inserting “, \$218,600,000 for fiscal year 2007, \$226,700,000 for fiscal year 2008, \$235,100,000 for fiscal year 2009, \$243,800,000 for fiscal year 2010, and \$252,800,000 for fiscal year 2011”.

SEC. 304. CONFIDENTIALITY AND INFORMED CONSENT.

Section 2661 of the Public Health Service Act (42 U.S.C. 300ff-61) is amended to read as follows:

“SEC. 2661. CONFIDENTIALITY AND INFORMED CONSENT.

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

“(b) INFORMED CONSENT.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, in testing an individual for HIV/AIDS, the applicant will test an individual only after the individual confirms that the decision of the individual with respect to undergoing such testing is voluntarily made.”

SEC. 305. PROVISION OF CERTAIN COUNSELING SERVICES.

Section 2662 of the Public Health Service Act (42 U.S.C. 300ff-62) is amended to read as follows:

“SEC. 2662. PROVISION OF CERTAIN COUNSELING SERVICES.

“(a) COUNSELING OF INDIVIDUALS WITH NEGATIVE TEST RESULTS.—The Secretary may

not make a grant under this part unless the applicant for the grant agrees that, if the results of testing conducted for HIV/AIDS indicate that an individual does not have such condition, the applicant will provide the individual information, including—

“(1) measures for prevention of, exposure to, and transmission of HIV/AIDS, hepatitis B, hepatitis C, and other sexually transmitted diseases;

“(2) the accuracy and reliability of results of testing for HIV/AIDS, hepatitis B, and hepatitis C;

“(3) the significance of the results of such testing, including the potential for developing AIDS, hepatitis B, or hepatitis C;

“(4) the appropriateness of further counseling, testing, and education of the individual regarding HIV/AIDS and other sexually transmitted diseases;

“(5) if diagnosed with chronic hepatitis B or hepatitis C co-infection, the potential of developing hepatitis-related liver disease and its impact on HIV/AIDS; and

“(6) information regarding the availability of hepatitis B vaccine and information about hepatitis treatments.

“(b) COUNSELING OF INDIVIDUALS WITH POSITIVE TEST RESULTS.—The Secretary may not make a grant under this part unless the applicant for the grant agrees that, if the results of testing for HIV/AIDS indicate that the individual has such condition, the applicant will provide to the individual appropriate counseling regarding the condition, including—

“(1) information regarding—

“(A) measures for prevention of, exposure to, and transmission of HIV/AIDS, hepatitis B, and hepatitis C;

“(B) the accuracy and reliability of results of testing for HIV/AIDS, hepatitis B, and hepatitis C; and

“(C) the significance of the results of such testing, including the potential for developing AIDS, hepatitis B, or hepatitis C;

“(2) reviewing the appropriateness of further counseling, testing, and education of the individual regarding HIV/AIDS and other sexually transmitted diseases; and

“(3) providing counseling—

“(A) on the availability, through the applicant, of early intervention services;

“(B) on the availability in the geographic area of appropriate health care, mental health care, and social and support services, including providing referrals for such services, as appropriate;

“(C)(i) that explains the benefits of locating and counseling any individual by whom the infected individual may have been exposed to HIV/AIDS, hepatitis B, or hepatitis C and any individual whom the infected individual may have exposed to HIV/AIDS, hepatitis B, or hepatitis C; and

“(ii) that emphasizes it is the duty of infected individuals to disclose their infected status to their sexual partners and their partners in the sharing of hypodermic needles; that provides advice to infected individuals on the manner in which such disclosures can be made; and that emphasizes that it is the continuing duty of the individuals to avoid any behaviors that will expose others to HIV/AIDS, hepatitis B, or hepatitis C; and

“(D) on the availability of the services of public health authorities with respect to locating and counseling any individual described in subparagraph (C);

“(4) if diagnosed with chronic hepatitis B or hepatitis C co-infection, the potential of developing hepatitis-related liver disease and its impact on HIV/AIDS; and

“(5) information regarding the availability of hepatitis B vaccine.

“(c) ADDITIONAL REQUIREMENTS REGARDING APPROPRIATE COUNSELING.—The Secretary may not make a grant under this part unless

the applicant for the grant agrees that, in counseling individuals with respect to HIV/AIDS, the applicant will ensure that the counseling is provided under conditions appropriate to the needs of the individuals.

“(d) COUNSELING OF EMERGENCY RESPONSE EMPLOYEES.—The Secretary may not make a grant under this part to a State unless the State agrees that, in counseling individuals with respect to HIV/AIDS, the State will ensure that, in the case of emergency response employees, the counseling is provided to such employees under conditions appropriate to the needs of the employees regarding the counseling.

“(e) RULE OF CONSTRUCTION REGARDING COUNSELING WITHOUT TESTING.—Agreements made pursuant to this section may not be construed to prohibit any grantee under this part from expending the grant for the purpose of providing counseling services described in this section to an individual who does not undergo testing for HIV/AIDS as a result of the grantee or the individual determining that such testing of the individual is not appropriate.”

SEC. 306. GENERAL PROVISIONS.

(a) APPLICABILITY OF CERTAIN REQUIREMENTS.—Section 2663 of the Public Health Service Act (42 U.S.C. 300ff-63) is amended by striking “will, without” and all that follows through “be carried” and inserting “with funds appropriated through this Act will be carried”.

(b) ADDITIONAL REQUIRED AGREEMENTS.—Section 2664(a) of the Public Health Service Act (42 U.S.C. 300ff-64(a)) is amended—

(1) in paragraph (1)—

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

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

(C) by adding at the end the following:

“(C) information regarding how the expected expenditures of the grant are related to the planning process for localities funded under part A (including the planning process described in section 2602) and for States funded under part B (including the planning process described in section 2617(b)); and

“(D) a specification of the expected expenditures and how those expenditures will improve overall client outcomes, as described in the State plan under section 2617(b);”;

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

(3) by adding at the end the following:

“(3) the applicant agrees to provide additional documentation to the Secretary regarding the process used to obtain community input into the design and implementation of activities related to such grant; and

“(4) the applicant agrees to submit, every 2 years, to the lead State agency under section 2617(b)(4) audits, consistent with Office of Management and Budget circular A133, regarding funds expended in accordance with this title and shall include necessary client level data to complete unmet need calculations and Statewide coordinated statements of need process.”

(c) PAYER OF LAST RESORT.—Section 2664(f)(1)(A) of the Public Health Service Act (42 U.S.C. 300ff-64(f)(1)(A)) is amended by inserting “(except for a program administered by or providing the services of the Indian Health Service)” before the semicolon.

TITLE IV—WOMEN, INFANTS, CHILDREN, AND YOUTH

SEC. 401. WOMEN, INFANTS, CHILDREN, AND YOUTH.

Part D of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-71 et seq.) is amended to read as follows:

“PART D—WOMEN, INFANTS, CHILDREN, AND YOUTH

“SEC. 2671. GRANTS FOR COORDINATED SERVICES AND ACCESS TO RESEARCH FOR WOMEN, INFANTS, CHILDREN, AND YOUTH.

“(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants to public and nonprofit private entities (including a health facility operated by or pursuant to a contract with the Indian Health Service) for the purpose of providing family-centered care involving outpatient or ambulatory care (directly or through contracts) for women, infants, children, and youth with HIV/AIDS.

“(b) ADDITIONAL SERVICES FOR PATIENTS AND FAMILIES.—Funds provided under grants awarded under subsection (a) may be used for the following support services:

“(1) Family-centered care including case management.

“(2) Referrals for additional services including—

“(A) referrals for inpatient hospital services, treatment for substance abuse, and mental health services; and

“(B) referrals for other social and support services, as appropriate.

“(3) Additional services necessary to enable the patient and the family to participate in the program established by the applicant pursuant to such subsection including services designed to recruit and retain youth with HIV.

“(4) The provision of information and education on opportunities to participate in HIV/AIDS-related clinical research.

“(c) COORDINATION WITH OTHER ENTITIES.—A grant awarded under subsection (a) may be made only if the applicant provides an agreement that includes the following:

“(1) The applicant will coordinate activities under the grant with other providers of health care services under this Act, and under title V of the Social Security Act, including programs promoting the reduction and elimination of risk of HIV/AIDS for youth.

“(2) The applicant will participate in the statewide coordinated statement of need under part B (where it has been initiated by the public health agency responsible for administering grants under part B) and in revisions of such statement.

“(3) The applicant will every 2 years submit to the lead State agency under section 2617(b)(4) audits regarding funds expended in accordance with this title and shall include necessary client-level data to complete unmet need calculations and Statewide coordinated statements of need process.

“(d) ADMINISTRATION; APPLICATION.—A grant may only be awarded to an entity under subsection (a) 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. Such application shall include the following:

“(1) Information regarding how the expected expenditures of the grant are related to the planning process for localities funded under part A (including the planning process outlined in section 2602) and for States funded under part B (including the planning process outlined in section 2617(b)).

“(2) A specification of the expected expenditures and how those expenditures will improve overall patient outcomes, as outlined as part of the State plan (under section 2617(b)) or through additional outcome measures.

“(e) ANNUAL REVIEW OF PROGRAMS; EVALUATIONS.—

“(1) REVIEW REGARDING ACCESS TO AND PARTICIPATION IN PROGRAMS.—With respect to a grant under subsection (a) for an entity for a fiscal year, the Secretary shall, not later than 180 days after the end of the fiscal year, provide for the conduct and completion of a review of the operation during the year of the program carried out under such subsection by the entity. The purpose of such review shall be the development of recommendations, as appropriate, for improvements in the following:

“(A) Procedures used by the entity to allocate opportunities and services under subsection (a) among patients of the entity who are women, infants, children, or youth.

“(B) Other procedures or policies of the entity regarding the participation of such individuals in such program.

“(2) EVALUATIONS.—The Secretary shall, directly or through contracts with public and private entities, provide for evaluations of programs carried out pursuant to subsection (a).

“(f) ADMINISTRATIVE EXPENSES.—

“(1) LIMITATION.—A grantee may not use more than 10 percent of amounts received under a grant awarded under this section for administrative expenses.

“(2) CLINICAL QUALITY MANAGEMENT PROGRAM.—A grantee under this section shall implement a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV/AIDS and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

“(g) TRAINING AND TECHNICAL ASSISTANCE.—From the amounts appropriated under subsection (1) for a fiscal year, the Secretary may use not more than 5 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.

“(h) DEFINITIONS.—In this section:

“(1) ADMINISTRATIVE EXPENSES.—The term ‘administrative expenses’ means funds that are to be used by grantees for grant management and monitoring activities, including costs related to any staff or activity unrelated to services or indirect costs.

“(2) INDIRECT COSTS.—The term ‘indirect costs’ means costs included in a Federally negotiated indirect rate.

“(3) SERVICES.—The term ‘services’ means—

“(A) services that are provided to clients to meet the goals and objectives of the program under this section, including the provision of professional, diagnostic, and therapeutic services by a primary care provider or a referral to and provision of specialty care; and

“(B) services that sustain program activity and contribute to or help improve services under subparagraph (A).

“(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated, \$71,800,000 for each of the fiscal years 2007 through 2011.”

SEC. 402. GAO REPORT.

Not later than 24 months after the date of enactment of this Act, the Comptroller General of the Government Accountability Office shall conduct an evaluation, and submit to Congress a report, concerning the funding provided for under part D of title XXVI of the Public Health Service Act to determine—

(1) how funds are used to provide the administrative expenses, indirect costs, and services, as defined in section 2671(h) of such title, for individuals with HIV/AIDS;

(2) how funds are used to provide the administrative expenses, indirect costs, and services, as defined in section 2671(h) of such title, to family members of women, infants, children, and youth infected with HIV/AIDS;

(3) how funds are used to provide family-centered care involving outpatient or ambulatory care authorized under section 2671(a) of such title;

(4) how funds are used to provide additional services authorized under section 2671(b) of such title; and

(5) how funds are used to help identify HIV-positive pregnant women and their children who are exposed to HIV and connect them with care that can improve their health and prevent perinatal transmission.

TITLE V—GENERAL PROVISIONS

SEC. 501. GENERAL PROVISIONS.

Part E of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–80 et seq.) is amended to read as follows:

“PART E—GENERAL PROVISIONS

“SEC. 2681. COORDINATION.

“(a) REQUIREMENT.—The Secretary shall ensure that the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Centers for Medicare & Medicaid Services coordinate the planning, funding, and implementation of Federal HIV programs (including all minority AIDS initiatives of the Public Health Service, including under section 2693) to enhance the continuity of care and prevention services for individuals with HIV/AIDS or those at risk of such disease. The Secretary shall consult with other Federal agencies, including the Department of Veterans Affairs, as needed and utilize planning information submitted to such agencies by the States and entities eligible for assistance under this title.

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

“(c) INTEGRATION BY STATE.—As a condition of receipt of funds under this title, a State shall provide assurances to the Secretary that health support services funded under this title will be integrated with other such services, that programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV/AIDS is enhanced.

“(d) INTEGRATION BY LOCAL OR PRIVATE ENTITIES.—As a condition of receipt of funds under this title, a local government or private nonprofit entity shall provide assurances to the Secretary that services funded under this title will be integrated with other such services, that programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

“SEC. 2682. AUDITS.

“(a) IN GENERAL.—For fiscal year 2009, and each subsequent fiscal year, the Secretary may reduce the amounts of grants under this title to a State or political subdivision of a State for a fiscal year if, with respect to such grants for the second preceding fiscal

year, the State or subdivision fails to prepare audits in accordance with the procedures of section 7502 of title 31, United States Code. The Secretary shall annually select representative samples of such audits, prepare summaries of the selected audits, and submit the summaries to the Congress.

“(b) POSTING ON THE INTERNET.—All audits that the Secretary receives from the State lead agency under section 2617(b)(4) shall be posted, in their entirety, on the Internet website of the Health Resources and Services Administration.

“SEC. 2683. PUBLIC HEALTH EMERGENCY.

“(a) IN GENERAL.—In an emergency area and during an emergency period, the Secretary shall have the authority to waive such requirements of this title to improve the health and safety of those receiving care under this title and the general public, except that the Secretary may not expend more than 5 percent of the funds allocated under this title for sections 2620 and section 2603(b).

“(b) EMERGENCY AREA AND EMERGENCY PERIOD.—In this section:

“(1) EMERGENCY AREA.—The term ‘emergency area’ means a geographic area in which there exists—

“(A) an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; or

“(B) a public health emergency declared by the Secretary pursuant to section 319.

“(2) EMERGENCY PERIOD.—The term ‘emergency period’ means the period in which there exists—

“(A) an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; or

“(B) a public health emergency declared by the Secretary pursuant to section 319.

“(c) UNOBLIGATED FUNDS.—If funds under a grant under this section are not expended for an emergency in the fiscal year in which the emergency is declared, such funds shall be returned to the Secretary for reallocation under sections 2603(b) and 2620.

“SEC. 2684. PROHIBITION ON PROMOTION OF CERTAIN ACTIVITIES.

“None of the funds appropriated under this title shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual. Funds authorized under this title may be used to provide medical treatment and support services for individuals with HIV.

“SEC. 2685. PRIVACY PROTECTIONS.

“(a) IN GENERAL.—The Secretary shall ensure that any information submitted to, or collected by, the Secretary under this title excludes any personally identifiable information.

“(b) DEFINITION.—In this section, the term ‘personally identifiable information’ has the meaning given such term under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

“SEC. 2686. GAO REPORT.

“The Comptroller General of the Government Accountability Office shall biennially submit to the appropriate committees of Congress a report that includes a description of Federal, State, and local barriers to HIV program integration, particularly for racial and ethnic minorities, including activities carried out under subpart III of part F, and recommendations for enhancing the continuity of care and the provision of prevention services for individuals with HIV/AIDS

or those at risk for such disease. Such report shall include a demonstration of the manner in which funds under this subpart are being expended and to what extent the services provided with such funds increase access to prevention and care services for individuals with HIV/AIDS and build stronger community linkages to address HIV prevention and care for racial and ethnic minority communities.

“SEC. 2687. DEFINITIONS.

“For purposes of this title:

“(1) AIDS.—The term ‘AIDS’ means acquired immune deficiency syndrome.

“(2) CO-OCCURRING CONDITIONS.—The term ‘co-occurring conditions’ means one or more adverse health conditions in an individual with HIV/AIDS, without regard to whether the individual has AIDS and without regard to whether the conditions arise from HIV.

“(3) COUNSELING.—The term ‘counseling’ means such counseling provided by an individual trained to provide such counseling.

“(4) FAMILY-CENTERED CARE.—The term ‘family-centered care’ means the system of services described in this title that is targeted specifically to the special needs of infants, children, women and families. Family-centered care shall be based on a partnership between parents, professionals, and the community designed to ensure an integrated, coordinated, culturally sensitive, and community-based continuum of care for children, women, and families with HIV/AIDS.

“(5) FAMILIES WITH HIV/AIDS.—The term ‘families with HIV/AIDS’ means families in which one or more members have HIV/AIDS.

“(6) HIV.—The term ‘HIV’ means infection with the human immunodeficiency virus.

“(7) HIV/AIDS.—

“(A) IN GENERAL.—The term ‘HIV/AIDS’ means HIV, and includes AIDS and any condition arising from AIDS.

“(B) COUNTING OF CASES.—The term ‘living cases of HIV/AIDS’, with respect to the counting of cases in a geographic area during a period of time, means the sum of—

“(i) the number of living non-AIDS cases of HIV in the area; and

“(ii) the number of living cases of AIDS in the area.

“(C) NON-AIDS CASES.—The term ‘non-AIDS’, with respect to a case of HIV, means that the individual involved has HIV but does not have AIDS.

“(8) HUMAN IMMUNODEFICIENCY VIRUS.—The term ‘human immunodeficiency virus’ means the etiologic agent for AIDS.

“(9) OFFICIAL POVERTY LINE.—The term ‘official poverty line’ means the poverty line established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

“(10) PERSON.—The term ‘person’ includes one or more individuals, governments (including the Federal Government and the governments of the States), governmental agencies, political subdivisions, labor unions, partnerships, associations, corporations, legal representatives, mutual companies, joint-stock companies, trusts, unincorporated organizations, receivers, trustees, and trustees in cases under title 11, United States Code.

“(11) STATE.—

“(A) IN GENERAL.—The term ‘State’ means each of the 50 States, the District of Columbia, and each of the territories.

“(B) TERRITORIES.—The term ‘territory’ means each of American Samoa, Guam, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, the Virgin Islands, the Republic of the Marshall Islands, the Federated States of Micronesia, and Palau.

“(12) YOUTH WITH HIV.—The term ‘youth with HIV’ means individuals who are 13 through 24 years old and who have HIV/AIDS.”

TITLE VI—DEMONSTRATION AND TRAINING

SEC. 601. DEMONSTRATION AND TRAINING.

Subpart I of part F of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-101 et seq.) is amended to read as follows:

“Subpart I—Special Projects of National Significance

“SEC. 2691. SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE.

“(a) IN GENERAL.—Of the amount appropriated under each of parts A, B, C, and D for each fiscal year, the Secretary shall use the greater of \$20,000,000 or an amount equal to 3 percent of such amount appropriated under each such part, but not to exceed \$25,000,000, to administer special projects of national significance to—

“(1) quickly respond to emerging needs of individuals receiving assistance under this title; and

“(2) to fund special programs to develop a standard electronic client information data system to improve the ability of grantees under this title to report client-level data to the Secretary.

“(b) GRANTS.—The Secretary shall award grants under subsection (a) to entities eligible for funding under parts A, B, C, and D based on—

“(1) whether the funding will promote obtaining client level data as it relates to the creation of a severity of need index under section 2618(a)(2)(E), including funds to facilitate the purchase and enhance the utilization of qualified health information technology systems;

“(2) demonstrated ability to create and maintain a qualified health information technology system;

“(3) the potential replicability of the proposed activity in other similar localities or nationally;

“(4) the demonstrated reliability of the proposed qualified health information technology system across a variety of providers, geographic regions, and clients; and

“(5) the demonstrated ability to maintain a safe and secure qualified health information system; or

“(6) newly emerging needs of individuals receiving assistance under this title.

“(c) COORDINATION.—The Secretary may not make a grant under this section unless the applicant submits evidence that the proposed program is consistent with the statewide coordinated statement of need, and the applicant agrees to participate in the ongoing revision process of such statement of need.

“(d) PRIVACY PROTECTION.—The Secretary may not make a grant under this section for the development of a qualified health information technology system unless the applicant provides assurances to the Secretary that the system will, at a minimum, comply with the privacy regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

“(e) REPLICATION.—The Secretary shall make information concerning successful models or programs developed under this part available to grantees under this title for the purpose of coordination, replication, and integration. To facilitate efforts under this subsection, the Secretary may provide for peer-based technical assistance for grantees funded under this part.”

SEC. 602. AIDS EDUCATION AND TRAINING CENTERS.

(a) AMENDMENTS REGARDING SCHOOLS AND CENTERS.—Section 2692(a)(2) of the Public

Health Service Act (42 U.S.C. 300ff-111(a)(2)) is amended—

(1) in subparagraph (A)—

(A) by inserting “and Native Americans” after “minority individuals”; and

(B) by striking “and” at the end;

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

(3) by adding at the end the following:

“(C) train or result in the training of health professionals and allied health professionals to provide treatment for hepatitis B or C co-infected individuals.”

(b) AUTHORIZATIONS OF APPROPRIATIONS FOR SCHOOLS, CENTERS, AND DENTAL PROGRAMS.—Section 2692(c) of the Public Health Service Act (42 U.S.C. 300ff-111(c)) is amended to read as follows:

“(c) AUTHORIZATION OF APPROPRIATIONS.—

“(1) SCHOOLS; CENTERS.—For the purpose of awarding grants under subsection (a), there is authorized to be appropriated \$34,700,000 for each of the fiscal years 2007 through 2011.

“(2) DENTAL SCHOOLS.—For the purpose of awarding grants under subsection (b), there is authorized to be appropriated \$13,000,000 for each of the fiscal years 2007 through 2011.”

SEC. 603. CODIFICATION OF MINORITY AIDS INITIATIVE.

Part F of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-101 et seq.) is amended by adding at the end the following:

“Subpart III—Minority AIDS Initiative

“SEC. 2693. MINORITY AIDS INITIATIVE.

“(a) IN GENERAL.—For the purpose of carrying out activities under this section to evaluate and address the disproportionate impact of HIV/AIDS on, and the disparities in access, treatment, care, and outcomes for, racial and ethnic minorities (including African Americans, Alaska Natives, Latinos, American Indians, Asian Americans, Native Hawaiians, and Pacific Islanders), there are authorized to be appropriated \$131,200,000 for fiscal year 2007, \$135,100,000 for fiscal year 2008, \$139,100,000 for fiscal year 2009, \$143,200,000 for fiscal year 2010, and \$147,500,000 for fiscal year 2011.

“(b) CERTAIN ACTIVITIES.—

“(1) IN GENERAL.—In carrying out the purpose described in subsection (a), the Secretary shall provide for—

“(A) emergency assistance under part A;

“(B) care grants under part B;

“(C) early intervention services under part C;

“(D) services through projects for HIV-related care under part D; and

“(E) activities through education and training centers under section 2692.

“(2) ALLOCATIONS AMONG ACTIVITIES.—Activities under paragraph (1) shall be carried out by the Secretary in accordance with the following:

“(A) For competitive, supplemental grants to improve HIV-related health outcomes to reduce existing racial and ethnic health disparities, the Secretary shall, of the amount appropriated under subsection (a) for a fiscal year, reserve the following, as applicable:

“(i) For fiscal year 2007, \$43,800,000.

“(ii) For fiscal year 2008, \$45,400,000.

“(iii) For fiscal year 2009, \$47,100,000.

“(iv) For fiscal year 2010, \$48,800,000.

“(v) For fiscal year 2011, \$50,700,000.

“(B) For competitive grants used for supplemental support education and outreach services to increase the number of eligible racial and ethnic minorities who have access to treatment through the program under section 2616 for therapeutics, the Secretary shall, of the amount appropriated for a fiscal year under subsection (a), reserve the following, as applicable:

“(i) For fiscal year 2007, \$7,000,000.

“(ii) For fiscal year 2008, \$7,300,000.

“(iii) For fiscal year 2009, \$7,500,000.

“(iv) For fiscal year 2010, \$7,800,000.

“(v) For fiscal year 2011, \$8,100,000.

“(C) For planning grants, capacity-building grants, and services grants to health care providers who have a history of providing culturally and linguistically appropriate care and services to racial and ethnic minorities, the Secretary shall, of the amount appropriated for a fiscal year under subsection (a), reserve the following, as applicable:

“(i) For fiscal year 2007, \$53,400,000.

“(ii) For fiscal year 2008, \$55,400,000.

“(iii) For fiscal year 2009, \$57,400,000.

“(iv) For fiscal year 2010, \$59,500,000.

“(v) For fiscal year 2011, \$61,800,000.

“(D) For eliminating racial and ethnic disparities in the delivery of comprehensive, culturally and linguistically appropriate care services for HIV disease for women, infants, children, and youth, the Secretary shall, of the amount appropriated under subsection (a), reserve \$18,500,000 for each of the fiscal years 2007 through 2011.

“(E) For increasing the training capacity of centers to expand the number of health care professionals with treatment expertise and knowledge about the most appropriate standards of HIV disease-related treatments and medical care for racial and ethnic minority adults, adolescents, and children with HIV disease, the Secretary shall, of the amount appropriated under subsection (a), reserve \$8,500,000 for each of the fiscal years 2007 through 2011.

“(c) CONSISTENCY WITH PRIOR PROGRAM.—With respect to the purpose described in subsection (a), the Secretary shall carry out this section consistent with the activities carried out under this title by the Secretary pursuant to the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2002 (Public Law 107-116).”

TITLE VII—MISCELLANEOUS PROVISIONS

SEC. 701. HEPATITIS; USE OF FUNDS.

Section 2667 of the Public Health Service Act (42 U.S.C. 300ff-67) is amended—

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

(2) in paragraph (3), by striking the period and inserting “; and”; and

(3) by adding at the end the following:

“(4) shall provide information on the transmission and prevention of hepatitis A, B, and C, including education about the availability of hepatitis A and B vaccines and assisting patients in identifying vaccination sites.”

SEC. 702. CERTAIN REFERENCES.

Title XXVI of the Public Health Service Act (42 U.S.C. 300ff et seq.) is amended—

(1) by striking “acquired immune deficiency syndrome” each place such term appears, other than in section 2687(1) (as added by section 501 of this Act), and inserting “AIDS”;

(2) by striking “such syndrome” and inserting “AIDS”; and

(3) by striking “HIV disease” each place such term appears and inserting “HIV/AIDS”.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Georgia (Mr. DEAL) and the gentleman from New Jersey (Mr. PALLONE) each will control 20 minutes.

The Chair recognizes the gentleman from Georgia.

GENERAL LEAVE

Mr. DEAL of Georgia. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on this legislation and to insert extraneous material on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Georgia?

There was no objection.

Mr. DEAL of Georgia. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in strong support of H.R. 6143, the Ryan White HIV/AIDS Treatment Modernization Act of 2006, because I believe that we must reform the unacceptable status quo for the benefit of those suffering from HIV/AIDS across our great Nation.

As my colleagues are aware, the Ryan White CARE Act was first authorized in 1996 and was reauthorized in 1996 and 2000. And although the legislative authority expired on September 30, 2005, the program continues to operate at its current funding level.

The outcomes and treatments for HIV and AIDS have changed over the years, and so have the needs of those who suffer from the disease. For example, persons with HIV now live longer due to advances in drug therapies.

However, many patients are on waiting lists for these life-saving drugs, because Ryan White funds are being spent on nonmedical services. Those include services not covered for Medicare or Medicaid beneficiaries, including buddy and companion services, dog walking, therapeutic touching, and housing assistance.

Dog walking? Therapeutic touching? Is this what the Federal Government really wants to pay for? The Ryan White CARE Act program is designed to provide needed medical services to people suffering from HIV/AIDS. If we do not pass this bill, the status quo will remain.

The AIDS Drug Assistance Program, ADAP, provides needed life-saving therapies to those suffering from HIV/AIDS. These are crucial medications that extend and prolong life.

Next year, funds to supplement States' ADAP spending will be used for hold-harmless payments based on an old, inaccurate case count. Patients will not receive needed drug therapies if the status quo remains. Currently, there is a 50 percent difference in funding for AIDS cases for some areas of the country over other areas due to outdated formulas.

Some States cannot find enough doctors to write prescriptions for needed medications, while others are paying for buddy and companion services. If we do not pass this legislation, the status quo will remain.

Mr. Speaker, the status quo to me is unacceptable, and I think it is unacceptable to the taxpayers, and it is unacceptable to those suffering from AIDS/HIV.

Mr. Speaker, I urge my colleagues to support this needed and timely legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, it is with great regret that I rise in opposition to this bill. Unlike previous reauthorizations of the Ryan White CARE Act, I believe the legislation before us has the potential to do great harm to systems of care around the country and place HIV/AIDS patients at risk.

In my home State of New Jersey, for example, we have tremendous need for CARE Act dollars. We have the highest proportion of cumulative AIDS cases in women. We rank third in cumulative pediatric AIDS cases, and fifth in overall cumulative AIDS cases. In the early days of this epidemic when the Federal Government refused to help, New Jersey stepped forward and did the right thing.

Ever since then, we have remained at the forefront of this battle working hard to provide the medical and support services HIV/AIDS patients need to live longer.

But that will all change if this bill is enacted. This bill will punish States like New Jersey for keeping people alive and preventing new infections. It sets up a very perverse disincentive. It says to States: you will be penalized for doing a good job. This is not the message that Washington should be sending back home.

Mr. Speaker, there are a number of reasons why this bill is flawed. The most obvious is that it is woefully underfunded. As a result, it sets up a vicious system of winners and losers. This bill pits AIDS against HIV, urban centers against rural communities. This is not how you treat a public health emergency.

If Republicans would stop draining the Treasury to help pay for the tax cuts, we would have the resources necessary to adequately address this epidemic. Ultimately this bill is flawed, Mr. Speaker. It has no business being considered in the waning days of the session on this Suspension Calendar.

Mr. Speaker, it needs to be fixed so that every State has the resources to treat their HIV/AIDS patients. I urge my colleagues to oppose this bill. Instead, let's pass a temporary reauthorization that holds every State harmless so that we can work out these problems.

Mr. Speaker, I reserve the balance of my time.

Mr. DEAL of Georgia. Mr. Speaker, I yield 4 minutes to the gentlewoman from California (Mrs. BONO), the original sponsor of this legislation.

Mrs. BONO. Mr. Speaker, I rise today in strong support of the Ryan White HIV/AIDS Treatment Modernization Act. Its consideration on the floor today is testament to the bipartisan nature of this legislation.

HIV/AIDS is a disease that has virtually touched all of us in all parts of our great Nation. Since its inception, the purpose of the Ryan White CARE Act has been to provide care.

As we discuss this specifics of this legislation, and the more technical aspects of the funding formulas, it is my

hope that each of us will bear in mind the true purpose of this legislation. It is critical that we recognize the significant steps that have been made towards ensuring that the funding we are providing here today is going to real people to meet very real and very imminent needs.

□ 1430

In bringing together systems of care from across the Nation, significant compromises have been made, and I assure you that they have been made in the interest of providing care to the individuals who need it the most. Every attempt has been made to ensure that funds are directed to areas of greatest need and are balanced by provisions that limit the loss of funds for jurisdictions.

I believe that none of us want to reduce funding for HIV services in any jurisdictions, but I ask you to consider carefully the existing disparities in funding and services, to bear in mind our solemn duty to serve people with HIV regardless of where they live and to support the effort of the Modernization Act to address those disparities.

In California's 45th district, I have had the opportunity to work closely with an exceptional provider of this care, the Desert AIDS Project. It has been my privilege to see firsthand what caring and dedicated people do with the funds and framework that have been provided in the Ryan White CARE Act. Their input throughout this process has been invaluable to me, and their work has been and continues to be inspiring. I would like to express my personal thanks to the great people of the Desert AIDS Project.

I would also like to express my deep appreciation to Chairman BARTON, Chairman DEAL and Ranking Member DINGELL for bringing this bill to the floor today.

This reauthorization has been the product of bipartisan and bicameral efforts. I would like to thank the committee staff who have dedicated so much time to this effort from both sides of the Capitol and from both sides of the aisle: Melissa Bartlett, John Ford, Shana Christrup and Connie Garner. And, finally, I would like to thank my personal staff, both past, Katherine Martin, and present, Taryn Nader, for their hard work and tireless efforts on behalf of the Ryan White CARE Act.

The goal of each Member of this body is to serve their constituencies and all citizens of this great country by passing legislation that meets the needs of our citizens. The CARE Act has for 16 years been a cornerstone of the care, treatment and support services necessary for the lives of people living with HIV and AIDS. It is vitally important to maintain its support and modernize its approach to ensure it continues to sustain the lives of people with HIV and AIDS.

I ask my colleagues for their support, Mr. Speaker.

Mr. PALLONE. Mr. Speaker, I yield 4 minutes to the gentleman from Cali-

fornia (Mr. WAXMAN), who has been a leader on this Ryan White CARE Act from the very beginning.

Mr. WAXMAN. Mr. Speaker, I rise in very reluctant opposition to this Ryan White HIV/AIDS Treatment Modernization Act of 2006.

I was the original sponsor of the legislation, and I have been a long-time supporter of it, but I think we find ourselves in a tragic situation today because the basis of the problem is that the population of those needing services has grown, but the funds for the Ryan White program have not grown with it. This program is chronically underfunded.

Well, that means if we want to give to some people who are very deserving, we are going to have to take it from others who are very deserving. This should not be the choice of the body in Congress today.

I recognize that a failure to pass the legislation could put many States, like my own, that have been collecting HIV data by code, at a severe risk of a loss of funding. Obviously, this is a situation in which we wish we would not find ourselves in, but if we adopt this bill we are agreeing to a long-term system that does not treat fairly States which must now begin to implement a whole new system for finding and reporting persons with HIV.

The bill favors States and cities that collected HIV data by name over those that collected it by code; and, as a result, many areas of the country will see drastic losses of funding. This is unfair.

Large and diverse code-based States, like California, would have to start from scratch, converting their approximately 40,000 code-based cases of HIV to names, and under California law, these cases cannot simply be retitled under a new names-based system. The State would have to contact 40,000 individuals. I do not think California will be able to get all of those individuals entered into the names-based system in 3 years.

So I cannot support legislation that would take critical dollars away from California simply because its data system is incomplete. We will have the same number of persons with HIV needing services. They should not lose needed services because of an unrealistic data requirement.

I wish I could support this bill. I would support it if this problem could be addressed, and I am hopeful that when this bill gets to the Senate and there are further deliberations we can get a better bill. I do not want to see no bill pass, particularly with the threat that we are hearing from the administration that they are going to penalize the code-based States, but I do not want to vote for a bill that I do not think is a good enough bill.

The Ryan White program has had a long history of broad bipartisan support. It did not pit interests of one area of the country against another. It did not ask cities and States to give up

critical funds to treat people in their areas. Ultimately, we must find the will to direct the necessary dollars to this problem. The people who continue to suffer from this epidemic deserve no less.

Mr. Speaker, I have to be reluctant and vote "no" and hope that we can get a better bill when this legislation passes the House and there are further deliberations with the Senate.

Mr. BARTON of Texas. Mr. Speaker, I ask unanimous consent that I be given control of the time on the majority side.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BARTON of Texas. Mr. Speaker, may I ask how much time remains?

The SPEAKER pro tempore. The gentleman from Texas (Mr. BARTON) has 14½ minutes remaining, and the gentleman from New Jersey (Mr. PALLONE) has 14 minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I yield myself such time as I may consume.

(Mr. BARTON of Texas asked and was given permission to revise and extend his remarks.)

Mr. BARTON of Texas. Mr. Speaker, I rise in support of H.R. 6143, the Ryan White HIV/AIDS Treatment Modernization Act of 2006. This legislation was introduced by Congresswoman BONO. It is the product of a year of bipartisan, bicameral negotiations. The bill reauthorizes and reforms the Ryan White program, the Federal Government's largest discretionary grant program specifically designed for people with HIV/AIDS.

We know that HIV/AIDS disproportionately affects people in poverty and racial/ethnic populations who are underserved by health care and prevention systems. We know that the most likely users of Ryan White services are persons with no or limited sources of health care. We know that Ryan White services keeps these people out of hospitals, increases their access to health care and improves their quality of life.

Here is what we also know about the current Ryan White program. We know that due to outdated, hold-harmless and double-counting provisions in the current law persons are not treated similarly across this country. We know that, under the current formula, there is reportedly a 50 percent increase in funding per AIDS case for some areas of the country over other areas of the country who get no increase or little increase at all. We know that sometimes this huge inequity occurs within the same State. We know that one city in particular is greatly advantaged by an outdated, hold-harmless formula, one that may allow even for deceased persons, someone who is no longer living, counted for current funding purposes. I do not think anyone would think that is right. In fact, I would say that is not right.

The Ryan White program was established to be the payor of last resort for

needed medical services for those suffering from HIV/AIDS. Then and now, that is a noble cause and one worth supporting. However, we know that in many States, including my own State of Texas, Ryan White dollars, Federal taxpayer dollars, are being used for nonhealth care services. What kind of services? For example, buddy/companion services, child care services, housing, transportation and many other types of services similar to these are being provided with Ryan White dollars. While some of these services may, arguably, be necessary to get people to health care and keep people in health care, others are misuses of Ryan White dollars under the current formula and need to be fixed.

The use of Ryan White funds for such services should be put into check. We should be asking the question, why are there waiting lists in some parts of the country to get lifesaving drugs? And why in some parts of the country are there no physicians to even write prescriptions for these lifesaving drugs? Again, this is just not right. It is not fair.

The bill before us would begin to right those wrongs. The bill before us would begin to treat people across the country in a fair and equitable fashion so that, no matter where you live, if you are eligible for Ryan White assistance, you will get access to health care, you will get access to treatment, you will get access to drugs.

This bill requires cities, States and providers to start making the right decisions when it comes to how to spend their Ryan White dollars by requiring that they spend at least 75 percent on core medical services. I repeat, they must spend at least 75 percent on core medical services. HIV/AIDS is, first and foremost, a medical condition and providing medical care should be the primary focus of the Federal bill.

I know that the bill is not perfect. I know that there have been significant compromises made by all parties at the table. I know that had any one party decided to write a reauthorization bill the bill would look different than it does today. This bill, though, reflects over a year of intense negotiations by all of the stakeholders. It reflects the input of many stakeholder groups and the Bush administration. The bill advances important consensus policy reforms.

The bill is also coming to this floor at a critical time for the Ryan White program. In just 3 days, again, 3 days from today, current law dictates that many areas of this country, including several large States, will not be able to include their HIV case counts to receive the appropriate Federal funding to provide services to persons in their States.

What does this mean? This means that thousands of HIV persons may have their health care needs put in jeopardy. This means that, under current law, the drug grant program will be reduced by 3 percent to pay for any

existing hold harmless. So, at a time when there are people on waiting lists for drugs in some parts of the country, access to drugs in other parts of the country will be hindered, be reduced. These drug dollars will come up short. According to the Department of Health and Human Services, there will be about a \$40 million shortfall. Those are real dollars that otherwise would go to help real people. I cannot underscore the urgency of passing this bill today to prevent these cuts.

I want to commend Congresswoman BONO for her leadership in preventing these losses. I also want to thank Congressman DINGELL, Senator KENNEDY and Senator ENZI in the other body for their hard work on this consensus bill to reauthorize the program.

At the staff level, I want to thank John Ford on the minority staff and Melissa Bartlett on the majority staff for their hard work in dedicating themselves during the last several months and the last year to produce the legislation that is before us today.

Finally, I want to thank the Legislative Counsel's office and, in particular, Pete Goodloe. He has worked very, very hard on this.

It is critical that we act today in a positive fashion so that we can prevent the cuts that go into effect 3 days from today.

The bill before us passed the Energy and Commerce Committee on a 38-10 bipartisan vote last week. If it passes this body under suspension, it will go to the other body, and we will work very hard to get it passed over there in the next 2 days. Because it is on suspension, it takes a two-thirds vote, which, if everyone is present and voting, we will need 291 Members to vote in favor of reauthorization of the Ryan White HIV/AIDS Act. I hope we get that vote later this afternoon.

Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 3 minutes to the gentleman from New York (Mr. ENGEL).

(Mr. ENGEL asked and was given permission to revise and extend his remarks.)

Mr. ENGEL. Mr. Speaker, I thank my friend from New Jersey for yielding to me; and, first of all, Mr. Speaker, I want to express my extreme displeasure that this bill comes here today on consent calendar, a bill with more than \$2 billion in this bill and we have 40 minutes to debate it. This is not a bill that should be under a suspension calendar. This is a bill that should have full and open debate among the Congress with not a 40-minute time limitation.

This is not a consensus bill. This is a contentious bill, and many of us are very, very upset. We are upset about the bill, and we are upset at the manner that this leadership brings this bill to the House floor.

This bill will destabilize established systems and care and will have a devastating effect on the ability of high

prevalent communities to address need; and, unfortunately, as home to 17 percent, which is one-sixth of the Nation's AIDS population, New York is just so upset that this bill has come out the way it has. This is profoundly important to our State. That is why all 29 Members of the New York delegation, Democrats and Republicans alike, have signed a letter opposing this bill and pledging to vote against the bill.

New York remains the epicenter of the HIV/AIDS crisis, leading the Nation in both the number of persons living with HIV/AIDS and number of new cases of HIV/AIDS each year.

But what does this bill do? It has been estimated that New York State stands to lose more than \$78 million in the first 4 years of the reauthorization. New York City will likely lose \$17 million in the first year alone.

□ 1445

This bill will result in deep cuts in medications and services for people living with HIV/AIDS throughout the State.

It reminds me of homeland security. Sometimes we need to use a little common sense. Homeland security, everyone knows, unfortunately, that New York City remains the number one terrorist target and Washington number two. So what did we have when we had the Department of Homeland Security come up with its budget? They cut New York City by 30 percent and cut Washington by 30 percent. The two biggest terrorist threats. That made no sense at all.

What happens here? New York City remains the epicenter of the AIDS epidemic, and what does this bill do? It cuts \$78 million for New York and \$17 million for New York City. It is shameful and disgraceful.

And despite what some may say, the HIV/AIDS epidemic has not shifted. It has expanded. One-half of all people living with AIDS reside in five States: New York, New Jersey, Florida, Texas, and California. Three of these States, New York, New Jersey and Florida, will face devastating losses under this reauthorization.

There is no question that other States have mounting epidemics and they are absolutely entitled and deserving of more funding. A good Ryan White bill would have ensured that every State had enough money to meet their needs; that every State would be held harmless; that every State would not be a winner or a loser, but that every State would have the resources needed to combat the scourge of AIDS.

I offered amendments in committee to increase funding for the bill with Mr. TOWNS, Ms. ESHOO, and Mrs. CAPPS. It failed on essentially a party-line vote. So I strongly urge my colleagues to vote against this bill.

Where are our spending priorities? We continue to pass irresponsible tax cuts in a time of war, and yet shortchange cities and states who are just trying to provide lifesaving services. We're truly talking about life and death

here, and it is shameful that we are pitting states against each other for scarce funding.

Compounding the funding problem is that a proposed Severity of Need Index, expected to be implemented in this reauthorization, may consider state and local resources in determining how much federal funding to grant to states.

This is not the right message to send to NY that has more HIV/AIDS cases than any other state in the nation and spends more of its state dollars on care for HIV/AIDS patients than any other state in the nation. We have always viewed caring for our HIV/AIDS patients as a partnership between the local, state and federal governments. The Severity of Need Index is a powerful disincentive for states and local areas to take action.

It is with great sadness that I will vote against this bill today. But NY needs to make sure that we can keep helping the nearly 110,000 people living in our state with HIV/AIDS. We need to make sure we can keep providing life saving drugs and healthcare services which are preventing the transmission of HIV, preventing the progression from HIV to AIDS and ultimately keeping people from dying. This bill compromises our ability to do this.

This is why Mayor Bloomberg opposes this bill, this is why Gov. Pataki opposes this bill and this is why I must as well. Our nation deserves better than the underlying bill before us and it is a disgrace that this is all it will get.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentlewoman from Florida (Ms. ROS-LEHTINEN).

Ms. ROS-LEHTINEN. Mr. Speaker, I thank the chairman for the time.

Mr. Speaker, this bill seeks to offer services by primary care providers for the uninsured and less fortunate individuals. We have to work together to improve the quality and the availability of care for persons living with HIV/AIDS.

In my congressional district of Miami-Dade County, we had the second highest rate of AIDS, major cases of AIDS of all the cities in 2004. And the number of people suffering with HIV/AIDS has reached epidemic proportions, especially within my district with minority communities. There are over 12,000 people living with AIDS in Miami-Dade County and almost 10,000 living with HIV.

We have got to remain vigilant in our efforts to provide for and protect the HIV infected, affected, and at-risk individuals living in this country, especially through prevention and education; and this bill seeks to do that.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. TOWNS).

Mr. TOWNS. Mr. Speaker, I thank the gentleman for yielding. This bill, maybe if we changed the name of it, maybe it might help some folks, because this is called the winner-loser bill. Calling it Ryan White is a misnomer. I think that is a shame, that we would move legislation without the opportunity to amend it and to try to make it better and to be able to deal with the States that are getting hurt.

We act as if we are not talking about human beings. New York State would lose \$17 million. And, of course, the Governor of the State has said he is against the bill and the mayor of the city indicated that he is against the bill. And every Member of the New York State delegation, New York City delegation has indicated that they are actually against this legislation.

I don't understand why we have to rush this and put this kind of bill on suspension. It seems to me that this is a bill that we would bring up and give people an opportunity to amend it and make it as strong as possible, because we are talking about lives. So the reauthorization does not have to be brought up this kind of way.

And let us be candid, Brooklyn itself would lose approximately \$3 million, and that is the epicenter of the disease. So I don't understand why we can't take our time and provide help for the people that truly need help. Of course I am against this bill in every way, and I am hoping that my colleagues understand that we can do a much better job and that we need to do a much better job. What we have to do now is to defeat it and then let us go back and come up with a bill that is going to improve the quality of life for people that need it. I hope the Members of this body will understand that.

These States that are losing, and there are quite a few of them, I think that we would want to do something and do it right on behalf of the people. So I urge my colleagues to vote "no" on this bill.

Mr. BARTON of Texas. Mr. Speaker, I yield 2 minutes to the gentlewoman from New York (Mrs. KELLY).

Mrs. KELLY. Mr. Speaker, I rise in strong support of the Ryan White CARE Act and the great care that it offers for those suffering from HIV/AIDS. But today I reluctantly rise in opposition to this legislation because it contains flawed provisions with harsh and negative effects for New York's Hudson Valley and New York State.

I represent Dutchess County, New York, and the eligible metropolitan area in that county. If this bill is passed, Dutchess County would lose up to 5 percent the first year, and then incrementally more in the second and third year. And by the fourth year, all funds for title I would be eliminated for Dutchess County.

Title I money goes for support and services for people living with HIV/AIDS. The patients benefiting from these services simply will not get their needed medication because the program won't exist. If the funds to Dutchess County disappear, there is absolutely nowhere near where the HIV/AIDS patients would be able to go for support, services, and medication because the entire State is suffering from the cuts for New York that this bill calls for.

This means over 1,600 people in Dutchess County alone will lose out with the passage of the Ryan White

CARE Act in its current form. This is unacceptable, and that is why I reluctantly ask that you vote against H.R. 6143 at this time. This legislation should be brought up under regular order so that amendments can be offered.

And while I strongly support the Ryan White Act, the HIV/AIDS problem is a problem that requires resources to fight. While we recognize the need to direct attention to those communities where this is an emerging problem, we must not do so at the cost of the places that need it the most. People in my district and the people of New York need these lifesaving funds. Please don't take away from them. Vote against H.R. 6143.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. SOLIS).

Ms. SOLIS. Mr. Speaker, I thank the gentleman.

Mr. Speaker, I am not reluctant to vote against this bill. I voted against it in committee because it is not the right measure we should be approving today. In fact, I supported some of our alternative amendments that were presented by folks on our side of the aisle.

For my community, this is devastating. We see an increase in communities like East Los Angeles, the hub of the Hispanic community in the San Gabriel Valley, that fought over 20 years to combat this disease, yet it continues to be on the rise. Yet you want to take away very important funding and reappropriate it to other parts of the country.

We need to expand the pie. We need to make sure people are covered everywhere. And I am glad to hear from my colleagues that while we know that this is not a good solution, but we are really working toward a deadline of October 1, we should hold off, make some rational decisions, and when we come back in November do the right thing for those afflicted by this disease.

I am very concerned, because a large number of Latinas, almost 20 to 25 percent, are now faced with this disease, and it is through heterosexual relationships. We have yet to understand what the cultural dichotomies are that exist in our communities. We have to understand that, get information tools out there, a campaign to combat this disease, and put all the resources that are necessary there.

I am glad that we were able to get some semblance of these concepts in the bill, but it is still not good enough. Places like Los Angeles and San Francisco and other epicenters that we heard of in New York and Miami, they are affected. Our communities need this funding.

So I just want to say to my colleagues that don't know much about this, because it is on suspension, take a very close look at what is going on in your district. All of my groups, the minority groups that I represent, are saying that they also are urging us to vote "no" on this bill.

The reauthorization of the Ryan White CARE Act has enormous implications for people living with HIV and AIDS, and the communities providing related health services.

The communities I represent in East Los Angeles and the San Gabriel Valley have fought this disease since its onset over 20 years ago.

Los Angeles is an epicenter of the HIV and AIDS epidemic, with between 50,000 and 60,000 persons living with HIV/AIDS.

As the epidemic grows, communities of color are disproportionately at risk.

Although only 14 percent of the U.S. population, Latinos constitute almost 20 percent of the AIDS cases diagnosed since the start of the epidemic.

I am proud of the work that has been accomplished to codify the Minority AIDS Initiative in this reauthorization, a priority of the TriCaucus.

I am pleased that the committee agreed to report language recognizing the importance of language services to persons with limited English proficiency at risk of and living with HIV and AIDS.

However, I cannot support this legislation.

We are being pushed to vote on this legislation because of an arbitrary October 1 deadline.

We could move to extend this deadline and create better, sounder policy, as my good friend Mr. PALLONE has suggested, but instead we are being pushed to vote on legislation that risks too much for the health of too many.

This bill considers language services a support service, when in reality, for many racial and ethnic minorities, language services are necessary to ensure proper HIV/AIDS related health care.

This bill also bases future funding levels on questionable runs and conflicting data.

I believe that, while we need to address the increasing incidence of HIV and AIDS in the south and rural areas, we must do this without risking those communities such as mine which have historically had large populations and which continue to struggle.

The position we are in today is not enviable, but we have the opportunity to work through the needs of our States and communities by rejecting the arbitrary deadlines.

I am rejecting this risky bill and encouraging my colleagues to join with me. Let's give our suffering communities a better policy for a brighter, healthier future.

Mr. BARTON of Texas. Mr. Speaker, may I inquire as to the time remaining.

The SPEAKER pro tempore. The gentleman from Texas has 4½ minutes remaining, and the gentleman from New Jersey has 7 minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I yield myself 2 minutes.

Mr. Speaker, I want to put into the RECORD a letter dated September 19, 2006, from the County of Los Angeles signed by Reginald Todd, the Chief Legislative Representative for that county to Congresswoman BONO, where he states strong support of the current bill before us, and I want to read one sentence from this letter:

"The county understands that absent this legislation the Health Resources and Services Administration will count only HIV cases for States with mature

named-based HIV reporting systems in allocating Federal fiscal year 2007 Ryan White CARE Act funds. This would have a devastating fiscal impact on California and the County of Los Angeles. The proposed CARE Act reauthorization effectively addresses many of the concerns raised by the County's Board of Supervisors in its August 30, 2006, letter to you."

COUNTY OF LOS ANGELES,
WASHINGTON, DC LEGISLATIVE OFFICE,
Washington, DC, September 19, 2006.

Hon. MARY BONO,
House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE BONO: I am writing to communicate Los Angeles County's support for the Ryan White HIV/AIDS Treatment Modernization Act of 2006, which is due to be marked up by the House Energy and Commerce Committee on September 20, 2006.

This Ryan White CARE Act reauthorization legislation would allow states, such as California, which have converted or are converting to a names-based HIV reporting system to use the data collected through their code-based HIV reporting system. As you know, this is extremely important for California and Los Angeles County, which is the nation's second most HIV/AIDS impacted local jurisdiction. The Centers for Disease Control and Prevention (CDC) currently does not count California's HIV cases, as it does not consider the State's name-based HIV reporting system to be mature. While hard work lies ahead for California to fully implement its names-based HIV reporting system, we are confident that this provision in the legislation will adequately protect existing systems of care for its residents who live with HIV and AIDS.

The County understands that, absent this legislation, the Health Resources and Services Administration (HRSA) will count only HIV cases for states with mature name-based HIV reporting systems in allocating Federal Fiscal Year 2007 Ryan White CARE Act funds. This would have a devastating fiscal impact on California and the County. The proposed CARE Act reauthorization legislation effectively addresses many of the concerns raised by the County's Board of Supervisors in its August 30, 2006 letter to you. To further strengthen this legislation, the County encourages you to support efforts to extend the hold harmless provision for a total of 4 years, and a provision that counts HIV cases in states working toward mature HIV surveillance systems in periods when a hold harmless provision is not in effect.

Thank you for your assistance to the County on this important issue.

Sincerely,

REGINALD N. TODD,
Chief Legislative Representative.

What we have before us, Mr. Speaker, is a classic case of a formula funding fight. Those States and those cities that were the epicenter of the AIDS epidemic 10 to 15 years ago benefit greatly from the current formula. However, the AIDS/HIV epidemic is moving. It is actually, luckily, thankfully, declining in some of the areas where it began; but, unfortunately, it is growing in other areas where it wasn't prevalent 10 or 15 years ago.

The proposed legislation reallocates the funds based on HIV cases and AIDS cases. The old formula only counts AIDS cases. The old formula only counts what is called a named-base case. The new formula would allow for,

in addition to named-based cases, also what are called code-based cases, where individuals still have to be counted, but they are not collectively sent to HHS.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. WATERS).

Ms. WATERS. Mr. Speaker, I thank the gentleman from New Jersey for the time.

Mr. Speaker, I came to this floor really intending to support this bill. But, you know, I am not going to do it. I am not going to support this bill. It is not worth the paper it is written on.

Here we are fighting with each other, people from New York and California and places fighting with people from the South because we have a piece of legislation that is pitting us against each other instead of funding what needs to be funded with HIV and AIDS.

Over 1 million people in the United States have HIV/AIDS. African Americans are only 13 percent of the population, but we account for a half of all the new AIDS cases. African American women represent 71 percent of the new AIDS cases among women, and African American teenagers represent 66 percent of the new AIDS cases among teenagers.

The Congressional Black Caucus has been struggling and working, and I have been working on this for 15 years. We are spending \$2 billion a week in Iraq. We only need \$1 billion more to fund all of these programs adequately. What are we doing? Let's not play with this. Don't accept this. Don't pit yourself against your friends and your colleagues. Tear it up. It is not worth the paper it is written on. Vote "no" on this bill. Throw it out and let's start all over again next year.

I am with my friends from New York. I support the South. But let's not be scrambling over pennies. People are dying. And don't tell me we don't have the resources to deal with it. Even if you didn't spend \$2 billion a week in Afghanistan, in Iraq, we would be able to fund this adequately.

Somebody does not care that Americans are dying. Somebody doesn't give a darn that it is decimating black populations. Let's stop playing the game. Let's stop it today. Stop this bill. Don't think you're so desperate you have to vote for anything in order to get a little something. Throw it out. It's not worth it.

Mr. BARTON of Texas. Mr. Speaker, I yield myself 30 seconds.

I appreciate the gentlewoman's passion, but I just want to point out the facts. If we don't pass this bill today, the City of Los Angeles, in 3 days, is going to lose over \$4 million, and the State is going to lose over \$6 million. The State could lose up to 21 percent of its AIDS funds.

Now, those are the facts.

□ 1500

Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to my colleague from New Jersey (Mr. PASCRELL).

Mr. PASCRELL. I rise today, Mr. Speaker, in strong opposition to the legislation before us. It reduces vital funding for States that are most heavily impacted.

I absolutely disagree with the Chair. He is wrong when he says that this problem has shifted. The epidemic has expanded. It has not shifted. There are more areas that are involved, and we should be fair to all areas besides New York, California, Florida, Texas and New Jersey. I can't support that idea. If Ryan White resources are to follow the epidemic, they must continue to flow to all jurisdictions, and be increased.

It is irresponsible to take an already inadequate pot of money and cover new areas with it, taking it away from the areas of need. If you don't understand what the need is in those five States that I recognize, I will give you the flat statistics: They are not diminishing in any sense of the imagination whatsoever. I don't know what facts you are looking at.

Under the proposed bill in the House, Mr. Speaker, funding for New Jersey will be cut by \$13 million. I looked at the numbers in New Jersey. I have worked on this problem for 15 years. I don't know where this gentleman is coming from when he says that the problem is less in those five States that I mentioned and increased in other areas. It just is not so. It is not true. Sixty thousand of these dollars will go directly to the two counties that I am involved in, a cut of 40 percent in the funding.

I urge you to vote against this proposed legislation. It will hurt all EMA and the States most affected by the devastating effects of HIV.

Mr. BARTON of Texas. Mr. Speaker, I reserve my time.

Mr. PALLONE. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I think if you have listened to those in opposition to this bill, you recognize that there is not a consensus. One of the things that disturbs me the most today is that this is on the suspension calendar. This does not belong on the suspension calendar because it is obviously a very controversial piece of legislation.

Let me tell you, I heard my colleague from New Jersey (Mr. PASCRELL). I went to one of the centers in my State in my district that treats AIDS and HIV patients, and I want to tell you, people are scared about this. They are very, very concerned that if this legislation passes in its current form that we are just not going to have the funding to deal with the AIDS and HIV cases in my State.

Really, when you have a situation where so many people are worried about the impact this is going to have, and we have clear indication that this is not going to be enough money, this is simply not the way to go.

I have no reason to believe if this bill goes to the other body that it is actually going to end up in something that

goes to the President's desk. It is simply a mistake to deal with this on the suspension calendar with all the controversy that exists over it.

Mr. Speaker, again, I want to stress again those of us who are in opposition to this bill, why we feel so strongly about it. The problem is that it is woefully underfunded. No one is suggesting that more money doesn't need to go to other parts of the country, that maybe the formula needs to be changed in some fashion. But the problem is there just isn't enough money to go around. So you have a situation where we are pitting one State against another or even different parts of the State of one State against other. It just isn't right.

My colleagues on this side of the aisle have pointed out over and over again how we are spending money in Iraq, we are spending money on tax cuts. The problem here is the Republicans, those on the other side of the aisle, are not prioritizing funding where it should go. It should go to health care. It should go in this case to not only the AIDS patients but also those with HIV.

The problem is we tried many times in committee to add through various amendments on our side of the aisle amendments that would increase the funding, hold harmless those States and those localities that need this funding under the current formula. Every time we tried to do that we were not successful because of the Republican leadership and the opposition, if you will, to the suggestions that we were making.

I can't stress enough, there is not enough funding in this bill. We really should go back to day one. One of the amendments that I had was simply reauthorize the program the way it is for another year and hold us harmless for a year as we tried to find a solution that would be acceptable to everyone. That did not happen; and, instead, instead of having a normal debate and allowing amendments on the floor in the normal course of procedure, we stand here today with this bill on the suspension calendar.

It shouldn't be here. The consensus doesn't exist. I urge my colleagues to vote against this legislation, and let's bring it back on an occasion when we can actually have a full debate and have amendments.

Mr. Speaker, I yield back the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I will include for the RECORD a list of over 20 organizations that have endorsed the bill, as well as a letter from the AIDS Institute dated September 28, 2006, signed by Dr. Gene Copello.

Mr. Speaker, I want to read from the AIDS Institute endorsement letter that was dated September 28 by Dr. Gene Copello. I won't read the entire letter, but I want to read parts of it.

It says, "Dear Representative: The AIDS Institute," and this is a non-

partisan institute, "urges you to vote 'yes' today on the Ryan White HIV/AIDS Treatment Modernization Act, H.R. 6143.

"While no bill that is crafted through a series of compromises is perfect, the AIDS Institute strongly supports its immediate passage because it would better direct limited resources throughout the country in a more equitable fashion. Additionally, it contains a number of important reforms that seek to update the law to better reflect today's epidemic.

"If the bill is not passed this week, a number of States and the District of Columbia will lose funding, and the important reforms contained in the bill will not be allowed to be implemented for the coming year."

Mr. Speaker, the bill before us is the result of bipartisan, bicameral negotiations over a several year period. It is not perfect, but it is a better bill and better legislation than current law. It more equitably allocates the funds not just for AIDS patients but also for HIV patients.

The States that lose in the new formula are guaranteed 95 percent of their current year funding for 3 years, 95 percent. And then, in the fourth or fifth year, they are allowed to petition through a supplemental fund to make up for these losses under the old baseline formula.

This is a very fair compromise. It begins to treat all States on an equal footing; and it also, for the first time, begins to count HIV cases as well as AIDS cases. It deserves to be supported.

Please vote "yes." We do need a two-thirds vote to pass this, because it is on the suspension calendar. So we need more than a majority vote.

Please vote "yes" on H.R. 6143.

ORGANIZATIONS THAT SUPPORT THE RYAN WHITE HIV/AIDS TREATMENT MODERNIZATION ACT

AbsoluteCare Medical Center.
ADAP Coalition.
AIDS Action Coalition; Huntsville, AL.
AIDS Alabama, Inc.
AIDS Healthcare Foundation.
AIDS Outreach of East Alabama Medical Center.
Alaska Native Tribal Health Consortium.
American Academy of HIV Medicine.
American Dietetic Association.
Am I My Brother's Keeper, Inc.
Brother 2 Brother.
Carepoint Adult, Child and Family.
Catholic Charities Diocese of Fort Worth.
First Ladies Summit.
Harabee Empowerment Center.
HIV Medicine Association.
Latino Coalition.
League of United Latin American Citizens (LULAC).
Log Cabin Republicans.
Lowcountry Infectious Diseases.
Montgomery AIDS Outreach.
National Black Chamber of Commerce.
National Coalition of Pastors Spouses.
National Minority Health Month.
New Black Leadership Coalition.
President's Advisory Council on HIV/AIDS.
Rep. Linda Upmeyer (Iowa State Rep, District 12).
South Alabama Cares.

Southern AIDS Coalition.

THE AIDS INSTITUTE,
September 28, 2006.

Re: Vote "yes" on Ryan White HIV/AIDS Treatment Modernization Act.

DEAR REPRESENTATIVE: The AIDS Institute urges YOU to vote "yes" today on the Ryan White HIV/AIDS Treatment Modernization Act (H.R. 6143). This important bill would reauthorize the Ryan White CARE Act for the next five years. Ryan White CARE Act programs provide lifesaving medical care, drug treatment, and support services to over 535,000 low-income people living with HIV/AIDS throughout the nation. The bill is the result of three long years of work and has been carefully crafted in an unprecedented bipartisan, bicameral fashion.

While no bill that is crafted through a series of compromises is perfect, The AIDS Institute strongly supports its immediate passage because it would better direct limited resources throughout the country in a more equitable fashion. Additionally, it contains a number of important reforms that seek to update the law to better reflect today's epidemic.

The bill prioritizes medical core services, including medications; takes into account HIV case counts, in addition to AIDS cases; and addresses such issues as co-morbidities, unspent funds, accountability, and coordination of services. While at the same time, the existing title structure and the AIDS service infrastructure together with the social service component of AIDS care and treatment remain.

If the bill is not passed this week, a number of states and the District of Columbia will lose funding, and the important reforms contained in the bill will not be allowed to be implemented for this coming year.

This reauthorization process has been long and divisive for all those involved. Unfortunately, it has pitted HIV/AIDS patients from one part of the country against another. Congress has to do what is best for the entire nation; just not one state or region.

The AIDS Institute urges you to vote "yes" on H.R. 6143.

We thank you for your interest in this legislation, and look forward to working with you to adequately fund Ryan White CARE Act programs to meet the growing domestic need for HIV/AIDS care and treatment. The AIDS Institute is extremely disappointed the bill provides absolutely no increase next year for the nation's AIDS Drug Assistance Programs (ADAPs). We hope you will join us in seeking new additional money for ADAP in FY07 as part of the Labor, HHS Appropriations bill.

Should you have any questions or comments, please feel free to contact me or Carl Schmid, Director Federal Affairs for The AIDS Institute at (202) 462-3042 or cschmid@theaidsinstitute.org.

Sincerely,

DR. A. GENE COPELLO,
Executive Director, The AIDS Institute.

Ms. LEE. Mr. Speaker, I must reluctantly rise in opposition to H.R. 6143.

As the Co-chair of the Congressional Black Caucus Global AIDS Taskforce, I have consistently fought for more funding for our HIV/AIDS programs.

Along with my colleagues in the CBC, we have helped lead efforts to raise awareness about HIV/AIDS in the African American community, and last year the House passed my resolution supporting Black HIV/AIDS Awareness Day.

I have also tried to do my part to encourage wider testing for HIV, introducing several resolutions on the subject, and just yesterday by getting tested with my colleagues in the CBC.

With my colleagues I have also worked to dramatically scale up U.S. foreign assistance on HIV/AIDS, provide the framework for the creation of the Global Fund, and focus assistance on orphans vulnerable to this disease.

Unfortunately today I must stand against this bill because it significantly cuts HIV/AIDS funding in my district in Alameda County. In its current form, this bill will force the consolidation and closure of AIDS service organizations who are on the front lines in fighting this disease.

I do believe there are some strengths to this bill. In particular the inclusion of the Minority AIDS Initiative—an initiative created through the leadership of my colleague MAXINE WATERS, the CBC, and President Clinton—should be applauded.

But without changes to the current formulas, or increased appropriations to fund these programs, I cannot support this bill in its current form.

Mr. LANTOS. Mr. Speaker, I rise in reluctant opposition to H.R. 6143, the Ryan White HIV/AIDS Treatment Modernization Act of 2006. I fear that this bill due to be reauthorized last year is now in danger of being rushed through to a vote just before a recess before an election.

The bill, in its current form, does not adequately address the challenge of HIV/AIDS. Because tax cuts for the wealthiest Americans have contributed to extraordinary deficits, we are forced to pinch pennies when it comes to saving the lives of millions of Americans. Rather than provide needed increases for the Ryan White program, this bill reduces funding in larger metropolitan areas and redistributes those funds to rural and suburban areas faced with an increase in the number of HIV/AIDS patients.

I am very concerned that all of those in need receive the necessary and appropriate treatment whether they live in urban, suburban, or rural communities. I firmly believe that the localities facing this increasing challenge should get the funds they need to care for their citizens. However, that should not come at the cost of taking away from cities like San Francisco, which has the highest per capita prevalence of people living with AIDS, and other cities such as Los Angeles, Chicago or New York. Saving our neighbors and loved ones from this epidemic should not come from a policy of robbing Peter to pay Paul.

The Ryan White Act and all of those afflicted by HIV/AIDS needs our attention and our support for additional funds. Short-changing this program insults its namesake, it insults the millions who have died from AIDS, it insults those who are currently living with it day in and day out, and it insults their families. There are millions of Americans who rely on this program to receive the services they so desperately need to live. I recognize that they are not just from San Francisco or New York, but they are also from Dubuque and Omaha, Charleston and Boise. I do not question the need for services and care. Geography should not determine whether you live or die from AIDS and that is why we should do more than simply shift money around.

Mr. Speaker, I had hoped that we would be able to succeed in passing legislation that would help benefit all the victims of this illness. Instead, a bill may pass today that does not accomplish this goal. Rather it will help some and hurt others, especially I fear in the

San Francisco Bay area. I urge my colleagues to take the needed time and bring us a bill we can all support wholeheartedly knowing that it will benefit all Americans with HIV/AIDS.

Mr. NADLER. Mr. Speaker, I rise today in reluctant opposition to H.R. 6143, the Ryan White HIV/AIDS Treatment Modernization Act of 2006. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is the centerpiece of the federal government's response to the HIV and AIDS epidemic. H.R. 6143 woefully under-funds the HIV/AIDS resources the CARE Act provides; this bill is a deeply flawed shadow of what it could and should be.

The Chairman has argued here today that the epicenter of the AIDS epidemic has shifted, and that the number of AIDS cases is on the wane. Therefore, he says, fewer resources are needed to fight the disease, and those funds can be spread around. I don't know where he gets his figures, Mr. Speaker. The Chairman is flatly wrong.

The fact is that New York State has the most HIV cases and the most AIDS cases of any other state in the nation—almost 17 percent of HIV/AIDS cases nationwide. More than half of people living with HIV in the United States reside in five states—New York, Florida, Texas, California, and New Jersey. The fact is that New York City has the oldest, largest, and most complex HIV/AIDS epidemic in the United States. New York City accounts for one of every six reported AIDS cases in the United States, and each year reports more AIDS cases than Los Angeles, San Francisco, Miami, and Washington, D.C. combined. And the fact is that the number of people who so desperately need the services in this bill has been and continues growing.

But the funding has not. The programs the CARE Act covers have been level funded for years, despite increases in healthcare costs and inflation. And this bill unfortunately continues that trend. Under the flawed funding formula in this bill, three of the highest prevalence states in the nation—New York, Florida, and New Jersey—will lose significant funding. The City of New York predicts a \$17.8 million loss in the first year alone, and more losses in each of the remaining 4 years of the reauthorization; New York State anticipates a loss of \$118 million over the life of this bill.

This will be unspeakably detrimental to the state's ability to care for the HIV/AIDS population. The reductions in funding will require cost containment measures, including deep cuts in covered drugs and services. In the first year alone, this will translate to the elimination of nutritional, housing, mental health, and transportation services, as well as increased out-of-pocket costs for participants. This will also lead to a major reduction and/or removal of entire classes of drugs from the state's pharmaceutical formularies.

We have a choice. We can go back to the table and negotiate a compromise. My friend from New Jersey, Representative PALLONE, has introduced legislation (H.R. 6191) that would temporarily reauthorize the program for one year to allow Congress to continue working on a bill that would not unfairly reduce funds for any state. Additionally, H.R. 6191 would increase authorized appropriation levels for all titles of the CARE Act so we can get the services and treatment to people who need it while we craft a bill that works. This is the bill we should be voting on today.

Mr. Speaker, my district has been on the frontline of the fight of this epidemic for over 20 years. I know a good approach when I see one, and the bill we are debating on the floor today isn't it. I urge a "no" vote on H.R. 6143.

Mr. MCGOVERN. Mr. Speaker, it's hard to believe, but it's been 25 years since the first AIDS case was reported in the United States. Growing from a cluster of cases in Los Angeles in 1981, this disease spread throughout every segment of our society—no one was left untouched, and we were all forced to watch helplessly as AIDS transformed into a worldwide pandemic. In all, there have been 1.6 million cases of HIV infection in the United States including over 26,000 in Massachusetts.

Thanks to research and medical advancements, we began to make great strides in HIV treatment. By 1987, the first antiviral drug was approved by the Food and Drug Administration (FDA), and 3 years later, in 1990, Congress passed the Ryan White CARE Act, which helped to improve the quality and availability of care for persons with HIV/AIDS. Gradually, with adequate care and treatment, those infected with HIV began to live longer, healthier lives.

Today, there are over 1 million people living with HIV/AIDS in the United States, the highest number in the history of this disease. But, with these improvements has come a greater need for the health care services and drug treatment provided by the CARE Act.

Each year, 40,000 people are infected with HIV in the United States. But rather than increasing funding for these programs, Congress has flat funded the CARE Act for a number of years. And unfortunately, the bill that this House is considering today, H.R. 6143, which reauthorizes the Ryan White CARE Act, once again fails to provide the necessary funds to meet the needs of this growing population. Instead, it shifts funds around—robbing Peter to pay Paul—while placing an even greater strain on the program's limited resources. As a result, vital medical and supportive services stand to be severely underfunded without any consideration for the human lives at risk.

A number of amendments were offered in Committee to increase funding for Title I, the Emergency Relief Grant Program, and Title II, the Care Grant Program. But, unfortunately, they were defeated by a largely party-line vote.

And, today, rather than allowing these and other amendments to be brought before the full House for consideration, this Republican-controlled Congress has closed off the process, providing us with only a mere up or down vote on this bill.

For these reasons, I oppose H.R. 6143, and I urge my colleagues to join me in voting no.

Mr. DINGELL. Mr. Speaker, I support H.R. 6143, the Ryan White HIV/AIDS Treatment Modernization Act of 2006, but I also support providing significantly more funding for it. Since 1990, the Ryan White funding has been an integral part of our domestic response to the HIV/AIDS epidemic, helping metropolitan areas, States, and territories pay for essential healthcare services and medications for people living with and affected by HIV/AIDS.

This is another program hurt by the majority's budget priorities. For every millionaire that gets a large tax cut, there are many people with HIV/AIDS not getting the help they need.

And this underfunding means that the reforms in this bill hurt some States and cities that have borne the brunt of this crisis.

Nonetheless, the bill before us has many improvements, and is worthy of support at this point even though authorization levels are too low. This bill recognizes the changing demographics of the HIV/AIDS epidemic in our Nation. It expands access, improves quality, and provides additional services to help target healthcare services and other support services to communities throughout our Nation that need them most.

The policy of this bill may be adequate, but it is only a paper promise without sufficient funding. As this bill goes to conference, the majority will have one more chance to recognize the human cost of their budget priorities and properly fund this program.

Ms. PELOSI. Mr. Speaker, 19 years ago, I came to Congress to fight AIDS, a disease that has taken nearly 18,000 lives in my city of San Francisco alone.

We have lost friends, family, and loved ones, but we have not lost our will to fight this terrible disease. This year, we mark the 25th anniversary of the first diagnosis of AIDS—a stark reminder that this epidemic is still among us, and that our work is not done.

Yet as we grieve for those we have lost, we are filled with hope as we see the strength of those who are fighting and living full lives with HIV and AIDS. This would not be possible without the help of the Federal Government through initiatives such as the Ryan White CARE Act. The act has been instrumental in our fight to defeat AIDS. It has greatly improved the quality and availability of health care services for people living with and affected by HIV and AIDS. I was proud to be a part of the creation of the Ryan White CARE Act.

Unfortunately, I must rise in opposition to this reauthorization.

There are a number of good provisions in this bill, including the recognition of emerging communities and the use of actual living AIDS counts rather than estimated living AIDS cases. That change will benefit many communities, including my constituents in San Francisco.

However, when it comes to meeting the needs of people living with AIDS, our mantra should be the same as the physicians who care for all patients: first, do no harm. The primary problem with this legislation is that it fails to provide adequate funding for the treatment of HIV/AIDS patients.

Had this Administration and the Republican-controlled Congress made a priority of funding the Ryan White program over the last several years, I would be standing here in strong support of this bill. But they have not, and I cannot support this bill.

Yet funding in this bill simply won't be able to meet the current demand for HIV/AIDS care in the United States. Under this reauthorization, San Francisco, with the highest per capita caseload of people living with AIDS in the country, stands to lose almost \$30 million over the next 5 years.

That is a far cry from the bipartisan consensus we were able to achieve on this issue between 1993 and 2001. During that time, funding—adjusted for both inflation and caseload growth—under the Ryan CARE Act increased by 70 percent.

Since 2001, funding has declined by 35 percent.

The problem is not that one part of the country gets too much money and some other parts of the country are left behind. Instead, people suffering from this disease—and those caring for them—are being forced to compete for pieces of an ever-shrinking pie.

If funding for this Act had simply kept pace with the number of people with AIDS and inflation, my city and all other cities and States would be getting increases in funding instead of grappling with how they can stretch—and where they will have to sacrifice—in meeting the growing demand for services.

In fact, the impact of the cuts will be compounded, because in San Francisco, these funds form the basis for matching funds from the city.

Due in no small part to this Federal, State and local investment, more people are living with HIV and AIDS now than dying from it. That is remarkable.

As the epicenter of the epidemic, San Francisco has experienced terrible loss of life—but from that loss, my city has created a standard of care that has been a model for the Nation.

But our problem has not gone away. There are more people living with AIDS in the San Francisco's area than at any point in the epidemic's history.

This legislation has far-reaching implications for the stability of HIV/AIDS funding in our State and cities. The programs funded by the Ryan White CARE Act have literally been lifesavers for people who live with HIV/AIDS.

It has provided critical support to the cities that have been the center of the epidemic, and to States that have been funding critical drug and support programs to treat the disease. This cut in funding to San Francisco means a loss in services for patients receiving primary medical care, a lack of access to counseling, support, outreach services, transitional and emergency housing and emergency payments for health care costs.

Where do these people go? What do we tell them when their ability to receive support to fight HIV/AIDS is cut off?

In prior reauthorizations of the Ryan White CARE Act, the changes that have been made were made at the margins in order to deal with emerging problems and developments; these changes did not, however, disrupt an initiative that was working.

Unlike those past reauthorizations, this bill would have a drastic destabilizing effect on many of the hardest-hit areas of the country, including California.

A basic goal of this reauthorization must be to ensure that the actions we take do not destabilize systems already in place. Unfortunately, the bill fails to meet this goal and jeopardizes the critical funding of areas throughout the country, in general, and the State and cities of California in particular.

In addition, the bill prematurely incorporates HIV reporting into the allocation formula, eliminates the hold harmless provision just when San Francisco and California need it the most, and allows the Administration to devise and implement a whole new funding formula without Congressional approval.

It is for these reasons, I must oppose this bill. And I will submit the entirety of my statement for the record.

The second major problem with this legislation is that there is simply no way to incorporate data on HIV cases into the funding formula on a consistent and comparable basis

across jurisdictions. The 2000 reauthorization of the Act included a requirement that HIV cases be incorporated into the funding distribution by no later than 2007. At that time, HIV reporting systems were in various stages of development across the country; although some states and cities had been reporting HIV cases by name since 1985, others had yet to implement an HIV-reporting system at all. Given this landscape, the drafters understood the need to provide sufficient time to allow states and cities to begin collecting HIV cases. At the time, they believed seven years to be adequate for such a transition. As it turns out, it was not.

As HIV reporting systems were developed, variations among these systems across jurisdictions emerged. Some areas reported HIV by the individual's name along with other identifying information. Others, like California, as a means of protecting the individual's confidentiality, opted not to report the person's name at all, and instead included only a unique code identifying the individual. The 2000 reauthorization of the Ryan White Act did not specify which type of reporting system jurisdictions were required to use and nothing in the law prohibited this kind of variation. So long as the Secretary found that the data on HIV cases was "sufficiently accurate and reliable," jurisdictions were free to report cases by name or by code. Thus, whether an area began collecting HIV by name or by code, they were on equally solid ground under the law.

It was not until December 2005, that CDC first gave a clear indication that it would deem only cases reported by name to be "sufficiently accurate and reliable." In a letter to all code-based States, CDC set forth its strong recommendation that those States convert their systems to names-based—it did not, however, establish any sort of legal requirement. At that point, 13 States used some form of a code-based reporting system. In response to CDC's announcement, almost all code-based States began the process of converting their HIV reporting systems to names-based systems.

The reported bill would rely exclusively on names-based HIV and AIDS cases in making funding allocations starting in fiscal year 2011. In order to meet this deadline, and have all of their names-based HIV cases counted for funding purposes, code-based jurisdictions will be required to have completely converted to names-based systems in less than 3 years.

For large and diverse code-based States with several very large cities, like California, this is simply not enough time to make this change. California essentially has to start from scratch. In its code-based system, California currently has approximately 40,000 cases of HIV (non-AIDS). Under California law, these cases cannot simply be re-tallied under the new names-based system. In order to incorporate these cases into the new system, the State must contact each of these 40,000 individuals, and ask them to come in to a testing site to be re-tested. Some of these individuals are homeless. Some are drug-abusers. Many don't speak English. When personnel and resources are already strained, California will simply not be able to get all of these individuals entered into the names-based system in 3 years.

The experience of other large code-based systems provides a sense of the difficulty of this task. New York, for example, converted to

a names-based system in 2000 and is now considered by CDC to be mature. However, it is widely acknowledged that New York's current names-based HIV count severely undercounts the true burden of HIV in the State simply because it has not had enough time to find and report all of its HIV cases.

I cannot support legislation that would disadvantage my State and city and take large amounts of dollars away simply because the data system is incomplete. The number of persons with HIV and with need for services remains. They should not lose needed services because of an unrealistic data requirement.

Under the language of the proposal, it is also unclear on what basis the funds will be allocated. GAO and the State of California, both of which have modeled the bill, have quite different case counts for the same State and city. The proposed language says code-based numbers are used to determine funding allocations. HRSA numbers used by GAO in their estimates are not code-based numbers. Those numbers purport to show need—not any scientific way of counting cases and a method which surely varies from jurisdiction to jurisdiction depending on how much the grantee estimated. What assurance is there that the GAO numbers will be used to allocate funds in fiscal year 2007 and the out years? This does not pass the test of good government.

Under the proposed language, the case count used in 2010 and 2011 in making the allocation to San Francisco will be substantially less than the actual number of HIV positive individuals who currently live in San Francisco. That simply is unfair and is not good policy.

Because HIV reporting systems across the country remain in a state of flux, it is critical that this reauthorization protect against severe losses in funding when the bill requires that the funding be based on HIV cases. The most effective way to accomplish this protection is to incorporate a hold-harmless provision for the entire life of the bill. Unfortunately, the current bill protects a jurisdiction's funding for only the first 3 years. This is not enough.

California faces the most drastic cuts at the very time the hold harmless under the bill comes to an end. By California's estimates, the State stands to lose nearly 25 percent of its total Ryan White Care Act funding during the 5th year of the bill alone. Our State simply cannot sustain these kinds of losses.

In year 5, when transition to names-based reporting becomes mandatory, California (and all other jurisdictions moving to names-based reporting) will lose substantially. The amount of loss is difficult to ascertain, because it will depend entirely upon how quickly California and other jurisdictions can transition to names-based reporting.

The elimination of the hold harmless will have a devastating impact on the provision of HIV/AIDS services in San Francisco. The hold harmless was adopted to protect the epicenters of this disease from experiencing drastic reductions in CARE funding from year to year that would disrupt the systems of care in place, and eliminating it now would cause this very consequence. As you may know, the city of San Francisco consistently has invested local funds into the fight against this disease and the care of those living with HIV/AIDS. San Francisco has been conscientiously preparing to absorb cuts as a result of the eventual loss of the hold harmless, but the more

than one-third cut in funding proposed is punitive and will eliminate critical care for thousands of people living with HIV/AIDS.

Finally, I cannot support the bill's inclusion of the so-called "severity of need index" (SONI). The bill requires the Secretary to develop a SONI to measure the relative needs of individuals living with HIV/AIDS, but fails to specify the factors that should be incorporated into this index, leaving it entirely up to the Secretary. Further, the bill then permits the Secretary to completely discard the current funding formula and distribute funding on the basis of this SONI beginning as early as FY 2011 without Congressional action. This is unacceptable. Congress—not the Administration—should be solely responsible for making such a drastic shift in the way funds are distributed under the Act.

Mr. GENE GREEN of Texas. I rise in support of this legislation to reauthorize the Ryan White CARE Act. Initially enacted in 1990, the Ryan White CARE Act provides critical medical treatment to individuals living with HIV and AIDS. The Ryan White program is essentially a payer of last resort and specifically targets uninsured and medically underserved individuals living with HIV and AIDS.

In my community in Harris County, our Hospital District utilizes more than \$26 million each year to coordinate essential health care and support services for more than 21,000 individuals in our community living with HIV and AIDS. The importance of this program cannot be overestimated; without CARE Act funds, many Americans living with HIV and AIDS would have no other source for treatment.

This reauthorization bill includes an important change in the criteria used to formulate funding under the Ryan White program. Thus far, funding was determined based on a grantee's estimated number of living AIDS cases, with a jurisdiction's number of HIV cases not included in funding determinations.

As the HIV/AIDS epidemic has shifted geographically, our funding formulas must change to meet increased need for care in certain areas. Southern States and rural areas are seeing higher numbers of individuals with HIV, for whom treatment is necessary. I wholeheartedly support the use of HIV counts in CARE Act funding formulas to provide these areas with the support they need to develop appropriate systems of care. However, it is important that the funding formula recognize that urban areas—particularly those in New York—continue to be the epicenter of the AIDS epidemic. Unfortunately, this bill does not provide the necessary assurances that communities with a high prevalence of HIV/AIDS will have the resources to maintain their systems of care.

In this kind of formula fight, the battle lines are drawn geographically rather than ideologically. I appreciate the work of Chairman BARTON, Ranking Member DINGELL, and their staffs, who worked tirelessly for more than 6 months to develop a bi-partisan, consensus bill that sought to address great need in every area of this country. Nevertheless, in this type of bill there are always winners and losers. This bill contains more winners than losers, and my State of Texas comes out a winner, relatively speaking. For that reason, I am happy to support this legislation and encourage my colleagues to do the same.

Mr. CROWLEY. Mr. Speaker, I rise in opposition to the Ryan White HIV/AIDS Treatment Modernization Act of 2006.

Today as we debate the Ryan White HIV/AIDS Treatment Modernization Act of 2006 we must take into account one fact. The fact is that New York is the epicenter of the HIV/AIDS epidemic, and while New York has the highest prevalence of HIV/AIDS in the country, they have made the most progress in battling this disease.

Now, in a normal situation, New York would be rewarded with more funds to battle this epidemic, and be set as an example for the rest of the country, however under this bill they would not be. In fact, the opposite would occur. Under the current proposal, New York City would lose a whopping \$17 million the first year, and New York State would lose an estimated total of \$78 million over the course of the 4 years of the reauthorization.

My district, in New York has one of the highest prevalence of HIV/AIDS in all of New York City. This bill would take precious funds away from individuals in my districts, as well as New York State, California, New Jersey, and Florida and other states that are on the front line of this fight.

To add insult to injury, the Republican Congress refuses to give this bill the due diligence it deserves. Instead they are debating this bill under Suspension of the rules, with no opportunity for Members to offer amendments and a short debate schedule.

This is unacceptable for New York, this is unacceptable for New Jersey, this is unacceptable for Florida, and most importantly this is unacceptable for the millions of people who will have to suffer as a result.

I urge my colleagues to vote "no" on this legislation. Instead let's continue to negotiate so New York, New Jersey, Florida and other states that stand to lose millions can be spared.

Mr. SOUDER. Mr. Speaker, as the nation's largest AIDS-specific care program, the Ryan White CARE Act plays a critical role in providing HIV/AIDS treatment and support equally to all U.S. citizens needing such medical care. Ryan White, as many of you know, was a fellow Hoosier and a heroic young man and this program that so many depend upon to stay healthy and alive is a great tribute to him.

Currently, the federal government is funding wasteful and unnecessary programs that would otherwise be held in check if this reauthorization had already been law. This bill would require that 75 percent of CARE Act funds be spent on primary medical care and medication. This is important because in the past, funds were misspent on unnecessary and dubious programs while thousands living with HIV were on waiting lists for AIDS medications.

Let me give a recent example of government waste that would have been better spent treating those with HIV but without access to treatment.

According to the Department of Health and Human Services, \$405,000 in federal funds was provided this month to the National Minority AIDS Council for its annual U.S. Conference on AIDS. Held at a beachside resort in Hollywood, Florida, the conference featured a "sizzling" fashion show, beach party, and "Latin Fiesta." Indirect costs are not yet available from HHS regarding the cost of sending 67 employees from the Centers for Disease Control and Prevention, 5 employees from the National Institutes of Health (NIH), and one NIH contractor.

While such spending strikes one as strange, the examples don't end there. The New York Times reported that New York was paying for dog walking and candle-lit dinners with AIDS funds, while other areas of the country do not even have sufficient funds to pay for medications for those living with HIV. Hot lunches, haircuts, art classes, and even tickets to Broadway shows were financed by federal funding.

Indeed, although the federal government spends over \$21 billion on HIV/AIDS annually, up to a staggering 59 percent of Americans with HIV are not in regular care. This misallocation of funds is great cause for concern and should motivate Members of Congress to respond by supporting the reauthorization of the Ryan White CARE Act. By doing so, greater oversight in funding would be provided.

The reauthorization of this act would prioritize medical care and treatment over less essential services and programs. I ask my colleagues to support this reauthorization.

Ms. ESHOO. Mr. Speaker, when Congress passed the Ryan White CARE Act in 1990, we sent hope to millions of Americans who were living under a death sentence that came with a diagnosis of HIV or AIDS. In large part because of Ryan White, outcomes have dramatically improved.

This bill fails to uphold the hopeful tradition of the original legislation because it creates a system of winner and losers in the allocation of federal resources. This major reauthorization of our federal HIV/AIDS policy is also being considered under suspension of the rules, prohibiting Members from offering amendments to address the serious deficiencies in the bill.

Last week, I offered an amendment with several of my colleagues from the California, New York and New Jersey delegations to increase the overall authorization levels in the bill which would help address the needs of communities more recently affected by the epidemic. Our amendment also extended the hold harmless provisions of the bill by two years to ensure that the historic epicenters of the disease do not experience precipitous declines in funding levels from year to year. Our amendment was defeated by a single vote.

Today we can't offer that amendment or any other. Instead, we're left with a "take it or leave it" proposed that doesn't adequately respond to the real needs of people suffering from HIV and AIDS.

Congress has responsibility to address the imminent crisis facing emerging communities, but we can't abandon the infrastructure of care already in place. By eliminating the hold harmless provision after three years in order to free up funding for emerging communities, some localities will experience sharp funding declines.

The bill also doesn't allow sufficient time for states to transit HIV code-based reporting systems to the more efficient names-based system. Although California is making enormous strides to comply, Governor Schwarzenegger reports that the state will likely miss the 2009 deadline, sustaining a loss of up to \$50 million, or 23 percent, of its total funding in FY2011. Such a loss has the potential to derail the entire state's HIV/AIDS care system.

Given my serious concerns about the ability of this bill to preserve current infrastructure of care while extending assistance to areas of

the country newly affected by the HIV/AIDS epidemic, and with no opportunity to address these concerns with amendments, I reluctantly oppose this bill.

The SPEAKER pro tempore (Mr. TERRY). The question is on the motion offered by the gentleman from Texas (Mr. BARTON) that the House suspend the rules and pass the bill, H.R. 6143, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. PALLONE. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this question will be postponed.

FORT McDOWELL INDIAN COMMUNITY WATER RIGHTS SETTLEMENT REVISION ACT OF 2006

Mr. HAYWORTH. Mr. Speaker, I move to suspend the rules and pass the Senate bill (S. 2464) to revise a provision relating to a repayment obligation of the Fort McDowell Yavapai Nation under the Fort McDowell Indian Community Water Rights Settlement Act of 1990, and for other purposes.

The Clerk read as follows:

S. 2464

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Fort McDowell Indian Community Water Rights Settlement Revision Act of 2006".

SEC. 2. DEFINITIONS.

In this Act:

(1) FORT McDOWELL WATER RIGHTS SETTLEMENT ACT.—The term "Fort McDowell Water Rights Settlement Act" means the Fort McDowell Indian Community Water Rights Settlement Act of 1990 (Public Law 101-628; 104 Stat. 4480).

(2) NATION.—The term "Nation" means the Fort McDowell Yavapai Nation, formerly known as the "Fort McDowell Indian Community".

(3) SECRETARY.—The term "Secretary" means the Secretary of the Interior.

SEC. 3. CANCELLATION OF REPAYMENT OBLIGATION.

(a) CANCELLATION OF OBLIGATION.—The obligation of the Nation to repay the loan made under section 408(e) of the Fort McDowell Water Rights Settlement Act (104 Stat. 4489) is cancelled.

(b) EFFECT OF ACT.—

(1) RIGHTS OF NATION UNDER FORT McDOWELL WATER RIGHTS SETTLEMENT ACT.—

(A) IN GENERAL.—Except as provided in subparagraph (B), nothing in this Act alters or affects any right of the Nation under the Fort McDowell Water Rights Settlement Act.

(B) EXCEPTION.—The cancellation of the repayment obligation under subsection (a) shall be considered—

(i) to fulfill all conditions required to achieve the full and final implementation of the Fort McDowell Water Rights Settlement Act; and

(ii) to relieve the Secretary of any responsibility or obligation to obtain mitigation