this country that are at stake, that are vulnerable.

I would urge further consideration of VAWA by the United States Congress.

ON THE 35TH ANNIVERSARY OF MEDICARE, CONGRESS SHOULD REPAIR GAPS IN COVERAGE

(Mr. DEUTSCH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. DEUTSCH. Mr. Speaker, this year we celebrate the 35th anniversary of Medicare. The program has benefited over 93 million Americans since it was signed into law on July 30, 1965, by President Johnson.

Yet, our health care system has changed dramatically since then, with medical technology in many ways leading the way, and Medicare has not kept pace with that. I am concerned about the widening gap between the Medicare program and the cutting edge of medical technology.

I am concerned because it means that more than 90,000 Medicare-aged people in my district cannot gain access to advanced treatment and technologies they need. As Congress looks at adjustments to the program, we must act now to repair the gaps in Medicare for the next 35 years of medical innovation.

Medicare's procedure for adding new technologies to the program involve coverage, coding, and payment decisions. Unfortunately, problems and delays have occurred at each of these stages. The result is that now it can take more than 4½ years or more to make the latest breakthrough treatments available to beneficiaries.

I believe that Medicare patients have waited long enough for a program that gives them access to the advanced medical technologies they need. That is why I am pleased to lend full support of H.R. 4395, the Medicare Patient Access to Technology Act, a bipartisan bill which hopefully we will pass this session, and which will lead to 21st century medicine for Medicare beneficiaries.

SUPPORT THE PRESIDENT'S REQUEST FOR INCREASED FUNDING FOR THE COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM

(Mr. BROWN of Ohio asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BROWN of Ohio. Mr. Speaker, I rise today to celebrate the 26th anniversary of the Community Development Block Grant Program. This program put local development decisions in the hands of those who know best, those who live and work in our community.

This long-term commitment to responsible flexibility has paid off. The average housing program leverage is $2.31 for every Federal dollar spent.

Unfortunately, the Republican leadership has chosen to commemorate 26 years of job creation and increased affordable housing and water improvements by stripping the block grant program of $300 million in the fiscal year 2001 VA–HUD bill.

In Lorais, Ohio, a community in my district struggling with the loss of industry and experiencing rents as much as 50 percent of income, these cuts translate into a loss of jobs, jobs that would have been created next year through construction projects, small business developments, and retraining programs.

This program is simple, it is effective, it is efficient. Communities in northeast Ohio and across the country are depending on it. Proposed 2001 funding levels will, unfortunately, hang them out to dry.

I urge my colleagues to continue our commitment to improving people's quality of life. Let us support the President's request and increase funding for the Community Development Block Grant Program.

RYAN WHITE CARE ACT AMENDMENTS OF 2000

Mr. GOSS. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 611 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 611

Resolved, That upon the adoption of this resolution it shall be in order without intervention of any point of order to consider in the House the bill (S. 2311) to revise and extend the Ryan White CARE Act programs under title XXVI of the Public Health Service Act, to improve access to health care and the quality of care under such programs, and to provide for the development of increased capacity to provide health care and related support services to individuals and families with HIV disease, and for other purposes. The bill shall be considered as read for amendment. The amendment in the nature of a substitute printed in the Congressional Record and numbered 1 pursuant to clause 8 of rule XVIII shall be considered as adopted. The previous question shall be considered as ordered on the bill, as amended, to final passage without intervening motion except: (1) one hour of debate on the bill, as amended, equally divided and controlled by the chairman and ranking minority member of the Committee on Commerce; and (2) one motion to recommit with or without instructions.

The SPEAKER pro tempore. The gentleman from Florida (Mr. GOSS) is recognized for 1 hour.

Mr. GOSS. Mr. Speaker, for purposes of debate only, I am pleased to yield the customary 30 minutes to my friend, the distinguished gentleman from Ohio (Mr. HALL), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for purposes of debate only.

Mr. Speaker, this is a fair and straightforward closed rule for a very important piece of legislation. The rule waives all points of order against consideration of the bill and provides that the amendment in the nature of a substitute printed in the CONGRESSIONAL RECORD shall be considered as adopted.

1030

This is largely a noncontroversial bill. As no members of the minority testified differently last night at the Committee on Rules, this rule should receive unanimous support, and I urge support.

This reauthorization of the Ryan White CARE Act recognizes the changing demographics of the AIDS epidemic in our country in a way that truly honors the memory of the courageous young boy for which the bill was originally named. Today, there are between 800,000 and 900,000 persons living with HIV in the United States of America with some 40,000 new infections annually. This conference report seeks to shift resources to the most needy areas while preserving the best features of the current programs.

The gentleman from Virginia (Chairman BLILEY) should be commended for his leadership and attention to this critical public health issue which is of concern to every Member of this body. I am hopeful that the progress made on this authorization will spur funding for another essential program for individuals afflicted with the HIV virus.

As my colleagues remember and well know, this House led the way and adopted the Ricky Ray Authorization Act in the last Congress. It authorized $750 million for compassion assistance and recognition to hemophiliacs who contracted AIDS through no fault of their own because of contaminated blood products in the 1980s.

Now, the first installment was provided last year, and this year the gentleman from Florida (Chairman YOUNG) of the Committee on Appropriations should be commended for exceeding the President's request in the House version of the Fiscal Year 2001 Labor-HHS appropriation bill for the next installment.

As negotiations continue and we near the end of this Congress, I am hopeful that the White House will become fully engaged on the Ricky Ray funding problem and work with leadership and Congress to provide full funding for these victims as soon as humanly possible. The need is great and the time is now.

I am confident that, if the White House shows true leadership and demonstrates that this problem is really a top priority for them, we will be able to move further toward full funding this year. Obviously we cannot undo the tragic events of the 1980s, but we can work to provide assistance to these individuals before it is any later.

Mr. Speaker, this rule should engender little debate. It is a fair rule for a good bill. I urge its adoption.

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

Mr. HALL of Ohio. Mr. Speaker, I want to thank the gentleman from

Florida (Mr. GOSS) for yielding me the time.

Mr. Speaker, this is a closed rule. It will allow for the consideration of S. 2311, which is called the Ryan White CARE Act Amendments of 2000. As the gentleman from Florida has described, this rule provides for 1 hour of general debate to be equally divided and controlled by the chairman and ranking minority member of the Committee on Commerce. Under this closed rule, no amendments can be offered on the House floor.

In 1990, Congress passed the Ryan White Comprehensive AIDS Resources Emergency Act. It was known as the Ryan White CARE Act. This law created programs to help Americans with AIDS and HIV, the virus that causes AIDS, and to slow the spread of HIV.

These programs expired October 1. The bill we are considering will reauthorize and strengthen the Ryan White CARE Act programs by expanding access, improving quality, and providing additional services. Some of the changes will help target health care services to the people who need it the most but who can least afford it.

Women, children, infants and youth with HIV will especially benefit from this bill as will low-income individuals and families. AIDS possesses one of the greatest health challenges of our generation, and there is no way to avoid its tragic grip. However, an active role by the Federal government can, in my opinion, ease the tragedy by reducing the number of new HIV cases and by supporting victims and their families.

The Ryan White CARE Act has worked. The Federal funds spent under this law have saved lives and reduced suffering. These are dollars that could not have been better spent. For example, between 1994 and 1999, pediatric AIDS cases declined by nearly 80 percent largely because of these programs funded by the Federal Government under this Act.

I would like to point out to my colleague that this act offers a framework that we should apply to tackling other tragic diseases, such as childhood cancer. I hope that Congress will learn from the success of this act.

This legislation extending the Ryan White CARE Act represents our best response to dealing with AIDS and its consequences. The bill we are considering is a compromise between the previously passed House and Senate versions. The Senate version passed by unanimous consent. The House version passed by a voice vote under suspension of the rules. I am proud to be a cosponsor of this House version.

Because there is general agreement between the House and Senate, there is no need for a formal conference committee.

I urge my colleagues to vote for the rule and for the bill.

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

Mr. GOSS. Mr. Speaker, I advise that we have no speakers lined up, and I would be prepared to yield back if the gentleman from Ohio (Mr. HALL) has no speakers.

Mr. HALL of Ohio. Mr. Speaker, I yield back the balance of my time.

Mr. GOSS. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

Mr. COBURN. Mr. Speaker, pursuant to House Resolution 611, I call up the Senate bill (S. 2311) to revise and extend the Ryan White CARE Act programs under title XXVI of the Public Health Service Act, to improve access to health care and the quality of care under such programs, and to provide for the development of increased capacity to provide health care and related support services to individuals and families with HIV disease, and for other purposes, and ask for its immediate consideration.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore (Mr. SIMPSON). Pursuant to House Resolution 611, the Senate bill is considered read for amendment.

The text of S. 2311 is as follows:

S. 2311

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 ''Ryan White CARE Act Amendments of 2000''.

SEC. 2. REFERENCES; TABLE OF CONTENTS.

(a) REFERENCES.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act (42 U.S.C. 201 et seq.).

(b) Table of Contents.—The table of contents of this Act is as follows:

TITLE I—AMENDMENTS TO HIV HEALTH CARE PROGRAM

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

SEC. 101. DUTIES OF PLANNING COUNCIL, FUNDING PRIORITIES, QUALITY ASSESSMENT.

Section 2602 (42 U.S.C. 300ff–12) is amended—

(1) in subsection (b)—

(A) in paragraph (2)(C), by inserting before the semicolon the following: '', including providers of housing and homeless services''; and

(B) in paragraph (4), by striking ''shall—'' and all that follows and inserting ''shall have the responsibilities specified in subsection (d).''; and

(2) by adding at the end the following:

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

''(1) PRIORITIES FOR ALLOCATION OF FUNDS.—The council shall establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a grantee should consider in allocating funds under a grant, based on the following factors:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(2) EXCEPTION.—Grantees under subsection (d)(1)(A) shall not be required to establish priorities for individuals not in care until epidemiologic measures are developed under paragraph (1).''.

SEC. 102. QUALITY MANAGEMENT.

(a) FUNDS AVAILABLE FOR QUALITY MANAGEMENT.—Section 2604 (42 U.S.C. 300ff–14) is amended—

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

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

''(c) QUALITY MANAGEMENT.—

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

''(2) USE OF FUNDS.—From amounts received under a grant awarded under this part, the chief elected official of an eligible area may use, for activities associated with its quality management program, not more than the lesser of—

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

''(B) $3,000,000.''.

(b) QUALITY MANAGEMENT REQUIRED FOR ELIGIBILITY FOR GRANTS.—Section 2605(a) (42 U.S.C. 300ff–15(a)) is amended—

(1) by redesignating paragraphs (3) through (6) as paragraphs (5) through (8), respectively; and

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

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

SEC. 103. FUNDED ENTITIES REQUIRED TO HAVE HEALTH CARE RELATIONSHIPS.

(a) USE OF AMOUNTS.—Section 2604(e)(1) (42 U.S.C. 300ff–14(d)(1)) (as so redesignated by section 102(a)) is amended by inserting ''and the State Children's Health Insurance Program under title XXI of such Act'' after ''Social Security Act''.

(b) APPLICATIONS.—Section 2605(a) (42 U.S.C. 300ff–15(a)) is amended by inserting after paragraph (3), as added by section 102(b), the following:

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

SEC. 104. SUPPORT SERVICES REQUIRED TO BE HEALTH CARE-RELATED.

(a) IN GENERAL.—Section 2604(b)(1) (42 U.S.C. 300ff–14(b)(1)) is amended—

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

(2) in subparagraph (A)—

(A) by striking ''outpatient'' and all that follows through ''substance abuse treatment and'' and inserting the following: ''OUTPATIENT HEALTH SERVICES.—Outpatient and ambulatory health services, including substance abuse treatment,''; and

(B) by striking ''; and'' and inserting a period;

(3) in subparagraph (B), by striking ''(B) inpatient case management'' and inserting ''(C) INPATIENT CASE MANAGEMENT SERVICES.—Inpatient case management''; and

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

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

(b) CONFORMING AMENDMENT TO APPLICATION REQUIREMENTS.—Section 2605(a) (42 U.S.C. 300ff–15(a)), as amended by section 102(b), is further amended—

(1) in paragraph (6) (as so redesignated), by striking ''and'' at the end thereof;

(2) in paragraph (7) (as so redesignated), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

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

SEC. 105. USE OF GRANT FUNDS FOR EARLY INTERVENTION SERVICES.

(a) IN GENERAL.—Section 2604(b)(1) (42 U.S.C. 300ff–14(b)(1)), as amended by section 104(a), is further amended by adding at the end the following:

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

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

''(II) is an entity constituting a point of access to services, as described in paragraph (2)(C), that maintains a relationship with an entity described in subclause (I) and that is serving individuals at elevated risk of HIV disease; and

''(ii) demonstrates to the satisfaction of the chief elected official that no other Federal, State, or local funds are available for the early intervention services the entity will provide with funds received under this paragraph.''.

(b) CONFORMING AMENDMENTS TO APPLICATION REQUIREMENTS.—Section 2605(a)(1) (42 U.S.C. 300ff–15(a)(1)) is amended—

(1) in subparagraph (A), by striking ''services to individuals with HIV disease'' and inserting ''services as described in section 2604(b)(1)''; and

(2) in subparagraph (B), by striking ''services for individuals with HIV disease'' and inserting ''services as described in section 2604(b)(1)''.

SEC. 106. REPLACEMENT OF SPECIFIED FISCAL YEARS REGARDING THE SUNSET ON EXPEDITED DISTRIBUTION REQUIREMENTS.

Section 2603(a)(2) (42 U.S.C. 300ff–13(a)(2)) is amended by striking ''for each of the fiscal years 1996 through 2000'' and inserting ''for a fiscal year''.

SEC. 107. HOLD HARMLESS PROVISION.

Section 2603(a)(4) (42 U.S.C. 300ff–13(a)(4)) is amended to read as follows:

''(4) LIMITATIONS.—

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

''(B) APPLICATION OF PROVISION.—Subparagraph (A) shall only apply with respect to those eligible areas receiving a grant under paragraph (2) for fiscal year 2000 in an amount that has been adjusted in accordance with paragraph (4) of this subsection (as in effect on the day before the date of enactment of the Ryan White CARE Act Amendments of 2000).''.

SEC. 108. SET-ASIDE FOR INFANTS, CHILDREN, AND WOMEN.

Section 2604(b)(3) (42 U.S.C. 300ff–14(b)(3)) is amended—

(1) by inserting ''for each population under this subsection'' after ''established priorities''; and

(2) by striking ''ratio of the'' and inserting ''ratio of each''.

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

SEC. 121. STATE REQUIREMENTS CONCERNING IDENTIFICATION OF NEED AND ALLOCATION OF RESOURCES.

(a) GENERAL USE OF GRANTS.—Section 2612 (42 U.S.C. 300ff–22) is amended—

(1) by striking ''A State'' and inserting ''(a) IN GENERAL.—A State''; and

(2) in the matter following paragraph (5)—

(A) by striking ''paragraph (2)'' and inserting ''subsection (a)(2) and section 2613'';

(b) APPLICATION.—Section 2617(b) (42 U.S.C. 300ff–27(b)) is amended—

(1) in paragraph (1)(C)—

(A) by striking clause (i) and inserting the following:

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

(B) in clause (iii), by striking ''and'' at the end; and

(C) by adding at the end the following:

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

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

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

(2) in paragraph (2)—

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

(B) by redesignating subparagraph (C) as subparagraph (F); and

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

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

''(D) with respect to fiscal year 2003 and subsequent fiscal years, assurances that, in the planning and allocation of resources, the State, through systems of HIV-related health services provided under paragraphs (1), (2), and (3) of section 2612(a), will make appropriate provision for the HIV-related health and support service needs of individuals who have been diagnosed with HIV disease but who are not currently receiving such services, based on the epidemiologic measures developed under paragraph (1)(C)(i);''.

SEC. 122. QUALITY MANAGEMENT.

(a) STATE REQUIREMENT FOR QUALITY MANAGEMENT.—Section 2617(b)(4) (42 U.S.C. 300ff–27(b)(4)) is amended—

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

''(C) the State will provide for—

''(i) the establishment of a quality management program to assess the extent to which medical services provided to patients under the grant are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections and to develop strategies for improvements in the access to and quality of medical services; and

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

(2) by redesignating subparagraphs (E) and (F) as subparagraphs (F) and (G), respectively;

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

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

(4) in subparagraph (F), as so redesignated, by striking ''and'' at the end; and

(5) in subparagraph (G), as so redesignated, by striking the period and inserting ''; and''.

(b) AVAILABILITY OF FUNDS FOR QUALITY MANAGEMENT.—

(1) AVAILABILITY OF GRANT FUNDS FOR PLANNING AND EVALUATION.—Section 2618(c)(3) (42 U.S.C. 300ff–28(c)(3)) is amended by inserting before the period '', including not more than $3,000,000 for all activities associated with its quality management program''.

(2) EXCEPTION TO COMBINED CEILING ON PLANNING AND ADMINISTRATION FUNDS FOR STATES WITH SMALL GRANTS.—Paragraph (6) of section 2618(c) (42 U.S.C. 300ff–28(c)(6)) is amended to read as follows:

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

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

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

SEC. 123. FUNDED ENTITIES REQUIRED TO HAVE HEALTH CARE RELATIONSHIPS.

Section 2617(b)(4) (42 U.S.C. 300ff–27(b)(4)), as amended by section 122(a), is further amended by adding at the end the following:

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

SEC. 124. SUPPORT SERVICES REQUIRED TO BE HEALTH CARE-RELATED.

(a) TECHNICAL AMENDMENT.—Section 3(c)(2)(A)(iii) of the Ryan White CARE Act Amendments of 1996 (Public Law 104–146) is amended by inserting ''before paragraph (2) as so redesignated'' after ''inserting''.

(b) SERVICES.—Section 2612(a)(1) (42 U.S.C. 300ff–22(a)(1)), as so designated by section 121(a), is amended by striking ''for individuals with HIV disease'' and inserting '', subject to the conditions and limitations that apply under such section''.

(c) CONFORMING AMENDMENT TO STATE APPLICATION REQUIREMENT.—Section 2617(b)(2) (42 U.S.C. 300ff–27(b)(2)), as amended by section 121(b), is further amended by adding at the end the following:

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

SEC. 125. USE OF GRANT FUNDS FOR EARLY INTERVENTION SERVICES.

Section 2612(a) (42 U.S.C. 300ff–22(a)), as amended by section 121, is further amended by adding at the end the following:

''(6) EARLY INTERVENTION SERVICES.—The State, through systems of HIV-related health services provided under paragraphs (1), (2), and (3) of section 2612(a), may provide early intervention services, as described in section 2651(b)(2), with follow-up referral, provided for the purpose of facilitating the access of individuals receiving the services to HIV-related health services, but only if the entity providing such services—

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

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

''(B) demonstrates to the State's satisfaction that no other Federal, State, or local funds are available for the early intervention services the entity will provide with funds received under this paragraph.''.

SEC. 126. AUTHORIZATION OF APPROPRIATIONS FOR HIV-RELATED SERVICES FOR WOMEN AND CHILDREN.

Section 2625(c)(2) (42 U.S.C. 300ff–33(c)(2)) is amended by striking ''fiscal years 1996 through 2000'' and inserting ''fiscal years 2001 through 2005''.

SEC. 127. REPEAL OF REQUIREMENT FOR COMPLETED INSTITUTE OF MEDICINE REPORT.

Section 2628 (42 U.S.C. 300ff–36) is repealed.

SEC. 128. SUPPLEMENT GRANTS FOR CERTAIN STATES.

Subpart I of part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.) is amended by adding at the end the following:

''SEC. 2622. SUPPLEMENTAL GRANTS.

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

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

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

''(2) demonstrate to the Secretary that there is severe need (as defined for purposes of section 2603(b)(2)(A) for supplemental financial assistance in areas in the State that are not served through grants under part A.

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

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

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

''(3) a demonstration that the State will maintain HIV-related activities at a level

that is equal to not less than the level of such activities in the State for the 1-year period preceding the fiscal year for which the State is applying to receive a grant under this part;

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

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

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

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

''(d) AMOUNT RESERVED FOR EMERGING COMMUNITIES.—

''(1) IN GENERAL.—For awarding grants under this section for each fiscal year, the Secretary shall reserve the greater of 50 percent of the amount to be utilized under subsection (e) for such fiscal year or $5,000,000, to be provided to States that contain emerging communities for use in such communities.

''(2) DEFINITION.—In paragraph (1), the term 'emerging community' means a metropolitan area—

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

''(B) for which there has been reported to the Director of the Centers for Disease Control and Prevention a cumulative total of between 1000 and 1999 cases of acquired immune deficiency syndrome for the most recent period of 5 calendar years for which such data are available.

''(e) APPROPRIATIONS.—With respect to each fiscal year beginning with fiscal year 2001, the Secretary, to carry out this section, shall utilize 50 percent of the amount appropriated under section 2677 to carry out part B for such fiscal year that is in excess of the amount appropriated to carry out such part in fiscal year preceding the fiscal year involved.

SEC. 129. USE OF TREATMENT FUNDS.

(a) STATE DUTIES.—Section 2616(c) (42 U.S.C. 300ff–26(c)) is amended—

(1) in the matter preceding paragraph (1), by striking ''shall—'' and inserting ''shall use funds made available under this section to—'';

(2) by redesignating paragraphs (1) through (5) as subparagraphs (A) through (E), respectively and realigning the margins of such subparagraphs appropriately;

(3) in subparagraph (D) (as so redesignated), by striking ''and'' at the end;

(4) in subparagraph (E) (as so redesignated), by striking the period and ''; and''; and

(5) by adding at the end the following:

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

(6) by striking ''In carrying'' and inserting the following:

''(1) IN GENERAL.—In carrying''; and

(7) by adding at the end the following:

''(2) LIMITATIONS.—

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

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

(b) SUPPLEMENT GRANTS.—Section 2616 (42 U.S.C. 300ff–26(c)) is amended by adding at the end the following:

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

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

''(2) CRITERIA.—The Secretary shall develop criteria for the awarding of grants under paragraph (1) to States that demonstrate a severe need. In determining the criteria for demonstrating State severity of need (as defined for purposes of section 2603(b)(2)(A)), the Secretary shall consider whether limitation to access exist such that—

''(A) the State programs under this section are unable to provide HIV/AIDS therapeutic regimens to all eligible individuals living at or below 200 percent of the Federal poverty line; and

''(B) the State programs under this section are unable to provide to all eligible individuals appropriate HIV/AIDS therapeutic regimens as recommended in the most recent Federal treatment guidelines.

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

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

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

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

''(5) FUNDING.—

''(A) RESERVATION OF AMOUNT.—The Secretary may reserve not to exceed 4 percent, but not less than 2 percent, of any amount referred to in section 2618(b)(2)(H) that is appropriated for a fiscal year, to carry out this subsection.

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

(c) SUPPLEMENT AND NOT SUPPLANT.—Section 2616 (42 U.S.C. 300ff–26(c)), as amended by subsection (b), is further amended by adding at the end the following:

''(f) SUPPLEMENT NOT SUPPLANT.—Notwithstanding any other provision of law, amounts made available under this section shall be used to supplement and not supplant other funding available to provide treatments of the type that may be provided under this section.''.

SEC. 130. INCREASE IN MINIMUM ALLOTMENT.

(a) IN GENERAL.—Section 2618(b)(1)(A)(i) (42 U.S.C. 300ff–28(b)(1)(A)(i)) is amended—

(1) in subclause (I), by striking ''$100,000'' and inserting ''$200,000''; and

(2) in subclause (II), by striking ''$250,000'' and inserting ''$500,000''.

(b) TECHNICAL AMENDMENT.—Section 2618(b)(3)(B) (42 U.S.C. 300ff–28(b)(3)(B)) is amended by striking ''and the Republic of the Marshall Islands'' and inserting '', the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau''.

SEC. 131. SET-ASIDE FOR INFANTS, CHILDREN, AND WOMEN.

Section 2611(b) (42 U.S.C. 300ff–21(b)) is amended—

(1) by inserting ''for each population under this subsection'' after ''State shall use''; and

(2) by striking ''ratio of the'' and inserting ''ratio of each''.

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

SEC. 141. AMENDMENT OF HEADING; REPEAL OF FORMULA GRANT PROGRAM.

(a) AMENDMENT OF HEADING.—The heading of part C of title XXVI is amended to read as follows:

''PART C—EARLY INTERVENTION AND PRIMARY CARE SERVICES''.

(b) REPEAL.—Part C of title XXVI (42 U.S.C. 300ff–41 et seq.) is amended—

(1) by repealing subpart I; and

(2) by redesignating subparts II and III as subparts I and II.

(c) CONFORMING AMENDMENTS.—

(1) INFORMATION REGARDING RECEIPT OF SERVICES.—Section 2661(a) (42 U.S.C. 300ff–61(a)) is amended by striking ''unless—'' and all that follows through ''(2) in the case of'' and inserting ''unless, in the case of''.

(2) ADDITIONAL AGREEMENTS.—Section 2664 (42 U.S.C. 300ff–64) is amended—

(A) in subsection (e)(5), by striking ''2642(b) or'';

(B) in subsection (f)(2), by striking ''2642(b) or''; and

(C) by striking subsection (h).

SEC. 142. PLANNING AND DEVELOPMENT GRANTS.

(a) ALLOWING PLANNING AND DEVELOPMENT GRANT TO EXPAND ABILITY TO PROVIDE PRIMARY CARE SERVICES.—Section 2654(c) (42 U.S.C. 300ff–54(c)) is amended—

(1) in paragraph (1), to read as follows:

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

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

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

(2) in paragraphs (2) and (3) by striking ''paragraph (1)'' each place that such appears and inserting ''paragraph (1)(A)''.

(b) AMOUNT; DURATION.—Section 2654(c) (42 U.S.C. 300ff–54(c)), as amended by subsection (a), is further amended—

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

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

''(4) AMOUNT AND DURATION OF GRANTS.—

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

''(B) CAPACITY DEVELOPMENT.—

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

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

(c) INCREASE IN LIMITATION.—Section 2654(c)(5) (42 U.S.C. 300ff–54(c)(5)), as so redesignated by subsection (b), is amended by striking ''1 percent'' and inserting ''5 percent''.

SEC. 143. AUTHORIZATION OF APPROPRIATIONS FOR CATEGORICAL GRANTS.

Section 2655 (42 U.S.C. 300ff–55) is amended by striking ''1996'' and all that follows through ''2000'' and inserting ''2001 through 2005''.

SEC. 144. ADMINISTRATIVE EXPENSES CEILING; QUALITY MANAGEMENT PROGRAM.

Section 2664(g) (42 U.S.C. 300ff–64(g)) is amended—

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

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

(2) in paragraph (4), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(5) the applicant will provide for the establishment of a quality management program to assess the extent to which medical services funded under this title that are provided to patients are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections and that improvements in the access to and quality of medical services are addressed.''.

SEC. 145. PREFERENCE FOR CERTAIN AREAS.

Section 2651 (42 U.S.C. 300ff–51) is amended by adding at the end the following:

''(d) PREFERENCE IN AWARDING GRANTS.—Beginning in fiscal year 2001, in awarding new grants under this section, the Secretary shall give preference to applicants that will use amounts received under the grant to serve areas that are otherwise not eligible to receive assistance under part A.''.

Subtitle D—Amendments to Part D (General Provisions)

SEC. 151. RESEARCH INVOLVING WOMEN, INFANTS, CHILDREN, AND YOUTH.

(a) ELIMINATION OF REQUIREMENT TO ENROLL SIGNIFICANT NUMBERS OF WOMEN AND CHILDREN.—Section 2671(b) (42 U.S.C. 300ff–71(b)) is amended—

(1) in paragraph (1), by striking subparagraphs (C) and (D); and

(2) by striking paragraphs (3) and (4).

(b) INFORMATION AND EDUCATION.—Section 2671(d) (42 U.S.C. 300ff–71(d)) is amended by adding at the end the following:

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

(c) QUALITY MANAGEMENT; ADMINISTRATIVE EXPENSES CEILING.—Section 2671(f) (42 U.S.C. 300ff–71(f)) is amended—

(1) by striking the subsection heading and designation and inserting the following:

''(f) ADMINISTRATION.—

''(1) APPLICATION.—''; and

(2) by adding at the end the following:

''(2) QUALITY MANAGEMENT PROGRAM.—A grantee under this section shall implement a quality management program.''.

(d) COORDINATION.—Section 2671(g) (42 U.S.C. 300ff–71(g)) is amended by adding at the end the following: ''The Secretary acting through the Director of NIH, shall examine the distribution and availability of ongoing and appropriate HIV/AIDS-related research projects to existing sites under this section for purposes of enhancing and expanding voluntary access to HIV-related research, especially within communities that are not reasonably served by such projects.''.

(e) AUTHORIZATION OF APPROPRIATIONS.—Section 2671(j) (42 U.S.C. 300ff–71(j)) is amended by striking ''fiscal years 1996 through 2000'' and inserting ''fiscal years 2001 through 2005''.

SEC. 152. LIMITATION ON ADMINISTRATIVE EXPENSES.

Section 2671 (42 U.S.C. 300ff–71) is amended—

(1) by redesignating subsections (i) and (j), as subsections (j) and (k), respectively; and

(2) by inserting after subsection (h), the following:

''(i) LIMITATION ON ADMINISTRATIVE EXPENSES.—

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

''(2) REQUIREMENTS.—

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

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

SEC. 153. EVALUATIONS AND REPORTS.

Section 2674(c) (42 U.S.C. 399ff–74(c)) is amended by striking ''1991 through 1995'' and inserting ''2001 through 2005''.

SEC. 154. AUTHORIZATION OF APPROPRIATIONS FOR GRANTS UNDER PARTS A AND B.

Section 2677 (42 U.S.C. 300ff–77) is amended to read as follows:

''SEC. 2677. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated—

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

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

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

SEC. 161. AUTHORIZATION OF APPROPRIATIONS.

(a) SCHOOLS; CENTERS.—Section 2692(c)(1) (42 U.S.C. 300ff–111(c)(1)) is amended by striking ''fiscal years 1996 through 2000'' and inserting ''fiscal years 2001 through 2005''.

(b) DENTAL SCHOOLS.—Section 2692(c)(2) (42 U.S.C. 300ff–111(c)(2)) is amended by striking ''fiscal years 1996 through 2000'' and inserting ''fiscal years 2001 through 2005''.

TITLE II—MISCELLANEOUS PROVISIONS

SEC. 201. INSTITUTE OF MEDICINE STUDY.

(a) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, the Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine for the conduct of a study concerning the appropriate epidemiological measures and their relationship to the financing and delivery of primary care and health-related support services for low-income, uninsured, and under-insured individuals with HIV disease.

(b) REQUIREMENTS.—

(1) COMPLETION.—The study under subsection (a) shall be completed not later than 21 months after the date on which the contract referred to in such subsection is entered into.

(2) ISSUES TO BE CONSIDERED.—The study conducted under subsection (a) shall consider—

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

(B) the effectiveness and efficiency of service delivery (including the quality of services, health outcomes, and resource use) within the context of a changing health care and therapeutic environment as well as the changing epidemiology of the epidemic;

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

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

(c) REPORT.—Not later than 90 days after the date on which the study is completed under subsection (a), the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report describing the manner in which the conclusions and recommendations of the Institute of Medicine can be addressed and implemented.

The SPEAKER pro tempore. Pursuant to House Resolution 611, the amendment in the nature of a substitute printed in the CONGRESSIONAL RECORD and numbered 1 is considered adopted.

The text of S. 2311, as amended pursuant to House Resolution 611, is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

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

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

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

Subtitle A—HIV Health Services Planning Councils

SEC. 101. MEMBERSHIP OF COUNCILS.

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

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

(2) in paragraph (2)—

(A) in subparagraph (C), by inserting before the semicolon the following: '', including providers of housing and homeless services'';

(B) in subparagraph (G), by striking ''or AIDS'';

(C) in subparagraph (K), by striking ''and'' at the end;

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

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

''(M) representatives of individuals who formerly were Federal, State, or local prisoners, were released from the custody of the penal system during the preceding 3 years, and had HIV disease as of the date on which the individuals were so released.''.

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

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

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

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

SEC. 102. DUTIES OF COUNCILS.

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

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

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

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

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

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

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

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

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

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

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

''(iv) coordination in the provision of services to such individuals with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment for such abuse;

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

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

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

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

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

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

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

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

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

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

(B) by striking the period and inserting ''; and''; and

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

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

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

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

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

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

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

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

(d) CONFORMING AMENDMENT.—Section 2603(c) of the Public Health Service Act (42 U.S.C. 300ff–12(b)) is amended by striking ''section 2602(b)(3)(A)'' and inserting ''section 2602(b)(4)(C)''.

SEC. 103. OPEN MEETINGS; OTHER ADDITIONAL PROVISIONS.

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

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

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

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

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

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

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

''(ii) The records, reports, transcripts, minutes, agenda, or other documents which were

made available to or prepared for or by the council shall be available for public inspection and copying at a single location.

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

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

Subtitle B—Type and Distribution of Grants

SEC. 111. FORMULA GRANTS.

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

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

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

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

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

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

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

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

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

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

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

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

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

''(iii) GRANTS AND TECHNICAL ASSISTANCE REGARDING COUNTING OF HIV CASES.—Of the amounts appropriated under section 318B for a fiscal year, the Secretary shall reserve amounts to make grants and provide technical assistance to States and eligible areas with respect to obtaining data on cases of HIV disease to ensure that data on such cases is available from all States and eligible areas as soon as is practicable but not later than the beginning of fiscal year 2007.''.

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

''(4) INCREASES IN GRANT.—

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

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

''(ii) for any second fiscal year in such period, the grant is not less than 95 percent of the amount of such base year grant;

''(iii) for any third fiscal year in such period, the grant is not less than 92 percent of the amount of the base year grant;

''(iv) for any fourth fiscal year in such period, the grant is not less than 89 percent of the amount of the base year grant; and

''(v) for any fifth or subsequent fiscal year in such period, if, pursuant to paragraph (3)(D)(ii)), the references in paragraph (3)(C)(i) to HIV disease do not have any legal effect, the grant is not less than 85 percent of the amount of the base year grant.

''(B) SPECIAL RULE.—If for fiscal year 2005, pursuant to paragraph (3)(D)(ii), data on cases of HIV disease are used for purposes of paragraph (3)(C)(i), the Secretary shall increase the amount of a grant made pursuant to paragraph (2) for an eligible area to ensure that the grant is not less than 98 percent of the amount of the grant made for the area in fiscal year 2004.

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

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

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

''(iii) A protection period begins with the trigger grant-reduction year and continues until the beginning of the first fiscal year for which the amount of the grant determined pursuant to paragraph (2) for the area equals or exceeds the amount of the grant determined under subparagraph (A).

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

SEC. 112. SUPPLEMENTAL GRANTS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) by striking paragraph (4);

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

(3) in paragraph (4) (as so redesignated), in subparagraph (B), by striking ''grants'' and inserting ''grant''.

Subtitle C—Other Provisions

SEC. 121. USE OF AMOUNTS.

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

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

(2) in subparagraph (A)—

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

(B) by striking ''; and'' and inserting a period;

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

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

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

(5) by adding at the end the following:

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

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

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

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

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

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

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

''(3) EARLY INTERVENTION SERVICES.—

''(A) IN GENERAL.—The purposes for which a grant under section 2601 may be used include providing to individuals with HIV disease early intervention services described in section 2651(b)(2), 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 disease 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.

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

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

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

(c) PRIORITY FOR WOMEN, INFANTS, AND CHILDREN.—Section 2604(b) (42 U.S.C. 300ff–14(b)) of the Public Health Service Act is amended in paragraph (4) (as redesignated by subsection (b)(1) of this section) by amending the paragraph to read as follows:

''(4) PRIORITY FOR WOMEN, INFANTS AND CHILDREN.—

''(A) IN GENERAL.—For the purpose of providing health and support services to infants, children, youth, and women with HIV disease, including treatment measures to prevent the perinatal transmission of HIV, the chief elected official of an eligible area, in accordance with the established priorities of the planning council, shall 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 acquired immune deficiency syndrome to the general population in such area of individuals with such syndrome.

''(B) WAIVER.—With respect the population involved, the Secretary may provide to the chief elected official of an eligible area a waiver of the requirement of subparagraph (A) 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.''.

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

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

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

''(c) QUALITY MANAGEMENT.—

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

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

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

''(B) $3,000,000.''.

SEC. 122. APPLICATION.

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

(1) by redesignating paragraphs (3) through (6) as paragraphs (5) through (8), respectively; and

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

''(3) that entities within the eligible area that receive funds under a grant under this part will maintain appropriate relationships with entities in the eligible area served that constitute key points of access to the health care system for individuals with HIV disease (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV counseling and testing sites, mental health programs, and homeless shelters), and other entities under section 2604(b)(3) and 2652(a), for the purpose of facilitating early intervention for individuals newly diagnosed with HIV disease and individuals knowledgeable of their HIV status but not in care;

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

(b) CONFORMING AMENDMENTS.—Section 2605(a) (42 U.S.C. 300ff–15(a)(1)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), by striking ''services to individuals with HIV disease'' and inserting ''services as described in section 2604(b)(1)''; and

(B) in subparagraph (B), by striking ''services for individuals with HIV disease'' and inserting ''services as described in section 2604(b)(1)'';

(2) in paragraph (7) (as redesignated by subsection (a)(1) of this section), by striking ''and'' at the end;

(3) in paragraph (8) (as so redesignated), by striking the period and inserting ''; and''; and

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

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

TITLE II—CARE GRANT PROGRAM

Subtitle A—General Grant Provisions

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

Section 2611(b) of the Public Health Service Act (42 U.S.C. 300ff–21(b)) is amended to read as follows:

''(b) PRIORITY FOR WOMEN, INFANTS AND CHILDREN.—

''(1) IN GENERAL.—For the purpose of providing health and support services to infants, children, youth, and women with HIV disease, including treatment measures to prevent the perinatal transmission of HIV, a State shall for each of such populations use, of the funds allocated under this part to the State for a fiscal year, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in the State) with acquired immune deficiency syndrome to the general population in the State of individuals with such syndrome.

''(2) WAIVER.—With respect the population involved, the Secretary may provide to a State a waiver of the requirement of paragraph (1) if the 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.''.

SEC. 202. USE OF GRANTS.

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

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

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

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

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

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

''(A) necessary to implement the strategy under section 2617(b)(4)(B), including activities facilitating the access of such individuals to HIV-related primary care services at entities described in subsection (c)(1);

''(B) conducted in a manner consistent with the requirement under section 2617(b)(6)(G) and 2651(b)(2); and

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

''(c) EARLY INTERVENTION SERVICES.—

''(1) IN GENERAL.—The purposes for which a grant under this part may be used include providing to individuals with HIV disease early intervention services described in section 2651(b)(2), 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 disease counseling and testing sites, health care points of entry specified by States or eligible areas,

federally qualified health centers, and entities described in section 2652(a) 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 applies only if the entity demonstrates to the satisfaction of the State involved that—

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

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

''(d) QUALITY MANAGEMENT.—

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

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

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

''(B) $3,000,000.''.

SEC. 203. GRANTS TO ESTABLISH HIV CARE CONSORTIA.

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

(1) in subsection (b)(1)—

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

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

(2) in subsection (c)(1)—

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

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

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

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

(3) in subsection (c)(2)—

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

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

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

''(D) the types of entities described in section 2602(b)(2).''.

SEC. 204. PROVISION OF TREATMENTS.

(a) IN GENERAL.—Section 2616(c) of the Public Health Service Act (42 U.S.C. 300ff–26(c)) is amended—

(1) in paragraph (4), by striking ''and'' after the semicolon at the end;

(2) in paragraph (5), by striking the period and inserting ''; and''; and

(3) by inserting after paragraph (5) the following:

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

''Of the amount reserved by a State for a fiscal year for use under this section, the State may not use more than 5 percent to carry out services under paragraph (6), except that the percentage applicable with respect to such paragraph is 10 percent if the State demonstrates to the Secretary that such additional services are essential and in no way diminish access to the therapeutics described in subsection (a).''.

(b) HEALTH INSURANCE AND PLANS.—Section 2616 of the Public Health Service Act (42 U.S.C. 300ff–26) is amended by adding at the end the following subsection:

''(e) USE OF HEALTH INSURANCE AND PLANS.—

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

''(2) LIMITATION.—The authority established in paragraph (1) applies only to the extent that, for the fiscal year involved, the costs of the health insurance or plans to be purchased or maintained under such paragraph do not exceed the costs of otherwise providing therapeutics described in subsection (a).''.

SEC. 205. STATE APPLICATION.

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

(1) by redesignating paragraphs (2) through (4) as paragraphs (4) through (6), respectively;

(2) by inserting after paragraph (1) the following paragraphs:

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

''(3) a determination of the needs of such population, with particular attention to—

''(A) individuals with HIV disease who know their HIV status and are not receiving HIV-related services; and

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

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

(A) by striking ''comprehensive plan for the organization'' and inserting ''comprehensive plan that describes the organization'';

(B) by striking '', including—'' and inserting '', and that—'';

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

(D) by inserting before subparagraph (C) the following subparagraphs:

''(A) establishes priorities for the allocation of funds within the State based on—

''(i) size and demographics of the population of individuals with HIV disease (as determined under paragraph (2)) and the needs of such population (as determined under paragraph (3));

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

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

''(iv) the efficiency of the administrative mechanism of the State for rapidly allocating funds to the areas of greatest need within the State;

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

''(C) includes a strategy to coordinate the provision of such services with programs for HIV prevention (including outreach and early intervention) and for the prevention and treatment of substance abuse (including programs that provide comprehensive treatment services for such abuse);'';

(E) in subparagraph (D) (as redesignated by subparagraph (C) of this paragraph), by inserting ''describes'' before ''the services and activities'';

(F) in subparagraph (E) (as so redesignated), by inserting ''provides'' before ''a description''; and

(G) in subparagraph (F) (as so redesignated), by inserting ''provides'' before ''a description''.

(b) PUBLIC PARTICIPATION.—Section 2617(b) of the Public Health Service Act, as amended by subsection (a) of this section, is amended—

(1) in paragraph (5), by striking ''HIV'' and inserting ''HIV disease''; and

(2) in paragraph (6), by amending subparagraph (A) to read as follows:

''(A) the public health agency that is administering the grant for the State engages in a public advisory planning process, including public hearings, that includes the participants under paragraph (5), and the types of entities described in section 2602(b)(2), in developing the comprehensive plan under paragraph (4) and commenting on the implementation of such plan;''.

(c) HEALTH CARE RELATIONSHIPS.—Section 2617(b) of the Public Health Service Act, as amended by subsection (a) of this section, is amended in paragraph (6)—

(1) in subparagraph (E), by striking ''and'' at the end;

(2) in subparagraph (F), by striking the period and inserting ''; and''; and

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

''(G) entities within areas in which activities under the grant are carried out will maintain appropriate relationships with entities in the area served that constitute key points of access to the health care system for individuals with HIV disease (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV counseling and testing sites, mental health programs, and homeless shelters), and other entities under section 2612(c) and 2652(a), for the purpose of facilitating early intervention for individuals newly diagnosed with HIV disease and individuals knowledgeable of their HIV status but not in care.''.

SEC. 206. DISTRIBUTION OF FUNDS.

(a) MINIMUM ALLOTMENT.—Section 2618 of the Public Health Service Act (42 U.S.C. 300ff–28) is amended—

(1) by redesignating subsections (b) through (e) as subsections (a) through (d), respectively; and

(2) in subsection (a) (as so redesignated), in paragraph (1)(A)(i)—

(A) in subclause (I), by striking ''$100,000'' and inserting ''$200,000''; and

(B) in subclause (II), by striking ''$250,000'' and inserting ''$500,000''.

(b) AMOUNT OF GRANT; ESTIMATE OF LIVING CASES.—Section 2618(a) of the Public Health

Service Act (as redesignated by subsection (a)(1) of this section) is amended in paragraph (2)—

(1) in subparagraph (D)(i), by inserting before the semicolon the following: '', except that (subject to subparagraph (E)), for grants made pursuant to this paragraph or section 2620 for fiscal year 2005 and subsequent fiscal years, the cases counted for each 12-month period beginning on or after July 1, 2004, shall be cases of HIV disease (as reported to and confirmed by such Director) rather than cases of acquired immune deficiency syndrome'';

(2) by redesignating subparagraphs (E) through (H) as subparagraphs (F) through (I), respectively; and

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

''(E) DETERMINATION OF SECRETARY REGARDING DATA ON HIV CASES.—If under 2603(a)(3)(D)(i) the Secretary determines that data on cases of HIV disease are not sufficiently accurate and reliable, then notwithstanding subparagraph (D) of this paragraph, for any fiscal year prior to fiscal year 2007 the references in such subparagraph to cases of HIV disease do not have any legal effect.''.

(c) INCREASES IN FORMULA AMOUNT.—Section 2618(a) of the Public Health Service Act (as redesignated by subsection (a)(1) of this section) is amended—

(1) in paragraph (1)(A)(ii), by inserting before the semicolon the following: ''and then, as applicable, increased under paragraph (2)(H)''; and

(2) in paragraph (2)—

(A) in subparagraph (A)(i), by striking ''subparagraph (H)'' and inserting ''subparagraphs (H) and (I)''; and

(B) in subparagraph (H) (as redesignated by subsection (b)(2) of this section), by amending the subparagraph to read as follows:

''(H) LIMITATION.—

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

''(I) with respect to fiscal year 2001, 99 percent;

''(II) with respect to fiscal year 2002, 98 percent;

''(III) with respect to fiscal year 2003, 97 percent;

''(IV) with respect to fiscal year 2004, 96 percent; and

''(V) with respect to fiscal year 2005, 95 percent,

of the amount such State or territory received for fiscal year 2000 under section 2611 or subparagraph (I)(i), respectively (notwithstanding such subparagraph). In administering this subparagraph, the Secretary shall, with respect to States or territories that will under such section receive grants in amounts that exceed the amounts that such States received under such section or subparagraph for fiscal year 2000, proportionally reduce such amounts to ensure compliance with this subparagraph. In making such reductions, the Secretary shall ensure that no such State receives less than that State received for fiscal year 2000.

''(ii) RATABLE REDUCTION.—If the amount appropriated under section 2677 for a fiscal year and available for grants under section 2611 or subparagraph (I)(i) is less than the amount appropriated and available for fiscal year 2000 under section 2611 or subparagraph (I)(i), respectively, the limitation contained in clause (i) for the grants involved shall be reduced by a percentage equal to the percentage of the reduction in such amounts appropriated and available.''.

(d) TERRITORIES.—Section 2618(a) of the Public Health Service Act (as redesignated by subsection (a)(1) of this section) is amended in paragraph (1)(B) by inserting ''the greater of $50,000 or'' after ''shall be''.

(e) SEPARATE TREATMENT DRUG GRANTS.—Section 2618(a) of the Public Health Service Act (as redesignated by subsection (a)(1) of this section and amended by subsection (b)(2) of this section) is amended in paragraph (2)(I)—

(1) by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively;

(2) by striking ''(I) APPROPRIATIONS'' and all that follows through ''With respect to'' and inserting the following:

''(I) APPROPRIATIONS FOR TREATMENT DRUG PROGRAM.—

''(i) FORMULA GRANTS.—With respect to'';

(3) in subclause (I) of clause (i) (as designated by paragraphs (1) and (2)), by inserting before the semicolon the following: '', less the percentage reserved under clause (ii)(V)''; and

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

''(ii) SUPPLEMENTAL TREATMENT DRUG GRANTS.—

''(I) IN GENERAL.—From amounts made available under subclause (V), the Secretary shall make supplemental grants to States described in subclause (II) to enable such States to increase access to therapeutics described in section 2616(a), as provided by the State under section 2616(c)(2).

''(II) ELIGIBLE STATES.—For purposes of subclause (I), a State described in this subclause is a State that, in accordance with criteria established by the Secretary, demonstrates a severe need for a grant under such subclause. In developing such criteria, the Secretary shall consider eligibility standards, formulary composition, and the number of eligible individuals at or below 200 percent of the official poverty line to whom the State is unable to provide therapeutics described in section 2616(a).

''(III) STATE REQUIREMENTS.—The Secretary may not make a grant to a State under this clause unless the State agrees that—

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

''(bb) the State will not impose eligibility requirements for services or scope of benefits limitations under section 2616(a) that are more restrictive than such requirements in effect as of January 1, 2000.

''(IV) USE AND COORDINATION.—Amounts made available under a grant under this clause shall only be used by the State to provide HIV/AIDS-related medications. The State shall coordinate the use of such amounts with the amounts otherwise provided under section 2616(a) in order to maximize drug coverage.

''(V) FUNDING.—For the purpose of making grants under this clause, the Secretary shall each fiscal year reserve 3 percent of the amount referred to in clause (i) with respect to section 2616, subject to subclause (VI).

''(VI) LIMITATION.—In reserving amounts under subclause (V) and making grants under this clause for a fiscal year, the Secretary shall ensure for each State that the total of the grant under section 2611 for the State for the fiscal year and the grant under clause (i) for the State for the fiscal year is not less than such total for the State for the preceding fiscal year.''.

(f) TECHNICAL AMENDMENT.—Section 2618(a) of the Public Health Service Act (as redesignated by subsection (a)(1) of this section) is amended in paragraph (3)(B) by striking ''and the Republic of the Marshall Islands'' and inserting ''the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau, and only for purposes of paragraph (1) the Commonwealth of Puerto Rico''.

SEC. 207. SUPPLEMENTAL GRANTS FOR CERTAIN STATES.

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

(1) by striking section 2621; and

(2) by inserting after section 2619 the following section:

''SEC. 2620. SUPPLEMENTAL GRANTS.

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

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

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

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

''(3) submit the information described in subsection (c).

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

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

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

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

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

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

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

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

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

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

''(2) for which there has been reported to the Director of the Centers for Disease Control and Prevention a cumulative total of between 500 and 1999 cases of acquired immune deficiency syndrome for the most recent period of 5 calendar years for which such data are available (except that, for fiscal year 2005 and subsequent fiscal years, cases of HIV disease shall be counted rather than cases of acquired immune deficiency syndrome if cases

of HIV disease are being counted for purposes of section 2618(a)(2)(D)(i)).

''(e) FUNDING.—

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

''(A) the greater of—

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

''(ii) $5,000,000;

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

''(B) the greater of—

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

''(ii) $5,000,000;

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

''(2) TRIGGER OF FUNDING.—This section shall be effective only for fiscal years beginning in the first fiscal year in which the amount appropriated under 2677 to carry out part B, excluding the amount appropriated under section 2618(a)(2)(I), exceeds by at least $20,000,000 the amount appropriated under 2677 to carry out part B in fiscal year 2000, excluding the amount appropriated under section 2618(a)(2)(I).

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

''(4) DISTRIBUTION.—Grants under this section for emerging communities shall be formula grants. There shall be two categories of such formula grants, as follows:

''(A) One category of such grants shall be for emerging communities for which the cumulative total of cases for purposes of subsection (d)(2) is 999 or fewer cases. The grant made to such an emerging community for a fiscal year shall be the product of—

''(i) an amount equal to 50 percent of the amount available pursuant to this subsection for the fiscal year involved; and

''(ii) a percentage equal to the ratio constituted by the number of cases for such emerging community for the fiscal year over the aggregate number of such cases for such year for all emerging communities to which this subparagraph applies.

''(B) The other category of formula grants shall be for emerging communities for which the cumulative total of cases for purposes of subsection (d)(2) is 1000 or more cases. The grant made to such an emerging community for a fiscal year shall be the product of—

''(i) an amount equal to 50 percent of the amount available pursuant to this subsection for the fiscal year involved; and

''(ii) a percentage equal to the ratio constituted by the number of cases for such community for the fiscal year over the aggregate number of such cases for the fiscal year for all emerging communities to which this subparagraph applies.''.

Subtitle B—Provisions Concerning Pregnancy and Perinatal Transmission of HIV

SEC. 211. REPEALS.

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

(1) in section 2626, by striking each of subsections (d) through (f);

(2) by striking sections 2627 and 2628; and

(3) by redesignating section 2629 as section 2627.

SEC. 212. GRANTS.

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

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

''(F) Making available to pregnant women with HIV disease, and to the infants of women with such disease, treatment services for such disease in accordance with applicable recommendations of the Secretary.'';

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

''(2) FUNDING.—

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

''(B) ALLOCATIONS FOR CERTAIN STATES.—

''(i) IN GENERAL.—Of the amounts appropriated under subparagraph (A) for a fiscal year in excess of $10,000,000—

''(I) the Secretary shall reserve the applicable percentage under clause (iv) for making grants under paragraph (1) both to States described in clause (ii) and States described in clause (iii); and

''(II) the Secretary shall reserve the remaining amounts for other States, taking into consideration the factors described in subparagraph (C)(iii), except that this subclause does not apply to any State that for the fiscal year involved is receiving amounts pursuant to subclause (I).

''(ii) REQUIRED TESTING OF NEWBORNS.—For purposes of clause (i)(I), the States described in this clause are States that under law (including under regulations or the discretion of State officials) have—

''(I) a requirement that all newborn infants born in the State be tested for HIV disease and that the biological mother of each such infant, and the legal guardian of the infant (if other than the biological mother), be informed of the results of the testing; or

''(II) a requirement that newborn infants born in the State be tested for HIV disease in circumstances in which the attending obstetrician for the birth does not know the HIV status of the mother of the infant, and that the biological mother of each such infant, and the legal guardian of the infant (if other than the biological mother), be informed of the results of the testing.

''(iii) MOST SIGNIFICANT REDUCTION IN CASES OF PERINATAL TRANSMISSION.—For purposes of clause (i)(I), the States described in this clause are the following (exclusive of States described in clause (ii)), as applicable:

''(I) For fiscal years 2001 and 2002, the two States that, relative to other States, have the most significant reduction in the rate of new cases of the perinatal transmission of HIV (as indicated by the number of such cases reported to the Director of the Centers for Disease Control and Prevention for the most recent periods for which the data are available).

''(II) For fiscal years 2003 and 2004, the three States that have the most significant such reduction.

''(III) For fiscal year 2005, the four States that have the most significant such reduction.

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

''(I) For fiscal year 2001, 33 percent.

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

''(III) For fiscal year 2003, 67 percent.

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

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

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

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

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

''(iii) In the case of a State that meets the conditions to receive amounts reserved under subparagraph (B)(i)(II), the Secretary shall in making grants consider the following factors:

''(I) The extent of the reduction in the rate of new cases of the perinatal transmission of HIV.

''(II) The extent of the reduction in the rate of new cases of perinatal cases of acquired immune deficiency syndrome.

''(III) The overall incidence of cases of infection with HIV among women of childbearing age.

''(IV) The overall incidence of cases of acquired immune deficiency syndrome among women of childbearing age.

''(V) The higher acceptance rate of HIV testing of pregnant women.

''(VI) The extent to which women and children with HIV disease are receiving HIV-related health services.

''(VII) The extent to which HIV-exposed children are receiving health services appropriate to such exposure.''; and

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

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

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

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

(A) the Secretary of Health and Human Services shall, for the purpose of making grants under paragraph (1) of such section, reserve from the amount specified in paragraph (2) of this subsection an amount equal to the difference between $14,000,000 and the amount appropriated under paragraph (2)(A) of such section for such fiscal year (notwithstanding any other provision of this Act or the amendments made by this Act);

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

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

(2) ALLOCATION FROM INCREASES IN FUNDING FOR PART B.—For purposes of paragraph (1), the amount specified in this paragraph is the

amount by which the amount appropriated under section 2677 of the Public Health Service Act for fiscal year 2001 and available for grants under section 2611 of such Act is an increase over the amount so appropriated and available for fiscal year 2000.

SEC. 213. STUDY BY INSTITUTE OF MEDICINE.

Subpart II of part B of title XXVI of the Public Health Service Act, as amended by section 211(3), is amended by adding at the end the following section:

''SEC. 2628. RECOMMENDATIONS FOR REDUCING INCIDENCE OF PERINATAL TRANSMISSION.

''(a) STUDY BY INSTITUTE OF MEDICINE.—

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

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

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

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

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

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

''(b) PROGRESS TOWARD RECOMMENDATIONS.—In fiscal year 2004, the Secretary shall collect information from the States describing the actions taken by the States toward meeting the recommendations specified for the States under subsection (a)(1)(C).

''(c) SUBMISSION OF REPORTS TO CONGRESS.—The Secretary shall submit to the appropriate committees of the Congress reports describing the information collected under subsection (b).''.

Subtitle C—Certain Partner Notification Programs

SEC. 221. GRANTS FOR COMPLIANT PARTNER NOTIFICATION PROGRAMS.

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

''Subpart III—Certain Partner Notification Programs

''SEC. 2631. GRANTS FOR PARTNER NOTIFICATION PROGRAMS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(c) REPORTING SYSTEM FOR CASES OF HIV DISEASE; PREFERENCE IN MAKING GRANTS.—In making grants under subsection (a), the Secretary shall give preference to States whose reporting systems for cases of HIV disease produce data on such cases that is sufficiently accurate and reliable for use for purposes of section 2618(a)(2)(D)(i).

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

TITLE III—EARLY INTERVENTION SERVICES

Subtitle A—Formula Grants for States

SEC. 301. REPEAL OF PROGRAM.

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

(b) CONFORMING AMENDMENTS.—Part C of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–41 et seq.), as amended by subsection (a) of this section, is amended—

(1) by redesignating subparts II and III as subparts I and II, respectively;

(2) in section 2661(a), by striking ''unless—'' and all that follows through ''(2) in the case of'' and inserting ''unless, in the case of''; and

(3) in section 2664—

(A) in subsection (e)(5), by striking ''2642(b) or'';

(B) in subsection (f)(2), by striking ''2642(b) or''; and

(C) by striking subsection (h).

Subtitle B—Categorical Grants

SEC. 311. PREFERENCES IN MAKING GRANTS.

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

''(d) CERTAIN AREAS.—Of the applicants who qualify for preference under this section—

''(1) the Secretary shall give preference to applicants that will expend the grant under section 2651 to provide early intervention under such section in rural areas; and

''(2) the Secretary shall give special consideration to areas that are underserved with respect to such services.''.

SEC. 312. PLANNING AND DEVELOPMENT GRANTS.

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

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

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

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

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

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

''(4) AMOUNT AND DURATION OF GRANTS.—

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

''(B) CAPACITY DEVELOPMENT.—

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

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

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

SEC. 313. AUTHORIZATION OF APPROPRIATIONS.

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

Subtitle C—General Provisions

SEC. 321. PROVISION OF CERTAIN COUNSELING SERVICES.

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

(1) in the matter preceding subparagraph (A), by striking ''counseling on—'' and inserting ''counseling—'';

(2) in each of subparagraphs (A), (B), and (D), by inserting ''on'' after the subparagraph designation; and

(3) in subparagraph (C)—

(A) by striking ''(C) the benefits'' and inserting ''(C)(i) that explains the benefits''; and

(B) by inserting after clause (i) (as designated by subparagraph (A) of this paragraph) the following clause:

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

SEC. 322. ADDITIONAL REQUIRED AGREEMENTS.

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

(1) in paragraph (3)—

(A) by striking ''7.5 percent'' and inserting ''10 percent''; and

(B) by striking ''and'' after the semicolon at the end;

(2) in paragraph (4), by striking the period and inserting ''; and''; and

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

''(5) the applicant will provide for the establishment of a quality management program—

''(A) to assess the extent to which medical services funded under this title that are provided to patients are consistent with the most recent Public Health Service guidelines for the treatment of HIV disease and related opportunistic infections, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines; and

''(B) to ensure that improvements in the access to and quality of HIV health services are addressed.''.

TITLE IV—OTHER PROGRAMS AND ACTIVITIES

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

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

(a) ELIMINATION OF REQUIREMENT TO ENROLL SIGNIFICANT NUMBERS OF WOMEN AND CHILDREN.—Section 2671(b) (42 U.S.C. 300ff–71(b)) is amended—

(1) in paragraph (1), by striking subparagraphs (C) and (D) and inserting the following:

''(C) The applicant will demonstrate linkages to research and how access to such research is being offered to patients.''; and

(2) by striking paragraphs (3) and (4).

(b) INFORMATION AND EDUCATION.—Section 2671(d) (42 U.S.C. 300ff–71(d)) is amended by adding at the end the following:

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

(c) QUALITY MANAGEMENT; ADMINISTRATIVE EXPENSES CEILING.—Section 2671(f) (42 U.S.C. 300ff–71(f)) is amended—

(1) by striking the subsection heading and designation and inserting the following:

''(f) ADMINISTRATION.—

''(1) APPLICATION.—''; and

(2) by adding at the end the following:

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

(d) COORDINATION.—Section 2671(g) (42 U.S.C. 300ff–71(g)) is amended by adding at the end the following: ''The Secretary acting through the Director of NIH, shall examine the distribution and availability of ongoing and appropriate HIV/AIDS-related research projects to existing sites under this section for purposes of enhancing and expanding voluntary access to HIV-related research, especially within communities that are not reasonably served by such projects. Not later than 12 months after the date of enactment of the Ryan White CARE Act Amendments of 2000, the Secretary shall prepare and submit to the appropriate committees of Congress a report that describes the findings made by the Director and the manner in which the conclusions based on those findings can be addressed.''.

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

(1) by redesignating subsections (i) and (j) as subsections (j) and (k), respectively; and

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

''(i) LIMITATION ON ADMINISTRATIVE EXPENSES.—

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

''(2) REQUIREMENTS.—

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

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

(f) AUTHORIZATION OF APPROPRIATIONS.—Section 2671 of the Public Health Service Act (42 U.S.C. 300ff–71) is amended in subsection (j) (as redesignated by subsection (e)(1) of this section) by striking ''fiscal years 1996 through 2000'' and inserting ''fiscal years 2001 through 2005''.

SEC. 402. AIDS EDUCATION AND TRAINING CENTERS.

(a) SCHOOLS; CENTERS.—

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

(A) in subparagraph (A)—

(i) by striking ''training'' and inserting ''to train'';

(ii) by striking ''and including'' and inserting '', including''; and

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

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

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

(D) by adding at the end the following:

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

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

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

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

''(1) IN GENERAL.—

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

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

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

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

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

(c) AUTHORIZATION OF APPROPRIATIONS.—

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

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

''(2) DENTAL SCHOOLS.—

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

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

Subtitle B—General Provisions in Title XXVI

SEC. 411. EVALUATIONS AND REPORTS.

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

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

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 318A the following section:

''DATA COLLECTION REGARDING PROGRAMS UNDER TITLE XXVI

''SEC. 318B. For the purpose of collecting and providing data for program planning and evaluation activities under title XXVI, there are authorized to be appropriated to the Secretary (acting through the Director of the Centers for Disease Control and Prevention) such sums as may be necessary for each of the fiscal years 2001 through 2005. Such authorization of appropriations is in addition to other authorizations of appropriations that are available for such purpose.''.

SEC. 413. COORDINATION.

Section 2675 of the Public Health Service Act (42 U.S.C. 300ff–75) is amended—

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

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

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

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

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

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

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

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

''(e) RECOMMENDATIONS REGARDING RELEASE OF PRISONERS.—After consultation with the Attorney General and the Director of the Bureau of Prisons, with States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary, consistent with the coordination required in subsection (a), shall develop a plan for the medical case management of and the provision of support services to individuals who were Federal or State prisoners and had HIV disease as of the date on which the individuals were released from the custody of the penal system. The Secretary shall submit the plan to the Congress not later than 2 years after the date of the enactment of the Ryan White CARE Act Amendments of 2000.''.

SEC. 415. AUDITS.

Part D of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–71 et seq.) is amended by inserting after section 2675 the following section:

''SEC. 2675A. AUDITS.

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

SEC. 416. ADMINISTRATIVE SIMPLIFICATION.

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

''SEC. 2675B. ADMINISTRATIVE SIMPLIFICATION REGARDING PARTS A AND B.

''(a) COORDINATED DISBURSEMENT.—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall develop a plan for coordinating the disbursement of appropriations for grants under part A with the disbursement of appropriations for grants under part B in order to assist grantees and other recipients of amounts from such grants in complying with the requirements of such parts. The Secretary shall submit the plan to the Congress not later than 18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000. Not later than 2 years after the date on which the plan is so submitted, the Secretary shall complete the implementation of the plan, notwithstanding any provision of this title that is inconsistent with the plan.

''(b) BIENNIAL APPLICATIONS.—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall make a determination of whether the administration of parts A and B by the Secretary, and the efficiency of grantees under such parts in complying with the requirements of such parts, would be improved by requiring that applications for grants under such parts be submitted biennially rather than annually. The Secretary shall submit such determination to the Congress not later than 2 years after the date of the enactment of the Ryan White CARE Act Amendments of 2000.

''(c) APPLICATION SIMPLIFICATION.—After consultation with the States, with eligible areas under part A, and with entities that receive amounts from grants under part A or B, the Secretary shall develop a plan for simplifying the process for applications under parts A and B. The Secretary shall submit the plan to the Congress not later than 18 months after the date of the enactment of the Ryan White CARE Act Amendments of 2000. Not later than 2 years after the date on which the plan is so submitted, the Secretary shall complete the implementation of the plan, notwithstanding any provision of this title that is inconsistent with the plan.''.

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

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

''SEC. 2677. AUTHORIZATION OF APPROPRIATIONS.

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

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

TITLE V—GENERAL PROVISIONS

SEC. 501. STUDIES BY INSTITUTE OF MEDICINE.

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

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

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

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

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

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

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

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

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

such assistance only if the infection has progressed to acquired immune deficiency syndrome.

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

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

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

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

(1) not later than 3 years after the date of the enactment of this Act, the study required in subsection (a) is completed and a report describing the findings made in the study is submitted to the appropriate committees of the Congress; and

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

SEC. 502. DEVELOPMENT OF RAPID HIV TEST.

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

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

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

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

(b) PREMARKET REVIEW OF RAPID HIV TESTS.—

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

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

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

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

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

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

(c) GUIDELINES OF CENTERS FOR DISEASE CONTROL AND PREVENTION.—Promptly after commercial distribution of a rapid HIV test begins, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish or update guidelines that include recommendations for States, hospitals, and other appropriate entities regarding the ready availability of such tests for administration to pregnant women who are in labor or in the late stage of pregnancy and whose HIV status is not known to the attending obstetrician.

SEC. 503. TECHNICAL CORRECTIONS.

(a) PUBLIC HEALTH SERVICE ACT.—Title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.) is amended—

(1) in section 2605(d)—

(A) in paragraph (1), by striking ''section 2608'' and inserting ''section 2677''; and

(B) in paragraph (4), by inserting ''section'' before 2601(a)''; and

(2) in section 2673(a), in the matter preceding paragraph (1), by striking ''the Agency for Health Care Policy and Research'' and inserting ''the Director of the Agency for Healthcare Research and Quality''.

(b) RELATED ACT.—The first paragraph (2) of section 3(c) of the Ryan White Care Act Amendments of 1996 (Public Law 104–146; 110 Stat. 1354) is amended in subparagraph (A)(iii) by striking ''by inserting the following new paragraph:'' and inserting ''by inserting before paragraph (2) (as so redesignated) the following new paragraph''.

TITLE VI—EFFECTIVE DATE

SEC. 601. EFFECTIVE DATE.

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

The SPEAKER pro tempore. Pursuant to House Resolution 611, the gentleman from Oklahoma (Mr. COBURN) and the gentleman from Ohio (Mr. BROWN) each will control 30 minutes.

The Chair recognizes the gentleman from Oklahoma (Mr. COBURN).

Mr. COBURN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this is a bill that is long overdue. Before we get into the topic of discussions on this bill, I think it is important that the American public know that this reauthorization is going to allow at least $1 billion per year to be spent in Ryan White CARE Act policies and procedures. Also, the American public should know that we are going to spend about $10 billion a year on this epidemic, both in terms of research, drug treatments, and all associated factors with it.

As we think about that, if we were to apply the same efforts to many other diseases in our country, we would be achieving far more than we are today.

This bill is long overdue. It is long overdue in a lot of ways. It is long overdue because the government has failed through the CDC and the FDA and the NIH to appropriately handle this epidemic.

Two decades ago, the HIV/AIDS epidemic was recognized. Our Federal response to HIV/AIDS epidemic at that time was to ignore proven public health policies. This bill institutes for the first time in the Ryan White CARE Act proven public health policies that will, in fact, make a difference in the number of people who are infected.

These include ensuring medical access to all who are infected, not a special select few; early intervention in people who are infected; reliable disease surveillance and partner notification, including a responsibility to not infect anyone else with this disease. We will also, for the first time, recognize all of those living with HIV rather than focusing exclusively on those with AIDS.

There are many other noteworthy changes made by this bill. Waiting lists to access life-saving HIV medications under the AIDS Drug Assistance program will be eliminated. Prevention will be incorporated as part of the comprehensive care program. Planning councils will be more representative of the infected population. Patients who rely on the CARE Act for their well-being will be given a greater voice in priority setting, and accountability safeguards will ensure that Federal AIDS funds will be spent on needed patient care. This bill will also provide Federal assistance to States to ensure that all pregnant women with HIV and their children are identified and provided care.

One of the most promising victories in the battle against AIDS was a 1994 finding that the administration of a drug could significantly reduce the chance that a child born to an HIV positive mother would become infected. Yet, despite these miracles, a significant number of women still are not tested for HIV during their pregnancy, and hundreds of children are needlessly infected each year with an incurable disease that will prematurely claim their lives.

This bill will provide up to $400 million annually to any State that makes identifying and ensuring proper care for HIV and infected women and their HIV-exposed newborns a priority.

The two States with such baby AIDS laws, New York and Connecticut, have experienced great success. Universal newborn HIV testing has resulted in the identification of all HIV-exposed births and has allowed hospital and health department staff to ensure that over 98 percent of HIV positive mothers are aware of their HIV status and have newborns referred for early diagnosis and care of HIV infection. That is according to Dr. Guthrie Birkhead, the director of the New York AIDS Institute.

Dr. Birkhead noted that the rates of prenatal care have been increasing, not decreasing as we were told would happen. There has been no detectable change in prenatal participation trends that might be related to the newborn testing program.

The Connecticut baby AIDS law, which requires every newborn to be screened for HIV if the mother's status is unknown, was enacted almost a year ago. In the first 10 months, 26 newborns who were perinatally exposed to HIV

have been identified. This is more than four times as many as were diagnosed with HIV in the previous 3 years combined.

This substantial financial incentive amounts to a Federal endorsement of universal HIV newborn testing as a routine medical practice. I must regrettably note that the organization in my profession that purports to represent physicians who care for mothers and women has yet to endorse this. The question we ought to ask ourselves is why the American College of Obstetricians and Gynecologists, knowing that we can save children's lives and we can treat women, has failed to yet endorse this.

This bill will also provide additional resources to support partner notification programs so that everyone who has been exposed to HIV is given the right to know that exposure. In addition, it will empower those who are infected to protect others from infection by providing prevention counseling as a part of a comprehensive care program. This includes providing advice on how to disclose one's HIV status to a potential partner and emphasizing to those living with HIV that they have a responsibility not to give this disease to anyone else.

Finally, the bill recognizes everyone living with HIV and guarantees access to life-saving treatment to all who are infected. Current funding formulas are based on AIDS infection, the end stage of HIV infection. The CDC only recently recommended that States begin tracking the full scope of the epidemic, not just AIDS. The American public ought to be asking why has it waited so long.

Over 12 years ago, the Presidential Commission on HIV warned the continual focus on AIDS rather than the full spectrum of HIV disease has left our Nation unable to deal adequately with the epidemic. Well, this bill changes that. This observation was absolutely correct. Yet, it was ignored by the CDC and Federal policy makers. The results have been devastating.

While our attention was placed on AIDS, the virus silently spread through communities of color, and more and more women became unknowingly infected. Only now are AIDS statistics revealing the paths that the virus took 10 years ago. Unfortunately, the casualties are increasingly rising for women and women of color.

While women and African-Americans comprise the majority of new HIV infections, they also receive less appropriate care according to the General Accounting Office. This is a direct result of the CARE Act's misplaced emphasis on AIDS data and determining funding and priority setting. That has changed with this bill.

All of these changes, while long overdue, will do much to improve our Nation's responsibilities to HIV and AIDS by ensuring medical access to all of those who are infected and by providing the proper care for all.

Mr. Speaker, I include the following letter for the RECORD, as follows:

GENERAL ACCOUNTING OFFICE,
Washington, DC, August 24, 2000.

Hon. TOM A. COBURN,
Vice Chair, Subcommittee on Health and Environment, Committee on Commerce, House of Representatives.

Subject: Ryan White CARE Act: Title I Funding for San Francisco

DEAR MR. COBURN: This letter responds to your request for additional information regarding funding for San Francisco under the Ryan White CARE Act. Specifically, you asked that we compare San Francisco's fiscal year 2000 title I grant award, which was determined using the act's hold-harmless provision, with what the award would have been had deceased AIDS cases been included in the calculation. You also asked how funding for San Francisco that was based on the inclusion of deceased AIDS cases would have compared with the amount San Francisco would have received if the fiscal year 2000 hold-harmless level had been reduced by 25 percent.

In brief, San Francisco's fiscal year 2000 title I grant award would have been 26 percent less had both living and deceased AIDS cases been used to calculate the award instead of the current hold-harmless provision. The reason for this result is the substantial decline in newly reported AIDS cases in San Francisco compared with other eligible metropolitan areas (EMA). Therefore, a 25-percent reduction in the current hold-harmless level would have provided San Francisco with funding comparable to what it would have received if title I grants had been calculated on the basis of both deceased and living cases.

This analysis is based on data obtained from the Centers for Disease Control and Prevention and computer models we developed to calculate how funding would change under various formula scenarios. We performed our work in August 2000 according to generally accepted government auditing standards.

BACKGROUND

The Ryan White CARE Act of 1990 provides health care and preventive services to people infected with the human immunodeficiency virus. Prior to the 1996 reauthorization of the act, the number of both living and deceased AIDS cases was used to distribute title I funds among EMAs. Under this practice, areas of the country with the longest experience with the disease had the most deceased cases and therefore received funding disproportionate to their share of living cases in need of care. The 1996 reauthorization eliminated this practice by counting only live AIDS cases. The effect of the change was to shift funding away from EMAs with higher proportions of deceased cases and toward those with newly diagnosed cases. As geographic trends in the disease change, the revised formula automatically realigns funding with the current distribution of the disease.

A hold-harmless provision was also included in the 1996 reauthorization to provide for a gradual transition to new funding levels for those EMAs that would otherwise have experienced substantial funding decreases. This provision allowed grant awards for affected EMAs to decline by no more than 5 percent by fiscal year 2000. In fiscal year 1996, four EMAs benefited from the hold-harmless provision: San Francisco, New York, Houston, and Jersey City. By fiscal year 1999, all but San Francisco had made the transition to the new formula.

Under the current title I formula, EMAs receive grant awards that are proportional to the number of living AIDS cases. In fiscal year 2000, Los Angeles had 6.9 percent of all AIDS cases nationally and received 6.7 percent of title I funding. Similarly, Miami had 4.4 percent of all AIDS cases and received 4.3 percent of title I funding. EMAs received $1,290 in title I funds per AIDS case in fiscal year 2000. However, because of the hold-harmless provision, San Francisco's grant award was substantially higher: it received $2,360 per AIDS case, or 80 percent more than other EMAs. As a consequence, San Francisco received 6.7 percent of title I formula funding even though it had just 3.8 percent of all living AIDS cases.

RESULTS OF DIFFERENT FUNDING APPROACHES

If both deceased and living AIDS cases had been used to calculate fiscal year 2000 title I formula grants instead of the hold-harmless provision, San Francisco's grant would have been about 4.9 percent of all title I formula funding, or 26 percent less than it actually was (see fig. 1). Thus, a 25-percent reduction in the current hold-harmless level, as provided for in H.R. 4807, would have an effect on San Francisco's funding similar to that of calculating grant awards on the basis of both deceased and living cases.

An important reason that San Francisco's share of living AIDS cases is so much lower than its share of title I formula funding is that the rate of new cases has declined to a much greater extent in San Francisco than in almost any other area of the country. As figure 2 shows, San Francisco's newly reported AIDS cases dropped by over 50 percent between 1990 and 1999, while other EMAs have shown either smaller declines (Los Angeles) or increases (Miami).

At the start of the decade, Los Angeles and San Francisco were reporting nearly the same number of new AIDS cases (2,130 in Los Angeles and 1,923 in San Francisco). By the end of the decade, San Francisco was reporting half as many new cases as Los Angeles (904 compared with 2,027). Similarly, at the start of the decade, Miami was reporting about half as many new AIDS cases as San Francisco (1,076 in Miami compared with 1,923 in San Francisco). By the end of the decade, Miami was reporting about 70 percent more new cases than San Francisco.

We did not obtain comments from other parties because your request pertains to the formula provisions in the law and not to the activities of any agency or organization.

If you have any questions regarding this letter, please contact me at (202) 512–7118 or Jerry Fastrup at (202) 512–7211. Greg Dybalski and Michael Williams made major contributions to this work.

Sincerely yours,

JANET HEINRICH,
Associate Director, Health Financing and Public Health Issues.

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

1045

Mr. BROWN of Ohio. Mr. Speaker, I yield myself such time as I may consume.

I first want to commend the gentleman from Oklahoma (Mr. COBURN) and the gentleman from California (Mr. WAXMAN) for their outstanding work on the Ryan White CARE Act Amendments of 2000.

I also want to acknowledge the gentlewoman from California (Ms. ESHOO). Her constituents should know she worked exceptionally hard on this bill, particularly on those provisions with particular significance to San Francisco. The same can be said of the gentlewoman from California (Ms. PELOSI).

She deserves a great deal of credit and praise for her ongoing involvement and input on these provisions.

This bill required a tremendous amount of work and negotiation. Staff members Paul Kim and Roland Foster put in a staggering number of hours, and it shows in the quality of the final product. John Ford, Marc Wheat, Karen Nelson, Eleanor Dehoney also deserves our thanks, as well as Stacey Rampey and Scott Boule.

Over the last several years, much has been written about ''The changing face of AIDS.'' This is not a wholly accurate characterization. HIV/AIDS is not a moving target. It does not leave one population when it moves to another population. Instead, HIV/AIDS expands to absorb new populations while continuing its progression in groups already affected by the virus.

When the AIDS epidemic surfaced in this country 19 years ago, white gay males were the at-risk population. That has not changed. The population still is at an elevated risk. But the epidemic has expanded its reach dramatically in these 2 decades. The latest HIV/AIDS statistics show that African American and Latino communities are significantly over-represented in the number of new HIV infections. African Americans comprise 12 percent of the population but accounted for more than 50 percent of the estimated 40,000 new HIV infections in 1999.

The aggressive nature of this virus calls for an equally aggressive response, and it speaks to the importance of updating and reauthorizing the Ryan White Act. Ryan White programs get information and services to the people who need them. They combat the illness as well as the alienation and isolation that can be one of its most disabling effects.

If HIV/AIDS is a war, and it is set to kill more people worldwide than World War I, World War II, Korea, and Vietnam combined, then the Ryan White programs are this Nation's front line defenses. The act was created in memory of Ryan White, a young teenager who became a national hero in the fight against HIV/AIDS. Ryan wanted to attend school. He wanted to be treated like other young people. Those seem like modest goals, but he had to overcome tremendous obstacles to achieve them.

Ryan was a hemophiliac and contracted HIV through a bad blood transfusion. But he fought against ignorance, he fought against fear, he fought against prejudice on behalf of all individuals with HIV/AIDS. Ryan died on April 8, 1990, at the age of 18. Ten years after his death, the law named after him carries on his legacy.

The Ryan White CARE Act has made a tremendous difference in the lives of people living with HIV/AIDS. In my district, which includes much of Ohio's only title I-eligible metropolitan area, so-called EMA, Ryan White programs provide primary care and support services and the kinds of medications that can tame HIV/AIDS into a chronic, rather than an acute, illness. There is more to do, and the Ryan White Act will continue to play a pivotal role.

In Ohio, while AIDS deaths have declined, the incidence of HIV/AIDS has increased dramatically. After declining steadily, the incidence of HIV/AIDS among young gay males is again on the rise. HIV/AIDS is expanding into new populations while continuing to spread in those populations originally at risk. Prevention is vital; treatment is vital; Ryan White programs are vital.

During the 13th International AIDS Conference held in Durbin, South Africa, scientists shared some amazing research findings. These findings provide sorely needed hope for developing nations ravaged by HIV/AIDS. The research indicates that the so-called AIDS cocktails, which have revolutionized HIV/AIDS treatment in the U.S. and other industrialized nations, can be successfully used even in countries lacking a sophisticated health care infrastructure.

That does not mean it will be easy. There must have been times when Ryan White himself felt overwhelmed by the intransigence, the callousness, and the hatred that he encountered. This Nation should fight AIDS here and abroad with that sense of commitment that he had. Reauthorizing Ryan White is part of that commitment, and I urge its passage.

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

Mr. COBURN. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida (Mr. BILIRAKIS), the chairman of the Subcommittee on Health of the Committee on Commerce.

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman for yielding me this time and for being here to lead our side on this very, very significant bill.

I too arise in support of this amendment to S. 2311, the Ryan White CARE Act Amendments of 2000. This final legislation is the result of negotiations between the Senate and the House, and the resulting bill is designed to bring the CARE Act into the 21st century.

I salute my committee colleagues, the gentleman from Oklahoma (Mr. COBURN) and the gentleman from California (Mr. WAXMAN), for their excellent work on this legislation; and I urge Members to support its passage.

My Subcommittee on Health and Environment held a hearing on the bill, and the full Committee on Commerce approved it by voice vote after adopting several bipartisan amendments to further refine and strengthen this very important measure.

Before the August recess, the House approved legislation to reauthorize the Ryan White CARE Act with strong bipartisan support. The act provides critical funding to address the needs of patients living with HIV and AIDS. S. 2311 reflects the agreements reached between the House and the Senate, and I expect this bill to be signed into law in the near future.

The Ryan White Comprehensive AIDS Resources Emergency, or ''CARE'' Act as we call it, was enacted in 1990 and Congress approved bipartisan legislation to reauthorize the law in 1996. The Ryan White CARE Act provides critical funding for health and social services to the estimated 1 million Americans living with HIV and AIDS. The bill before us will ensure that these patients continue to receive the care and medications they need to enhance and prolong their lives.

The bill makes an important change by relying on the number of HIV-infected individuals as opposed to only the number of persons living with AIDS as the basis for allocating funding under titles I and II of the Ryan White CARE Act. By targeting resources to the front line of the epidemic, we will be able to reduce transmission rates and ensure the necessary infrastructure is in place to provide care to HIV-positive individuals as soon as possible.

This change will allow the Federal Government to be proactive instead of reactive in the fight against HIV and AIDS. It should be noted, however, Mr. Speaker, that this shift will only occur when reliable data on HIV prevalence is available.

The bill also includes a ''hold harmless'' provision to ensure that no metropolitan area will suffer a drastic reduction in CARE Act funds. The bill which originally passed the House would have hurt certain cities such as San Francisco. In this regard, Mr. Speaker, I will submit for the RECORD a letter that GAO sent to the gentleman from Oklahoma (Mr. COBURN). After lengthy negotiations, it has been agreed the hold harmless reduction will be a compromised 15 percent over the next 5 years.

The Ryan White CARE Act must be reauthorized to improve our public health strategies. The bill before us will ensure that the HIV/AIDS epidemic can be tracked more accurately and that appropriate funding and information about this disease can be directed effectively. I have been very encouraged to hear from patient advocates in support of this measure. For example, AIDS Action stated that it is ''very pleased with the compromise bill that has been negotiated between the House and the Senate. It represents a modernization of the CARE Act and will allow us to provide quality care for people with HIV and AIDS.''

In closing, Mr. Speaker, I want to again recognize the hard work of all the Members and their staffs, whose bipartisan efforts advanced this reauthorization bill. The gentleman from Oklahoma (Mr. COBURN) and the gentleman from California (Mr. WAXMAN), who I mentioned previously, and staff members Roland Foster and Paul Kim worked very hard to advance this measure in the House, working with Senators JEFFORDS, FRIST, and KENNEDY. And obviously, working with my counterpart on the other side in the

subcommittee, the gentleman from Ohio (Mr. BROWN), the gentleman from Michigan (Mr. DINGELL), et cetera, we were able to craft this compromise legislation.

It is a critical piece of legislation that can literally save lives, and I urge all Members to join me today in supporting this important legislation.

Mr. BROWN of Ohio. Mr. Speaker, I yield 5 minutes to the gentlewoman from California (Ms. PELOSI), who has been one of the real leaders in this whole process in pulling this bill together.

Ms. PELOSI. Mr. Speaker, I thank the gentleman for yielding me this time, and I want to compliment him on his great leadership on this legislation; he and the gentleman from Florida (Mr. BILIRAKIS) for their leadership, and I associate myself with the comments that the gentleman from Florida made in recognition of those who worked so hard to make it a success; and, if it is allowed, to especially recognize the work of Senator KENNEDY for bringing about the compromises that exist in this bill.

The gentleman from California (Mr. WAXMAN) has been a champion in Congress since the onset of the AIDS epidemic, and his leadership is very much in evidence in this bill; and the ranking member, the gentleman from Ohio (Mr. BROWN), helped us through some difficult times here, but I think the product is one that this whole body can wholeheartedly support. That is why, Mr. Speaker, I rise in strong support of the reauthorization of the Ryan White CARE Act.

Passage of this vital legislation is the most important action this Congress can take on the issue of AIDS this year. And I would like to thank again the Committee on Commerce, the gentleman from Michigan (Mr. DINGELL), the gentleman from Virginia (Mr. BLILEY), the gentleman from Florida (Mr. BILIRAKIS), the gentleman from California (Mr. WAXMAN), the gentleman from Ohio (Mr. BROWN), and also point out the distinguished work of the gentlewoman from California (Ms. ESHOO).

The gentlewoman from California (Ms. ESHOO) lives in the same metropolitan area that I do. We are in the same area for care and treatment and prevention for people with HIV/AIDS. This is about care today, but her leadership on the committee has been indispensable to the success that we see here today with this legislation.

Since the beginning of the AIDS epidemic, my district in San Francisco has been one of the most severely impacted in the country. When I came to the Congress 13 years ago, we had already lost over 13,000 of our friends and loved ones to the AIDS epidemic. That is 13,000, 13 years ago. We have suffered greatly, but we have learned a lot we would like the rest of the country to benefit from as we have responded to this challenge.

The Ryan White CARE Act was modeled on a system of community-based care that we developed to face the crisis in the 1980s. As a result of this work early in the epidemic, San Francisco produced data that showed the country that comprehensive HIV/AIDS care and services not only saved lives but also saved money and valuable health care resources. Today, the CARE Act programs provide foundation for care and treatment for low-income individuals with HIV and AIDS.

The recent declines we have seen in AIDS deaths are a direct result of the therapies and services that have been made more widely available through the CARE Act to large numbers of uninsured and underinsured people with HIV and AIDS. Each year, the CARE Act ensures that approximately half a million people, 500,000 people, living with HIV and AIDS have access to the medical services, including pharmaceuticals that are needed to sustain and prolong life. This represents approximately two-thirds of the individuals living with HIV/AIDS in this country.

Although great strides have been made, there is much more to be done. The combination therapies that have brought us so much hope are still not reaching all those in need. The changing nature of the HIV/AIDS epidemic, along with the continuing impact of it in traditionally affected communities, has created new challenges for the CARE Act. People of color now represent the majority of new AIDS cases, and the proportion of new AIDS cases among women has grown from 11 percent in 1990 to 23 percent in most recent statistics.

In addition, new HIV infections have remained constant at 40,000 cases per year. These new infections, combined with the decline in AIDS deaths, means more individuals than ever before are living with HIV and in need of treatment regimens that are costly, complicated and lifelong. As a result, the demand on HIV care providers has grown.

The Ryan White CARE Act's remarkable ability to adapt to the changing nature of the AIDS epidemic was confirmed earlier this year when a GAO report concluded that the CARE Act is helping our public health infrastructure adjust to these new challenges by directing services to African Americans, Hispanics, and women in higher proportions than their representation in the AIDS population.

Again, I thank our colleagues, including the gentleman from Oklahoma (Mr. COBURN) and the Committee on Commerce for their great work. This program is an important example of the way that effective leadership at the Federal, State, and local levels can translate into improved health outcomes for the people of this country. I think it also is a wonderful example of bipartisanship, where we can all come together and give what I hope will be unanimous support for this act. I urge my colleagues to vote ''yes'' on the reauthorization.

Mr. Speaker, I serve on the Subcommittee on Labor, Health and Human Services, and Education of the Committee on Appropriations, and one of the priorities we have there is research, prevention, and care for people with HIV/AIDS.

1100

We want to focus heavily on prevention. We must continue our research for a cure. We are trying to find a vaccine and, hopefully, that will happen before not too long. But we must never forget the people out there who are diagnosed with HIV and AIDS now.

I am pleased that the bill eventually will recognize and count those infected with HIV but not full-blown cases of AIDS in the numbers and in the formula. I wish that would have been sooner. But, nonetheless, there is the recognition. I commend the legislators on the committee, members of the committee, for making that distinction and having it be a part of our formula down the road.

Once again, Mr. Speaker, I want to commend the gentleman from California (Mr. WAXMAN) who I see now on the floor. As I said earlier, he has been a champion since day one on this issue. We have all been very well-served by his leadership, that of the gentleman from Ohio (Mr. BROWN) and others.

I urge my colleagues to vote aye.

Mr. COBURN. Mr. Speaker, I ask unanimous consent that the remainder of the time on our side be controlled by the gentleman from Florida (Mr. BILIRAKIS).

The SPEAKER pro tempore (Mr. SIMPSON). Is there objection to the request of the gentleman from Oklahoma?

There was no objection.

Mr. BILIRAKIS. Mr. Speaker, I yield 3½ minutes to the gentlewoman from Maryland (Mrs. MORELLA).

Mrs. MORELLA. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, I rise in strong support of the Ryan White CARE Act Amendments of 2000. I want to thank the gentleman from Florida (Chairman BILIRAKIS) for his leadership in bringing this bill to the floor and the gentleman from Ohio (Mr. BROWN), the ranking member, for his role in so doing.

And also, there are other colleagues of ours who deserve particular attention. The gentleman from Oklahoma (Mr. COBURN), the gentleman from California (Mr. WAXMAN) and the gentleman from Ohio (Mr. BROWN) worked very hard. They were dedicated in their commitment and their hard work has paid off for these critical programs.

The CARE Act represents the largest authorization of Federal funds specifically designated to provide health and social services to people infected with HIV. Declaring an AIDS emergency, Congress passed the Ryan White Comprehensive AIDS Resources Emergency Act in August of 1990. Six years later, we voted to reauthorize the CARE Act

by a unanimous vote in the House of Representatives and a 97–3 vote in the Senate.

Over the last 9 years, the CARE Act has helped increase the availability of primary care health and support services especially for the uninsured and underinsured persons with HIV disease. The multi-title structure of the CARE Act has worked effectively to dramatically improve the quality of life for people living with HIV and their families. It has helped to reduce cost of inpatient care and increase access to care for underserved populations, including people of color.

The legislation we are considering today revises the grant formulas to shift the emphasis of the programs away from treating people with full-blown AIDS to people with the viral precursor, HIV, of AIDS. This legislation includes a new formula beginning in 2005 for distributing funds to States and cities based on the number of both AIDS and HIV cases compared to the current formula, which allocates funds based solely on AIDS cases.

Also included in this measure is $20 million to reduce HIV mother-to-child transmission. The bill also addresses prevention of the disease by including $30 million for tracking the disease and encouraging people to notify their partners.

Additionally, those receiving care through Ryan White programs are required to enroll in counseling programs.

Today, promising new drug therapies have brought new hope and new challenges to the battle against the epidemic, but these new drugs do not constitute a cure and an effective vaccine is still years away. Moreover, the treatments do not work for everyone, they are difficult to access especially for communities of color, and their long-term efficacy remains unknown. Nonetheless, AIDS deaths have declined dramatically in the last 3 years and more people are living longer with HIV.

The HIV/AIDS epidemic thus remains an enormous health emergency in the United States, and it will remain so into this century. The state of the epidemic points to an increase rather than a decrease in the overall need for health care, drug treatment, social services. As a Nation, we must continue our effort to expand access to these services for people living with HIV/AIDS, particularly in communities of color and women.

This Ryan White CARE Act has proven to be an essential and effective part of the Federal response to the HIV/AIDS crisis. This legislation will ensure we continue this response.

I certainly ask this body to support this comprehensive, meaningful and truly successful legislation.

Mr. BROWN of Ohio. Mr. Speaker, I yield 4½ minutes to the gentleman from California (Mr. WAXMAN) who played a very central role in the negotiations on this bill.

Mr. WAXMAN. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, I rise in strong support of S. 2311, the Ryan White CARE Act Amendments of 2000.

As the original author of the Ryan White CARE Act and the coauthor of the House reauthorization bill, H.R. 4807, I want to applaud the Members and the staffs on both sides of the aisle for moving this crucial legislation with such speed and bipartisan cooperation.

I want to recognize the gentleman from Oklahoma (Mr. COBURN) for his commitment to reauthorizing this Act and his leadership in fashioning the compromises that allowed us to move the bill I think virtually unanimously through the House and to get an agreement with the Senate. He made this consensus legislation a reality.

The gentleman from Florida (Chairman BILIRAKIS), the gentleman from Ohio (Mr. BROWN), the gentleman from Virginia (Chairman BLILEY), and the gentleman from Michigan (Mr. DINGELL) have lent their unqualified support. And numerous Members, including the gentlewoman from California (Ms. PELOSI), the gentleman from New York (Mr. TOWNS), the gentlewoman from California (Ms. ESHOO), the gentleman from Texas (Mr. RODRIGUEZ) and the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) have helped ensure its passage.

Mr. Speaker, the original CARE Act was enacted in the wake of a decade of lost opportunities. I told this House in 1990 that, ''Having missed our opportunity to provide an ounce of prevention, we must now prepare to pay for pounds and pounds of cure.''

Today, the AIDS epidemic is everywhere. It threatens everyone. But there is still no vaccine and there is still no cure. Nevertheless, the Ryan White CARE Act has made an enormous difference. It provides care to tens of thousands of Americans living with HIV/AIDS. It helps their families cope with the burdens of AIDS and HIV infection, and it provides urgently needed funding to community providers and hospitals to combat the epidemic.

Today's overwhelming bipartisan support for the CARE Act demonstrates that Congress understands how crucial it is to the health and welfare of our country.

Mr. Speaker, this legislation preserves the best features of the CARE Act while making reforms to better respond to a changing epidemic.

First and foremost, this legislation better addresses the needs of individuals with HIV who have not developed AIDS. In 2004, we will determine whether to use nationwide data on HIV infection in the CARE Act. I believe this will happen, and I have been told by the State of California that they will have such data by 2004.

We also call on States and cities to do more to reach those who are not receiving care and to serve the needs of our historically underserved communities. We call for ending lingering disparities in care and for better coordination of HIV/AIDS treatment with prevention.

We have also focused CARE Act programs on the needs of vulnerable populations. Funds will be allocated to better reflect the proportions of women, children, infants and youth with HIV. I expect this will increase such funding for those populations in the future.

This legislation also greatly expands our national effort to eliminate the perinatal transmission of HIV/AIDS. These new funds will help bring the number of babies born with HIV in our country down to zero.

We also redirect funding to cities and States in the greatest need of assistance. The title I and title II ''hold harmless'' provisions have been revised to ensure a manageable transition to funding allocations which better reflect the epidemic. At the same time, potential disruptions in patient care are minimized. And the title I, title II, and AIDS Drug Assistance Program (ADAP) supplemental grants will assist cities and States with the greatest need of funds.

These are the principal reforms to the CARE Act. They will expand access, improve quality, and enhance services for individuals with HIV and AIDS.

Regrettably, Mr. Speaker, much more could be done and much more needs to be done. We must expand Medicaid to provide care to individuals with HIV who have not developed AIDS. We must lead the global search for an effective HIV vaccine and a cure for AIDS. And we must provide resources and our hard-earned expertise to help other countries combat the epidemic.

For today, though, I am pleased that we will fulfill the expectations of Jeanne White, the mother of Ryan White, and of so many Americans living with HIV and AIDS by reauthorizing the Ryan White CARE Act.

Mr. Speaker, I rise in strong support of the Ryan White CARE Act Amendments.

As the original author of the Ryan White CARE Act and the co-author of the House reauthorization bill, H.R. 4807, I want to applaud the Members and the staff on both sides of the aisle for moving this crucial legislation with such speed and bipartisan cooperation.

I want to recognize Dr. COBURN for his commitment to reauthorizing the CARE Act. He has made this consensus legislation a reality. Chairman BILIRAKIS and Mr. BROWN, Chairman BLILEY and Mr. DINGELL have lent their unqualified support. And numerous Members, including Ms. PELOSI, Mr. TOWNS, Mr. ESHOO, Mr. RODRIGUEZ and Dr. CHRISTENSEN, have helped ensure its passage.

Mr. Speaker, the original CARE Act was enacted in the wake of a decade of lost opportunities. I told this House in 1990 that, ''Having missed our opportunity to provide an ounce of prevention, we must now prepare to pay for pounds and pounds of cure.''

Ten years ago, there were those who spoke of the AIDS epidemic as a thing of the past. There were those who dismissed the disease

as a danger to others, and not themselves. And there were those who opposed the Ryan White CARE Act.

Mr. Speaker, they were wrong then, and they are wrong today. The AIDS epidemic is everywhere. It threatens everyone. It is devastating the globe from Russia to subSaharan Africa. And there is still no vaccine. There is still no cure.

But in the face of these challenges, the CARE Act has made a difference. The CARE Act provides care to tens of thousands of Americans living with HIV/AIDS. If helps their families cope with the burdens of AIDS and HIV infection. And it provides urgently needed funding to community providers and hospitals to combat the epidemic.

Today's overwhelming bipartisan support for the CARE Act demonstrates that Congress understands how crucial it is to the health and welfare of our country.

Let me highlight the important ways this legislation preserves the best and proven features of the CARE Act, while making important and substantial reforms to better respond to a changing epidemic. I am particularly pleased that this consensus House and Senate legislation reflects virtually all of the provisions and agreements reached by this House in H.R. 4807.

Most important of all, this legislation better addresses the needs of individuals with HIV who have not developed AIDS. With 40,000 new infections every year and improved prospects for delaying the onset of AIDS, the number of new deaths from AIDS has declined but the number of individuals with HIV is rising inexorably. In response, this legislation calls on the Secretary of Health and Human Services to determine in 2004 whether we have nationwide data on accurate and reliable cases of HIV infection which can be used in allocating CARE Act funds. I believe this will happen, and I have been told by the State of California that they are confident they will have such data by 2004.

We also call on States and cities to better determine the number and demographics of individuals with HIV. We require special efforts to reach those who are not receiving care and serve the needs of our historically underserved communities. We call for ending lingering disparities in care. And we require States, cities and the Federal government to develop new strategies to better coordinate HIV/AIDS treatment with prevention.

The need for better coordination cuts across systems of care, Federal agencies, States, cities, providers and community organizations. Ten years ago, I described the CARE Act as providing ''a continuum of prevention services—counseling and testing, diagnostics for those who test positive, and therapeutics for those whose diagnostics indicate a medical intervention.'' Patients receiving care under the CARE Act today deserve seamless continuity between testing, counseling, treatments, support and prevention services.

Just last week, the Institute of Medicine released a comprehensive report on our nation's HIV prevention efforts. They concluded that ''prevention services for HIV-infected people should be integrated into the standard of care at all primary care centers, sexually-transmitted disease clinics, drug treatment facilities, and mental health centers.'' This is precisely what we set out to accomplish in H.R. 4807, and this policy is reflected fully in this final consensus legislation.

This legislation also strengthens the responsiveness of CARE Act programs to the public. Title I Planning Councils will include a greater number of independent individuals with HIV/AIDS. Planning Council meetings and records will be exposed to greater public ''sunshine.'' All Planning Council members will receive improved training. And States will make their planning more accessible to a broader range of public stakeholders.

We have also focused CARE Act programs on the needs of vulnerable populations. Just yesterday, the Office of National AIDS Policy announced that half of the 40,000 new HIV infections every year occur among our teens and young adults. In this legislation, funds will be allocated to better reflect the proportions of women, children, infants and youth with HIV. I expect this will increase such funding for these populations in the future.

We have also strengthened the Title IV program for medical care, social services, and access to research for low-income children, youth, women and families. States and cities must develop novel strategies to coordinate their HIV/AIDS services and substance abuse services. And the Secretary of Health and Human Services must develop a plan in consultation with the Attorney General for the treatment of prisoners with HIV/AIDS.

This legislation greatly expands our national effort to eliminate the perinatal transmission of HIV/AIDS. The last ten years have seen a dramatic decline in such cases, due largely to the treatment of pregnant mothers with zidovudine. In an important compromise, we have increased an existing $10 million CARE Act grant program by $20 million, with a proportion of new funds set aside for States with either mandatory newborn testing or significant declines in perinatal transmission. I am confident these funds will be well spent on offering counseling and testing to all pregnant women, outreach to high-risk women and other innovative prevention efforts.

Funding has also been redirected to cities and States with the greatest need of additional assistance. The Title I and Title II ''hold harmless'' provisions have been revised to ensure a manageable transition to funding allocations which better reflect the current distribution and epidemiology of the epidemic. This will be accomplished while minimizing potential disruptions in care for individuals with HIV/AIDS. Under Title II, States' base funds as well as their total funding will be held harmless to a small percentage of loss.

Under Title I, a city's potential loss in its formula allocation is limited to a percentage of the amount allocated to the city in the base year preceding its need for the hold harmless. In its fifth, consecutive year of need for the hold harmless, a city would lose no more than 15 percent of its base year allocation. Such losses would not be compounded, as was contemplated in the original Senate bill. But if the Secretary determines that data on HIV prevalence will be used in Title I formula grants in 2005, no city may lose more than 2 percent of its 2004 formula allocation in 2005.

Additionally, Title I supplemental grants and new AIDS Drug Assistance Program (ADAP) supplemental grants will be directed to cities and States with ''severe need'' for such funding, based on more objective and quantitative criteria. And new Title II supplemental formula grants will be given to ''emerging communities'' with AIDS case counts which fall below the threshold for Title I eligibility.

These are the principal reforms to the CARE Act. They will expand access, improve quality and enhance services for individuals with HIV/AIDS. And I want to recognize the hard work of House staff, including Roland Foster, Paul Kim, Karen Nelson, Marc Wheat, John Ford, Eleanor Dehoney, Brent Delmonte, Katie Porter, Anne Esposito and House Legislative Counsel Pete Goodloe, in making this possible.

Mr. Speaker, much more could be done and much more needs to be done. We must expand Medicaid to provide care to individuals with HIV who have not developed AIDS. We must lead the global search for an effective HIV vaccine and a cure to AIDS. And we must provide resources and our hard-earned expertise to help other countries combat the epidemic.

For today, though, I am pleased we will fulfill the expectations of Jeanne White, the mother of Ryan White, and of so many Americans living with HIV and AIDS by reauthorizing the Ryan White CARE Act.

Mr. BILIRAKIS. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. GILMAN) the chairman of the Committee on International Relations.

Mr. GILMAN. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, I rise today in support of S. 2311, the Ryan White CARE Act Amendments as adopted by the Senate. It is a primary source of Federal AIDS prevention and treatment funding. I commend the gentleman from Florida (Mr. BILIRAKIS), the subcommittee chairman on health and environment; the gentleman from Oklahoma (Mr. COBURN); the gentleman from Ohio (Mr. BROWN); and the gentleman from California (Mr. WAXMAN) for their full support of this important measure.

This legislation accomplishes many of our most important HIV goals: modifying the eligibility requirements and allocation formulas for grants to State and local governments; giving States increased flexibility to provide a wider range of treatments and support services; emphasizing the provision of services for women, infants, and children by substituting special grant set-asides; capping administrative and evaluation expenses for the grant programs; and requiring States to implement the Center for Disease Control guidelines regarding HIV testing and counseling for pregnant women.

Also included in this measure is an important fund, $20 million, to reduce HIV transmission from mothers to their babies and $30 million for tracking the disease and encouraging people to notify their partners, and provisions to require people receiving care through Ryan White programs to enroll in counseling programs.

In short, Mr. Speaker, this legislation not only demonstrates the bipartisan humanitarian spirit of this Congress, but also in working together in areas of mutual concern that we can accomplish worthy goals.

Accordingly, I am in strong support of the Ryan White CARE Amendments and I urge our colleagues to adopt it at the earliest possible date.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2½ minutes to the gentlewoman from California (Mrs. CAPPS) who is a registered nurse and has been a real leader on all kinds of public health issues.

Mrs. CAPPS. Mr. Speaker, I thank my colleague for yielding me the time.

Mr. Speaker, I rise in strong support of the Ryan White CARE Act Amendments of 2000. I commend my colleagues on the Committee on Commerce and others for all of their hard work.

Today's medical advances allow many individuals with AIDS to lead longer and more productive lives. However, as patients live longer, the cost of their care and treatment has placed an ever-greater demand on community-based organizations and State and local governments.

In the face of these challenges, the Ryan White CARE Act has made a great difference. This CARE Act provides care to tens of thousands of Americans living with HIV/AIDS.

Recently I spoke with the Health Educator, Jayne Brechwald, with the Santa Barbara County Health Care Services in my district. She works on a daily basis with members of the community who benefit greatly from Ryan White funding. She spoke in strong support of funding for crucial services such as Meals on Wheels, food banks, housing counseling. She also praised programs which help those diagnosed navigate the options available for them. These include the medical care, education, and dental care that are so important during this terrifying time in a person's life.

In Jayne's words, ''Ryan White funding is really about local control. The program requires that we do a needs assessment every year so that we have a very targeted, specific idea of how the population we serve is changing and how the funding is being utilized.''

I believe that the Ryan White Act represents the Federal Government at its best. This program defers to local expertise, while providing the needed helping hand of targeted Federal funding.

Mr. Speaker, I applaud this legislation and urge its passage.

Mr. BILIRAKIS. Mr. Speaker, I yield 2½ minutes to the gentleman from Pennsylvania (Mr. GREENWOOD).

Mr. GREENWOOD. Mr. Speaker, I thank the gentleman for yielding me the time. I also thank the gentleman from Florida (Mr. BILIRAKIS) for his leadership on this issue; as well as the minority chair of the Subcommittee on Health, the gentleman from Ohio (Mr. BROWN); and the gentleman from Oklahoma (Mr. COBURN) and the gentleman from California (Mr. WAXMAN) for their collaboration. Anytime the gentleman from Oklahoma (Mr. COBURN) and the gentleman from California (Mr. WAXMAN) agree on something, it has got to be pretty close to right on.

Mr. Speaker, I also want to thank Dorothy Mann from the Philadelphia area, a friend of mine, who helped negotiate one of the toughest aspects of this bill; and that has to do with the testing of newborns.

1115

AIDS is clearly the worst epidemic in modern history. It is a tragedy, and it has struck down so many millions of people around the world. But of all of its victims, certainly the children, the newborns, are the most innocent and the ones who tug most heavily on our hearts.

Four million women become pregnant in this country every year and 7,000 of those 4 million women are HIV positive. Several hundred of the babies that they bear will be born HIV positive. Of those little children, fully half of them will die before they reach the age of 3; and by the age of 5, 90 percent of them have perished. So obviously anything that can be done to rescue these children from that horrible fate needs to be done. When a woman's HIV status is known during her pregnancy, in two-thirds of the cases the child can be prevented from becoming HIV positive with AZT treatments that are given during pregnancy, during labor and several weeks afterwards, and Cesarian deliveries seem to very dramatically reduce the likelihood that the child will become HIV positive.

What we have done in this bill to try to solve the logjam between those who do and those who do not believe in mandatory testing is we have put $30 million in here to go to those States that either have mandatory testing laws or do the most through a variety of programs to reduce the incidence of HIV being passed on to newborns. In New York, they have had a law on the books for 3 years; and they have been able to identify every child who could potentially become exposed to HIV through delivery. They have been able to prevent all of that. In 98 percent of the cases, the mother has been able to get treatment. It has been wildly successful.

This bill goes a long way to making sure that that track record will apply to every State in the Union.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from the District of Columbia (Ms. NORTON).

Ms. NORTON. Mr. Speaker, I thank the gentleman for yielding time, and I thank him and his partners on the other side for their hard work in bringing this most important legislation to the floor.

This week, the surgeon general was quoted as saying the epidemic has evolved to become increasingly an epidemic of people of color, of women and of the young. We have got to get rid of this epidemic, not let it evolve; and what we are doing here this morning will have a great deal to do with getting rid of it.

The disease has moved to a devastating place, Mr. Speaker, to the poorest communities of color. Blacks are only 12 percent of the population. They are 50 percent of the new cases. Almost 80 percent of the new cases among women are black and Latino women. Half of the new cases occur in youth. We are now finding that we have to educate each new cohort perhaps every 4 or 5 years of gay men because the newest cohort needs to learn what those that have passed on in their 20s perhaps had to learn. We are dealing with a preventable disease. But when people get this disease, they need our care and they need our love.

I am grateful to the gay and lesbian community of this country for the way in which they brought this issue to the forefront and now have helped us gather a bipartisan majority for the Ryan White bill. If we continue to do what we are doing today, we will show what we all know, that this is a disease, unlike heart disease and unlike cancer, that we can prevent. This is a disease that we can eliminate. I thank all of those who contributed to this moment on the House floor.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. WOOLSEY).

(Ms. WOOLSEY asked and was given permission to revise and extend her remarks.)

Ms. WOOLSEY. Mr. Speaker, I rise in support of H.R. 4807, to reauthorize the Ryan White CARE Act. This reauthorization is very important to our Nation. It is particularly important to my constituents in the North Bay across the Golden Gate Bridge from San Francisco, and for all of the people in the entire San Francisco Bay region. This act provides crucial services for care and treatment for individuals with HIV and AIDS. To date, the CARE act has worked to dramatically improve the quality of life for people living with HIV and for their families. It has reduced the use of costly inpatient care as well as increased the access to high-quality care for underserved populations.

By supporting this important legislation, Mr. Speaker, we are ensuring that the thousands of Americans living with HIV/AIDS can continue to receive the care and the treatment that is absolutely necessary for their comfort and for their survival.

Mr. Speaker, we must spare no effort to fight the HIV/AIDS epidemic. By reauthorizing the Ryan White CARE Act, we are taking a positive step to successfully dealing with this very deadly disease. We must adopt the reauthorization.

Mr. BROWN of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. DAVIS).

(Mr. DAVIS of Illinois asked and was given permission to revise and extend his remarks.)

Mr. DAVIS of Illinois. Mr. Speaker, I rise today in strong support of the Ryan White CARE Act. And I rise because this legislation has meant so much to so many people throughout the country. The Ryan White CARE

Act has meant so much that there are many people who feel as they tell their stories that without it they simply would not be alive.

Mr. John Davis, the newly elected co-chair of the city of Chicago's HIV services planning council, says if it was not for the Ryan White CARE Act, he would probably be dead. Mr. Davis, a former heroin addict, says that his road to recovery began with him seeking help at a Ryan White-funded housing program.

Like Mr. Davis, thousands of others throughout the country have had the same experiences. Mr. Derrick Hicks from Chicago is able to live longer and get access to medications he may not otherwise be able to afford. And so, as we continue to see the impact and the effects of this program throughout the country, I simply rise to support it and say that without it many people would not have had the quality of life. I urge continued support.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself the balance of my time.

I again ask for this House's support for the Ryan White CARE Act. It is a tremendous testament to bipartisanship support and the negotiating skills of the gentleman from Oklahoma (Mr. COBURN) and the gentleman from California (Mr. WAXMAN) and their staffs. I ask for unanimous support from this House for this very good legislation that will make a big difference in dealing with this dreadful disease.

Mr. BILIRAKIS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would like to echo the remarks that the gentleman from Ohio (Mr. BROWN) just made. I had planned to do so, also. It is just amazing what can be done from a bipartisan standpoint if people really are sincere and really care about solving an issue rather than being concerned about demagoguery, if you will, or with some of the things that take place. The fact that the gentleman from Oklahoma (Mr. COBURN) and the gentleman from California (Mr. WAXMAN) worked so well on this and were able to get it done speaks well for both of them and for the Congress when it works in that way.

Mr. Speaker, I yield the balance of my time to the gentleman from Oklahoma (Mr. COBURN).

(Mr. COBURN asked and was given permission to revise and extend his remarks.)

Mr. COBURN. Mr. Speaker, I want to first recognize Paul Kim for his great help on the gentleman from California's (Mr. WAXMAN) staff; Marc Wheat, the majority counsel on our side; and Roland Foster, a staff member of mine who has been with me for 6 years since I have been in Congress.

This is a good bill. There is no question about it. But this bill is not enough. Forty thousand people this year are going to become infected with HIV. It does not have to happen. We should be asking the CDC, we should be asking the FDA, we should be asking the NIH why they would not use proven public health policy to stop this epidemic.

The best way to treat people with HIV today is to make sure no one else ever encounters this disease. This is a preventable disease. Although we have gone a long way from where we were in putting in the public health policies that should be there, they are still not there. The reason they are not there is not a good enough reason. We have proven in the medical community that we can secure and hold confidentially anybody's HIV status. We have been perfect on that score. And to use that as a reason now not to move to the next step, I challenge my friend, the gentleman from Ohio (Mr. BROWN), and I challenge the gentleman from Florida (Mr. BILIRAKIS) that in the next Congress and the Congress that follows that you will look very closely at what public health policies could do to prevent that 40,000 people from never getting the disease.

We know. We handled the tuberculosis epidemic in this country. We stopped it dead with a whole lot less effort. This is something we can accomplish. We have proven with this bill that if we will work and talk together and understand each other's motivations, problems and concerns, that through discussion and bipartisan approach that we can solve those problems. The 40,000 people out there this year that are going to get infected deserve for us to do that. As I leave this body, what I would ask is the Members of this body, look at real problems, not the political things that surround it; and if we will do that, 40,000 people will not be infected.

I thank the gentleman from Ohio (Mr. BROWN) for his work. The gentleman from California (Mr. WAXMAN) has been great to work with. I appreciate the ability that we can express ourselves through true concern and solve a problem. I would hope that every Member of this body will support this bill.

I also would leave one message with my colleagues. There are diseases much greater than this disease that face our country today. Diabetes will take tons more people than HIV. Breast cancer will take tons more people than HIV. And yet we are not anywhere close to the same dollar commitment in those diseases as we are HIV. Because we have had a misguided policy on treatment of HIV, we are spending dollars that could be spent in other areas. I would beg the body to look at that.

Mr. BLILEY. Mr. Speaker, I rise in support of this amendment to S. 2311, the Ryan White CARE Act Amendments of 2000. I congratulate Dr. COBURN and Mr. WAXMAN for their excellent work on this legislation, and salute my colleagues on the Commerce Committee who, through workmanlike diligence and thoughtfulness, have dramatically improved the way the Ryan White CARE Act will work now and into the future.

Before the August recess, the House acted on a bi-partisan basis to authorize the Ryan White CARE Act. This very important Act provides funding to address the needs of those living with HIV and AIDS. Because of the importance of this legislation, I made it a priority to resolve the differences between the House-passed bill and the bill passed in the other body. As the newsletter AIDS Policy and Law reported, ''The negotiators decided to use the House bill, sponsored by Representatives TOM COBURN, and HENRY WAXMAN, as the vehicle for renewing the statute through fiscal year 2005. The Senate bill was scrapped, with only a few of its provisions being folded into the Coburn-Waxman H.R. 4807.'' The negotiating team, which included my staff and those from the offices of Representatives BILIRAKIS, WAXMAN, DINGELL, BROWN, Senators JEFFORDS, FRIST, and KENNEDY, achieved a good compromise. I have an additional statement that explains our work in greater detail that I will enter into the record for myself and the negotiators just mentioned. I commend the passage of this important legislation to my colleagues.

As many of my colleagues may recall, President Reagan's HIV Commission concluded that ''early diagnosis of HIV infection is essential'' because HIV infection ''can be treated more effectively when detected early.'' The medical breakthroughs which have been developed in the twelve years since the inception of this report make early intervention even more important than ever, and I am pleased that this legislation recognizes that partner counseling and referral activities are the most effective early intervention to identify those who do not know their status in the early stages of the disease.

Very importantly, this bill begins the process of basing Ryan White CARE Act funding on HIV cases, not AIDS cases. Such a change will ensure that Ryan White CARE Act dollars go where the disease is growing quickly, not to the areas with the highest historical incidences of AIDS. It also provides incentives for States to implement re commendations belatedly issued by the Centers for Disease Control and Prevention to move to HIV reporting systems, one of the most important public health initiatives in America at the close of the 20th Century.

It is a national tragedy that public health officials in the States were unable or unwilling to move to HIV reporting years ago. The identification of HIV reporting as a serious public health concern was identified by the first Presidential Commission on HIV, appointed by President Ronald Reagan, which stated that ''The term 'AIDS' is obsolete. 'HIV infection' more correctly defines the problem. The medical, public health, political, and community leadership must focus on the full course of HIV infection rather than concentrating on later stages of the disease . . . Continual focus on AIDS rather than the entire spectrum of HIV disease has left our nation unable to deal adequately with the epidemic. Federal and state data collection efforts must now be focused on early HIV reports, while still collecting data on symptomatic disease.''

It is imperative that the Ryan White CARE Act be reauthorized to provide

the incentives to move public health in the right direction so that the HIV/AIDS epidemic can be tracked more accurately, and appropriate funding and information about this disease be better directed.

As many of my colleagues will recall, when we last brought the Ryan White bill to the floor in July, the most contentious issue was the bill's ''hold harmless'' provision. The bill which originally passed the House would have trimmed the substantial overpayments received by San Francisco so that it would eventually receive no more per capita than any other metropolitan area.

After lengthy negotiations, it has been agreed that the hold harmless reduction will be a compromise between the original House and Senate provisions, which will now be a reduction of 15% over the next five years to slow the transition to equitable funding.

I ask my colleagues to join with me in support of this important legislation that moves us in the right direction as we enter the 21st Century.

RYAN WHITE CARE ACT AMENDMENTS OF 2000

MANAGERS' STATEMENT OF EXPLANATION

The Ryan White CARE Act Amendments of 2000 reauthorize Title XXVI of the Public Health Service Act to ensure that individuals living with HIV and AIDS receive health care and related support services. The legislation contains authorization for appropriations and programmatic changes to ensure the CARE Act programs respond to evolving demographic trends in the HIV/AIDS epidemic and advances in treatment and care.

I. BACKGROUND

In March, 1990, Congress enacted the Ryan White CARE Act, honoring Ryan White, a young man who taught the Nation to respond to the HIV/AIDS epidemic with hope and action rather than fear. By the spring of 1990, over 128,000 people had been diagnosed with AIDS in the United States and 78,000 had died of the disease. The CARE Act was reauthorized in 1996, as the epidemic spread to more than 600,000 Americans diagnosed with AIDS and amidst the nationwide recognition that CARE Act programs were indispensable to the care and treatment of Americans with HIV/AIDS.

The CARE Act Amendments of 2000 marks the second reauthorization of the CARE Act. In the last twenty years, the HIV/AIDS epidemic has claimed over 420,000 American men, women, and children. Today, the Centers for Disease Control and Prevention estimates that there are currently between 800,000 and 900,000 persons living with HIV in the United States, with 40,000 new infections annually.

While there is still no cure, the CARE Act has been instrumental in responding to the public health, social and economic burdens of the HIV/AIDS epidemic. However, the steady expansion and changed demographics of the epidemic, as well as the improved survival time for people living with AIDS, are placing increasing stress on State and local health care systems, community based organizations and families providing care. Most importantly, the epidemic is expanding beyond major cities to smaller cities and rural regions, and disproportionately affecting women, communities of color, children and youth.

The Ryan White CARE Act Amendments of 2000 preserves the best and proven features of existing CARE Act programs. But the CARE Act Amendments of 2000 also makes important and substantial reforms to respond to the significant changes in the HIV/AIDS epidemic of the last 5 years.

II. ORGANIZATION OF SERVICES UNDER THE CARE ACT AMENDMENTS OF 2000

Title I. Emergency Relief for Areas with Substantial Need for Services: Provides emergency relief grants to 51 eligible metropolitan areas (EMAs) disproportionately affected by the HIV epidemic to provide primary care and HIV-related support services to people with HIV and AIDS. Half of the Title I funding is distributed by formula; the remaining half is distributed competitively, based on the demonstration of severity of need and other criteria.

Planning Council membership has been revised to include HIV prevention providers, homeless and housing service providers, and representatives of prisoners. A third of Planning Council members must be individuals with HIV/AIDS receiving care who are not officers, employees or consultants to Title I grantees.

Title II. CARE Grant Program: Provides formula grants to States, District of Columbia, Puerto Rico and U.S. territories to improve the quality of health care and support services for individuals with HIV disease and their families. The funds are used: to provide medical support services, to continue health insurance payments, to provide home care services, and, through the AIDS Drug Assistance Programs (ADAP), to provide medications necessary for the care of these individuals. Supplemental formula grants are awarded to States with ''emerging communities'' which are ineligible for grants under Title I.

Subtitle B provides discretionary grants to States for the reduction of perinatal transmission of HIV, and for HIV counseling, testing, and outreach to pregnant women. Subtitle C provides discretionary grants to States for partner notification, counseling and referral services.

Title III. Early Intervention Services: Funds nonprofit entities providing primary care and outpatient early intervention services, including case management, counseling, testing, referrals, and clinical and diagnostic services to individuals diagnosed with HIV. The unfunded program of State formula grants in current law is repeated.

Title IV. Other Programs and Activities: Provides grants for comprehensive services to children, youth, and women living with HIV and their families. Such services include primary, specialty and psychosocial care, as well as HIV outreach and prevention activities. Grantees must demonstrate linkages to, and provide clients with access and education on, HIV/AIDS clinical research.

Title IV newly authorizes the AIDS Education and Training Centers (AETC), a network of 14 regional centers conducting clinical HIV education and training of health providers, to provide prenatal and gynecological care. The HIV/AIDS Dental Reimbursement program, covering uncompensated oral health care for patients with HIV/AIDS, is expanded to provide community-based care in underserved areas.

Under Subtitle B, general provisions authorize CDC data collection for CARE Act planning and evaluation, enhanced interagency coordination of HIV services and prevention, development of a plan for the case management of prisoners with HIV, and administrative provisions related to audits, and a plan for simplification of CARE Act grant disbursements.

Title V. General Provisions: Authorizes Institute of Medicine (IOM) studies and expansion of Federal support for the development of rapid HIV tests. Makes necessary and technical corrections in Title XXVI of the Public Health Service Act.

III. SUMMARY OF SELECTED PROVISIONS

Use of HIV Case Data in Formula Grants

In order to target funding more accurately to reflect the HIV/AIDS epidemic, the Managers have revised and updated the Title I and Title II formulas to make use of data on cases of HIV infection as well as of AIDS. In Fiscal Year (FY) 2005, HIV and AIDS case data is intended to be used in the Title I and Title II formulas.

However, no later than July 1, 2004, the Secretary shall determine whether HIV case data, as reported to and confirmed by the Director of CDC, is sufficiently accurate and reliable from all eligible areas and States for such use in the formula. The Secretary shall also consider the findings of the Institute of Medicine (IOM) study undertaken under section 501(b).

If the Secretary makes an adverse determination regarding HIV case data, the Managers intend that only AIDS case data will be used in FY2005 formula allocations. The Secretary shall also provide grants and technical assistance to States and eligible areas to ensure that accurate and reliable HIV case data is available no later than FY2007.

Planning and priority setting

The Managers have strengthened the capacity of EMAs and States to plan, prioritize, and allocate funds, based on the size and demographic characteristics of the populations with HIV disease in the eligible area. Planning, priority setting, and funding allocation processes must take into account the demographics of the local HIV/AIDS epidemic, existing disparities in access HIV-related health care, and resulting adverse health outcomes. It is the intent of the Managers that CARE Act dollars more closely follow the shifting trends in the local epidemic and address disparities in health care access and health outcomes as well as the need for capacity development within the local and State HIV health care infrastructures.

The Managers intend both EMAs and States to develop strategies to bring into and retain in care those individuals who are aware of their HIV status but are not receiving services. As part of this process, the Managers place the highest priority on EMAs and States focusing on eliminating disparities in access and services among affected subpopulations and historically underserved communities. The Managers recognize, however, that the relative availability or lack of HIV prevalence data will be reflected in the scope, goals, timetable and allocation of funds for implementation of the strategy.

The Managers also expect the Secretary to collaborate with Title I and II grant recipients and providers to develop epidemiologic measures and tools for use in identifying persons with HIV infection who know their HIV status but are not in care. The Managers recognize the difficulty the EMAs and States may experience in identifying persons with HIV infection who are not in care and who may be unknown to any health or social support system. The efforts on the part of EMAs and States to accomplish these important tasks, however, should not be delayed until this process is complete. Instead, the Managers expect Title I and II grant recipients to establish and implement strategies responsive to these urgent needs before the development of nationally uniform measures, to the extent that is practicable and to which necessary prevalence data is reasonably available.

The Managers have also authorized outreach activities in Title I and II intended to

identify individuals with HIV disease know their HIV status but are not receiving services. The intent is to ensure that EMAs and States understand that outreach activities which are consistent with early intervention services and necessary to implement the aforementioned strategies, are appropriate uses of Title I and II funds. It is not the Managers' intent that such activities supplant or otherwise duplicate activities such as case finding, surveillance and social marketing campaigns currently funded and administered by the Centers for Disease Control and Prevention (CDC). Instead, this authorization reflects the urgency of increasing the coordination between HIV prevention and HIV care and treatment services in all CARE Act programs.

Hold harmless provisions

The hold-harmless provisions are intended to minimize loss and stabilize systems of care in EMAs and States, while assuring that funds are allocated in Title I and II to reflect the current distribution and epidemiology of the epidemic.

The Managers have revised the Title I hold harmless to limit a potential loss in an EMA's formula allocation to a small percentage of the amount allocated to the eligible are in the previous (or base) year. An EMA may lose no more than 15 percent of its base formula allocation over five years, beginning with 2 percent in the first year and increasing in subsequent years. If the Secretary determines that data on HIV prevalence are accurate and reliable for use in determining Title I formula grants for Fiscal Year 2005, all EMAs may lose no more than 2 percent of their Fiscal Year 2004 formula allocation in that year.

Should an EMA experience a decline in its Title I formula allocation followed by an intervening year in which there is not decline, its losses in any subsequent, nonconsecutive year of decline would once again be limited to 2 percent (ie., the intervening year 'resets the clock').

The Managers intend to ensure that essential primary care and support services are not compromised by short-term fluctuations in AIDS case counts. Because no new EMA is expected by HRSA's Bureau of HIV/AIDS to require that hold harmless in the first three or four years of this reauthorization period, the Managers expect this policy will shield all eligible areas, save those currently requiring the hold harmless, from any meaningful loss in Title I formula funding.

Under the Title II hold harmless, a State or territory may lose no more than 1 percent from the previous fiscal year amounts, or 5 percent over the 5-year reauthorization period. This protection extends to base Title II funding (which excludes funds for AIDS Drug Assistance Programs (ADAP)), as well as to overall Title II funding.

Women, child, infants, and youth set-aside

The Managers are aware of the rising incidence of HIV among youth and women, particularly women of color, and recognize the challenges in assuring them access to primary care and support services for HIV and AIDS. The Managers intend to increase the availability of primary care and health-related supportive services under Title I and Title II for each of the four groups described in the set-aside. Youth are added as a new category within this set-aside. The Managers intend the term ''youth'' to include persons between the ages of 13 and 24, and ''children'' to include those under the age of 13, including infants.

The Managers clarify that the set-asides for women, infants, children, and youth with HIV disease be allocated proportionally, based on the percentage of the local HIV-infected population that each group represents. The Managers intend that the States and EMAs continue to make every effort to reach and serve women, infants, children, and youth living with HIV/AIDS by allocating sufficient resources under Titles I and II to serve each of these populations. The Managers also recognize that these priority populations often comprise a greater proportion of HIV cases rather than AIDS cases in a local area. This distinction should be taken into account where necessary prevalence data is reasonably available.

The Mangers are aware that these populations may also have access to HIV care through other parts of Title XXVI, Medicaid, State Children's Health Insurance Program (SCHIP), and other Federal and State programs. Therefore, the requirements to proportionally allocate funds provided under Title II to each of these populations may be waived for States which reasonably demonstrate that these populations are receiving adequate care.

Capacity development

Titles I, II and III of this legislation provide a new focus on strengthening the capacity of minority communities and underserved areas where HIV/AIDS is having a disproportionate impact. Currently, many underserved urban and rural areas are not able to compete successfully for planning grants and early intervention service grants due to the lack of infrastructure and experience with the Ryan White Care Act programs. This gap in services available is increasingly important, as the HIV and AIDS epidemic extends into rural communities. In addition to authorizing capacity development under Titles I and II, the Managers establish a preference for rural areas under Title III that will allow program administrators to target capacity development grants, planning grants, and the delivery of primary care services to rural communities with a growing need for HIV services. However, urban areas are not excluded from consideration for future grants nor is funding reduced to current grants in urban areas.

Quality management

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

The Managers expect the Secretary to provide States with guidance and technical assistance for establishing quality management programs, including disseminating such models as have been developed by States and are already being utilized by Title II programs and in clinical practice environments. Furthermore, the Managers intend that the Secretary provide clarification and guidance regarding the distinction between use of CARE Act funds for such program expenditures that are covered as their planning and evaluation and funds for program support costs. It is not the Managers' intent to divert current program resources or to reassign current program support costs or clinical quality programs to new cost areas, if they are an integral part of a State's current quality management efforts.

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

Early intervention services

The Managers authorize early intervention services as eligible services under Titles I and II under certain circumstances. The Managers intend to allow grantees to provide certain early intervention services, such as HIV counseling, testing, and referral services, to individuals at high risk for HIV infection, in accordance with State or EMA planning activities. The Managers recognize the range of organizations that may be eligible to provide early intervention services, including other grantees under Titles I, II and III such as community based organizations (CBOs) that act as points of entry into the health care system for traditionally underserved and minority populations.

The Managers believe that referral relationships maintained by providers of early intervention services are essential to increasing the number of people with HIV/AIDS who are identified and to bringing them into care earlier in the progression of their disease.

Health-care related support services

The Managers wish to stress the importance of CARE Act funds in meeting the health care needs of persons and families with HIV disease. The Act requires support services provided through CARE Act funds to be health care related. States and EMAs should ensure that support services meet the objective of increasing access to health care and ongoing adherence with primary care needs. The Managers reaffirm the critical relationship between support service provision and positive health outcomes.

Title I planning council duties and membership

The Managers have amended numerous aspects of CARE Act programs to enhance the coordination between HIV prevention and HIV/AIDS care and treatment services. In this case, Planning Council membership of the providers of HIV prevention services will help assure this coordination. To improve representation of underserved communities, providers of services to homeless populations and representatives of formerly incarcerated individuals with HIV disease are included in planning council membership. It is the intent of the Managers that the needs of all communities affected by HIV/AIDS and all providers working with the service areas be represented. The Managers also intend the Planning Councils more adequately reflect the gender and racial demographics of the HIV/AIDS population within their respective EMAs.

The Managers also intend that patients and consumers of Title I services constitute a substantial proportion of Planning Council memberships. The prohibition of officers,

employees and consultants is not intended to impede the participation qualified, motivated volunteers with Title I grantees from serving on Planning Councils where they do not maintain significant financial relationships, volunteers may be reimbursed reasonable incidental costs, including for training and transportation, which help to facilitate their important contribution to the Planning Councils.

To ensure that new Planning Council members are adequately prepared for full participation in meetings, the Managers direct the Secretary to ensure that proper training and guidance is provided to members of the Councils. The Managers also expect Planning Councils to provide assistance, such as transportation and childcare, to facilitate the participation of consumers, particularly those from affected subpopulations and historically underserved communities.

Consistent with the ''sunshine'' policies of the Federal Advisory Committee Act (FACA), all meetings of the Planning Councils shall be open to the public and be held after adequate notice to the public. Detailed minutes, records, reports, agenda, and other relevant documents should also be available to the public. The Managers intend for such documents to be available for inspection and copying at a single location, including posting on the Internet.

Title I supplemental

In order to target funding to areas in greatest need of assistance, severity of need is given a greater weight of 33 percent in the award of Title I supplemental grants. The Managers intend that Title I supplemental awards are not intended to be allocated on the basis of formula grant allocations. Instead, such supplemental awards are to be directed principally to those eligible areas with ''severe need,'' or the greatest or expanding public health challenges in confronting the epidemic. The Managers have included additional factors to be considered in the assessment of severe need, including the current prevalence of HIV/AIDS, and the degree of increasing and unmet needs for services. Additionally, the Managers believe that syphilis, hepatitis B and hepatitis C should be regarded as important co-morbidities to HIV/AIDS.

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

Title II base minimum funding

The minimum Title II base award is increased in order to increase the funding available to States for the capacity development of health system programs and infrastructure. The Federated States of Micronesia and the Republic of Palau are included as entities eligible to receive Title II funds, in recognition of the need to establish a minimum level of funding to assist in building HIV infrastructure.

Title II public participation

The Managers urge States to strengthen public participation in the Ryan White Title II planning process. While the Managers do not intend that States be mandated to consult with all entities participating in the Title I planning process, reference to such entities is intended to provide guidance to the States that such entities are important constituencies which the States should endeavor to include in their planning processes. Moreover, States may demonstrate compliance with the new requirement of an enhanced process of public participation by providing evidence that existing mechanisms for consumer and community input provide for the participation of such entities. The intent is to allow States to utilize the optimal public advisory planning process, such as special planning bodies or standing advisory groups on HIV/AIDS, for their particular population and circumstances.

The Managers are also aware of the difficulties that some States with limited resources may encounter in convening public hearings over large geographic or rural areas and encourage the Secretary to work with these States to develop appropriate processes for public input, and to consider such limitations when enforcing these requirements.

Title II HIV care consortia

The Managers intend that the States continue to work with local consortia to ensure that they identify potential disparities in access to HIV care services at the local level, with a special emphasis on those experiencing disparities in access to care, historically underserved populations, and HIV infected persons not in care. However, the Managers do not intend that States and/or consortia be mandated to consult with all entities participating in the Title I planning process. Rather, reference to such entities is intended to provide guidance to the States that such entities are important constituencies which the States should endeavor to include in their planning processes.

Title II ''emerging communities'' supplement

There continues to be a growing need to address the geographic expansion of this epidemic, and this Act continues the efforts made during the last reauthorization to direct resources and services to areas that are particularly underserved, including rural areas and metropolitan areas with significant AIDS cases that are not eligible for Title I funding. A supplemental formula grant program is created within Title II to meet HIV care and support needs in non-EMA areas. There are a large number of areas within States that do not meet the definition of a Title I EMA but that, nevertheless, experience significant numbers of people living with AIDS. This provision stipulates that these ''emerging communities,'' defined as cities with between 500 and 1,999 reported AIDS cases in the most recent 5-year period, be allocated 50 percent of new appropriations to address the growing need in these areas. Funding for this provision is triggered when the allocations to carry out Part B, excluding amounts allocated under section 2618(a)(2)(I), are $20,000,000 in excess of funds available for this part in fiscal year 2000, excluding amounts allocated under section 2618(a)(2)(I). States can apply for these supplemental awards by describing the severity of need and the manner in which funds are to be used.

The Managers intend to acknowledge the challenges faced by many areas with a significant burden of HIV and AIDS and a lack of health care infrastructure or resources to provide HIV care services. This supplemental program allows the Secretary to make grants to States to address HIV service needs in these underserved areas. The Managers understand the necessity to continue to support existing and expanding critical Title II base services.

AIDS Drug Assistance Program supplemental grant and expanded services

Under this Act, the AIDS Drug Assistance Program (ADAP) has been strengthened to assist States in a number of areas. The Secretary is authorized to reserve 3 percent of ADAP appropriations for discretionary supplemental ADAP grants which shall be awarded in accordance with severity of need criteria established by the Secretary. Such criteria shall account for existing eligibility standards, formulary composition and the number of patients with incomes at or below 200 percent of poverty. The Managers also encourage the Secretary to consider such factors as the State's ability to remove restrictions on eligibility based on current medical conditions or income restrictions and to provide HIV therapeutics consistent with PHS guidelines.

States are also required to match the Federal supplemental at a rate of 1:4. The Managers expect the State to continue to maintain current levels of effort in its ADAP funding. The Managers intend that the 25 percent State match required to receive funds under this section be implemented in a flexible manner that recognizes the variations between Federal, State, and programmatic fiscal years.

In addition, up to 5 percent of ADAP funds will be allowed to support services that directly encourage, support, and enhance adherence with treatment regimens, including medical monitoring, as well as purchase health insurance plans where those plans provided fuller and more cost-effective coverage of AIDS therapies and other needed health care coverage. However, up to 10 percent of ADAP funds may be expended for such purposes if the State demonstrates that such services are essential and do not diminish access to therapeutics. Finally, the Managers recognize that existing Federal policy provides adequate guidelines to states for carrying out provisions under this section.

Partner notification, perinatal transmission, and counseling services

Discretionary grants are authorized under this Act for partner notification, counseling and referral services. The Managers have also expanded the existing grant program to States for the reduction of perinatal transmission of HIV, and for HIV counseling, testing, and outreach to pregnant women. Funding for perinatal HIV transmission reduction activities is expanded, with additional grants available to States with newborn testing laws or States with significant reductions in perinatal HIV transmission. In addition, this Act further specifies information to be conveyed to individuals receiving HIV positive test results in order to reduce risk of HIV transmission through sex or needle-sharing practices.

Coordination of coverage and services

This Act also strengthens the requirements made on the States and EMAs in a number of areas aimed at improving the coordination of coverage and services. Grantees must assess the availability of other funding sources, such as Medicaid and the State Children's Health Insurance Program (SCHIP) and improve efforts to ensure that CARE Act funds are coordinated with other available payers.

Titles III and IV administrative expenses

The administrative cap for the directly funded Title III programs is increased. The administrative cap for Title III grants is raised from 7.5 percent to 10 percent to correspond with the 10 percent cap on individual contractors in Title I. The Secretary is directed to review administrative and program support expenses for Title IV, in consultation with grantees. In order to assure that

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

Title IV access to research

This Act removes the requirement that Title IV grantees enroll a ''significant number'' of patients in research projects. Title IV provides an important link between women, children, and families affected by HIV/AIDS and HIV-related clinical research programs. The ''significant number'' requirement is removed here to eliminate the incentive for providers to inappropriately encourage or pressure patients to enroll in research programs.

To maintain appropriate access to research opportunities, providers are required to develop better documentation of the linkages between care and research. The Secretary of Health and Human Services (HHS), through the National Institutes of Health (NIH), is also directed to examine the distribution and availability of HIV-related clinical programs for purposes of enhancing and expanding access to clinical trials, including trials funded by NIH, CDC and private sponsors. The Managers encourage the Secretary to assure that NIH-sponsored HIV-related trials are responsive to the need to coordinate the health services received by participants with the achievement of research objectives. Nor do the Managers intend this requirement to require the redistribution of funds for such research projects.

Part F Dental Reimbursement Program

The Managers have established new grants for community-based oral health care to support collaborative efforts between dental education programs and community-based providers directed at providing oral health care to patients with HIV disease in currently unserved areas and communities without dental education programs. Although the Dental Program has been tremendously successful, there is still a large HIV/AIDS population that has not benefitted because there is not a dental education institution participating in their area. These patients are also in need of dental services that could be provided at community sites if more community-based providers would partner with a dental school or residency program. In these partnerships, dental students or residents could provide treatment for HIV/AIDS patients in underserved communities under the direction of a community-based dentist who would serve as adjunct faculty. By encouraging dental educational institutions to partner with community-based providers, the Managers intend to address to unmet need in these areas by ensuring that dental treatment for the HIV/AIDS population is available in all areas of the country, not just where dental schools are located.

Technical assistance and guidance

The Managers reaffirm the Secretary's responsibility in providing needed guidance and tools to grantees in assisting them in carrying out new requirements under this Act. The Secretary is required to work with States and EMAs to establish epidemiologic measures and tools for use in identifying the number of individuals with HIV infection, especially those who are not in care. The legislation requests an IOM study to assist the Secretary in providing this advice to grantees.

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

Data collection through CDC

The Managers believe that an additional authorization for HIV surveillance activities under the CDC will serve to advance the purposes of the CARE Act. To better identify and bring individuals with HIV/AIDS into care, States and cities may use such funding to enhance their HIV/AIDS reporting systems and expand case finding, surveillance, social marketing campaigns, and other prevention service programs. Notwithstanding its strong interest in improving the coordination between HIV prevention and HIV care and treatment services, the Managers intend that this enhanced funding for CDC and its grantees ensure that CARE Act programs and funds not duplicate or be diverted to activities currently funded and administered by the CDC.

Coordination

This Act requires the Secretary to submit a plan to Congress concerning the coordination of Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), and Health Care Financing Administration (HCFA), to enhance the continuity of care and prevention services for individuals with HIV disease or those at risk of such disease. The Managers believe that much greater effort is required to ensure that the provision of HIV prevention and care services becomes as seamless as possible, and that coordination be pursued at the Federal level, in the States and local communities to eliminate any administrative barriers to the efficient provision of high quality services to individuals with HIV disease.

A second plan for submission to Congress focuses on the medical case management and provision of support services to persons with HIV released from Federal or State prisons.

Administrative simplification

The Managers intend for the Secretary of HHS to explore opportunities to reduce the administrative requirements of Ryan CARE Act grantees through simplifying and streamlining the administrative processes required of grantees and providers under Titles I and II. In consultation with grantees and service providers of both parts, the Secretary is directed to (1) develop a plan for coordinating the disbursement of appropriations for grants under Title I with the disbursement of appropriations for grants under Title II, (2) explore the impact of biennial application for Titles I and II on the efficiency of administration and the administrative burden imposed on grantees and providers under Titles I and II, and (3) develop a plan for simplifying the application process for grants under Titles I and II. It is the intent of the Managers to improve the ability of grantees to comply with administrative requirements while decreasing the amount of staff time and resources spent on administrative requirements.

Program and service studies

The Managers request that the Secretary, through the IOM, examine changing trends in the HIV/AIDS epidemic and the financing and delivery of primary care and support services for low-income, uninsured, and underinsured and individuals with HIV disease. The Secretary is directed to make recommendation regarding the most effective use of scarce Federal resources. The purpose of the study is to examine key factors associated with the effective and efficient financing and delivery of HIV services (including the quality of services, health outcomes, and cost-effectiveness). The Managers expect that the study would include examination of CARE Act financing of services in relation to existing public sector financing and private health coverage; general demographics and comorbidities of individuals with HIV disease; regional variations in the financing and costs of HIV service delivery; the availability and utility of health outcomes measures and data for measuring quality of Ryan White funded service; and available epidemiological tools and data sets necessary for local and national resource planning and allocation decisions, including an assessment of implementation of HIV infection reporting, as it impacts these factors.

The Managers also require an IOM study focuses on determining the number of newborns with HIV, where the HIV status of the mother is unknown; perinatal HIV transmission reduction efforts in States; and barriers to routine HIV testing of pregnant women and newborns when the mothers' HIV status is unknown. The study is intended to provide States with recommendations on improving perinatal prevention services and reducing the number of pediatric HIV/AIDS cases resulting from perinatal transmission.

Development of Rapid HIV Test

The Managers encourage the Secretary to expedite the availability of rapid HIV tests which are safe, effective, reliable and affordable. The Managers intend that the National Institutes of Health expand research which may lead to such tests. The Managers also intend that the Director of CDC should take primary responsibility, in conjunction with the Commissioner of Food and Drugs, for a report to Congress on the public health need and recommendations for the expedited review of rapid HIV tests. The Managers believe that the Food and Drug Administration should account for the particular applications and urgent need for rapid HIV tests, as articulated by public health experts and the CDC, when determining the specific requirements to which such tests will be held prior to marketing.

Department of Veterans Affairs

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

International HIV/AIDS Initiatives

The Managers note that the CARE Act provides a model of service delivery and Federal partnerships with States, cities and community-based organizations which should prove valuable in global efforts to combat the HIV/AIDS epidemic. The Managers strongly encourage the Secretary, the Bureau of HIV/AIDS at HRSA, and the CDC to provide technical assistance available to other countries which has already proven invaluable in helping to limit the suffering caused by HIV/AIDS. It is the Managers' hope that the hard-earned knowledge and experience gained in this country can benefit people with HIV/AIDS overseas.

Ms. ESHOO. Mr. Speaker, I strongly support S. 2311, the Ryan White Care Act Amendments of 2000. Enactment of this legislation will truly make a difference in people's lives.

The Ryan White CARE Act, without question, was the most important legislation Congress has ever enacted for people living with HIV and AIDS. Every year, CARE Act funds provide lifesaving medical and social services for tens of thousands of uninsured and underinsured Americans battling these devastating diseases. AIDS medications, viral load testing, treatment education, and case management are just a few of the essential support services provided by federal CARE Act dollars.

Each of the programs created under the CARE Act services a specific need yet, combined, they make up the health care and social service safety net of last resort. Since it's creation in 1990, reliability and stability have been the two cornerstones of the Ryan White law. When we passed the House version of the reauthorization in July, I spoke out against a provision that ran directly contrary to this safety net principle. A 25 percent reduction in the ''hold harmless'' that was part of the original House bill would have caused a rapid destabilization of systems of care in the Bay Area and potentially around the country. I fought that provision and I'm so pleased that the bill before us today includes a more equitable formula that reflects the changing face of the disease without gutting funding to any one Eligible Metropolitan Area (EMA).

More people than ever are living with HIV/AIDS and the CARE Act must keep pace with the increasing demands. When the CARE Act was passed in 1990, there were 155,619 AIDS cases. In 1996, there were 481,234 cases. Today, America has 733,374 recorded cases of HIV/AIDS. AIDS is the leading cause of death among African Americans between the ages of 25–44 and the second leading cause of death among Latinos in the same age group. HIV/AIDS are still very much with us and we must ensure that all those infected get the medical and social services they need to live longer, more productive lives.

And that's exactly what's been happening. Access to new medications and treatments, such as combination antiretroviral therapies, has significantly lengthened the life expectancy of people with HIV/AIDS. People with AIDS are living longer and those with HIV aren't progressing as quickly to full-blown AIDS. Thankfully, it's no longer necessarily a death sentence. This, in turn, underscores the increasing need for services. As people live longer, their dependence on CARE Act programs greatly increases; hence, the importance of reauthorizing the Ryan White Act.

So, I thank my colleagues, Senators KENNEDY and JEFFORDS and Representatives BROWN, WAXMAN and COBURN, and their staffs, for their work on S. 2311 and for their dedication to reauthorizing the CARE Act this year. It's a good bill that will do wonderful things for people across this country. I urge my colleagues' enthusiastic support.

Mrs. CHRISTENSEN. Mr. Speaker, I rise in support of S. 2311, Ryan White Care Act. I am very thankful that were are acting on this very important bill, before we run out of time, to ensure that individuals living with HIV and AIDS will receive the health care and related supported services that they need. While, S. 2311 is not perfect, it does provide the necessary authorizations for appropriations and programmatic changes to ensure that the CARE Act is responsive to the evolving demographic trends in the HIV/AIDS epidemic and advances in treatment care.

I am also pleased that one of my major concerns with the House bill to reauthorize the CARE Act, HR 4807, involving incentives for HIV testing of pregnant women and infants, is not in the bill before us today. I oppose mandatory testing of any sub-population, and I strongly believe, that this body must give full consideration to the IOM study as it relates to this issue.

I am encouraged that S. 2311 also changes city and state funding formulas to encompass all who are infected with HIV and not just provide resources for individuals who have progressed to AIDS. This change responds to the changing nature of the epidemic and the newer treatment protocols, which begin medication earlier.

It allows for treatment programs to begin and expand critical prevention efforts. This bill also more effectively represents the burden of the disease and the need for care. In addition, this measure makes a concerted effort to support the fact, that the funding ''needs'' to follow the trends of the disease (which are disproportionately and increasingly affecting people of color).

It also encourages reporting of HIV infections by states (many do not now report). Such adherence to reporting, will improve our ability to be more progressive and get in front of this epidemic by increasing prevention and outreach efforts.

Another major area that is of critical concern to the Congressional Black Caucus and the communities we represent (which are primarily people of color), is the community planning councils, their composition, effectiveness and operations. This process has not worked well for many disenfranchised communities under existing authorization. Community input is essential to effective service provision at the local level. Therefore, we are encouraged by the requirement in the bill that planning, priority setting and funding allocation processes must take into account the demographics of the local HIV/AIDs epidemic, existing disparities in access to HIV—related care.

In this regard, I also encourage that African Americans and other people of color be appropriately represented in the clinical trials and investigator pools based on the trends of the disease.

I would be remiss if, I did not say that based on the past epidemiology, and several studies and forecasts, FY 2001 funding for the all important ADAP program falls around $100 million dollars short of what will be needed to provide treatment to those infected.

This dramatic shortfall represents the many low income, uninsured and under-insured Americans who will not receive appropriate care, and further puts this country far from where we need to be in fighting this epidemic and saving the lives of those infected and most at-risk.

We in the Caucus and our partners in the Congress and the communities we serve, remain vigilant in the nation's fight against the HIV/AIDS crisis. The Ryan White Care Act is the lifeline to countless Americans infected with HIV and AIDS. It is our best ammunition in the war against this devastating disease that is plaguing our nation. Clearly, we in the U.S. Congress must not wait until this disease begins to mirror the pandemic in Africa. An enhanced, strengthened, responsive and adequately funded Ryan White Care Act is absolutely essential to intensified care, treatment, prevention and outreach.

I urge my colleagues to support this much needed and important bill.

Mr. HORN. Mr. Speaker, I rise to express my strong support for the Ryan White Care Act Amendments of 2000. Over the past ten years, the Ryan White Care Act has represented a unique partnership between federal, state and local officials in delivering prevention and treatment services to those affected by this disease.

The good news is the Care Act has expanded access to high quality health care, which is more important than ever in accommodating the growing numbers of people living with HIV and AIDS. As a result, it is important that federal funds distributed to states and cities most impacted by the disease, such as Long Beach, are needs-based. These amendments are an important step towards the equitable distribution of federal resources for people living with HIV and AIDS.

These amendments will also allow heavily impacted areas such as Long Beach to use their funds now for early intervention services, so they can locate people living with HIV and get them into care. With HIV infecting more than 40,000 Americans each year—at an average treatment cost of $200,000 per individual—prevention strategies remain the most cost effective use of public health dollars.

Today, there are nearly 3800 AIDS cases in Long Beach alone. The Ryan White Care Act Amendments will go a long way in improving access to health care for these Americans, in addition to slowing the rate of new infections, especially in communities of color. I am pleased to lend my support to this important bill and encourage all my colleagues to do the same.

Ms. SCHAKOWSKY. Mr. Speaker, I rise in strong support of S. 2311, the Ryan White CARE Act Amendments of 2000. This bill will make a real and profound difference in the lives of persons living with HIV/AIDS by providing resources for essential primary care health and support services.

The Ryan White CARE Act was first passed in 1990. Since that time, the face of the HIV/AIDS epidemic has changed but the need for the Ryan White CARE Act has not. Today, it is more important than ever that we act to expand access to health and social services.

Since coming to Congress, I have had the opportunity to visit with many of my constituents who have benefited from the Ryan White CARE Act. Person after person has told me that, without this Act, they would be unable to afford the treatments needed so that they can remain healthy and productive members of their community. As members of Congress, we have supported increased medical research efforts that have led to promising treatment advances for people living with HIV/AIDS. The Ryan White CARE Act helps to ensure that people can actually obtain that treatment. It helps them find affordable housing and employment opportunities. It is a program that works and deserves our continued support.

In my district, as in other parts of the country, the HIV/AIDS epidemic continues to threaten individuals, families and communities.

I want to recognize the outstanding efforts of many in combating this crisis, both here and in the Chicagoland area. In particular, I want to thank Representative HENRY WAXMAN for his outstanding leadership. As the original sponsor of the Ryan White CARE Act, he has worked to make sure that it remains effective and is flexible enough to address the changing nature of this epidemic.

I also want to point out the enormous efforts of the City of Chicago and, specifically, the Department of Public Health. Mayor Richard Daley has developed a strategic plan to provide a comprehensive response to this epidemic, working with providers, prevention experts, community representatives and, most importantly, people living with HIV/AIDS. Recognizing that today there are more people living with an AIDS diagnosis in Chicago than at any other time, the City is working to prevent new infections, provide access to drug therapies and other treatments, improve other services such as affordable housing, and ensure that resources are used as effectively as possible to reflect changing needs. Reauthorization of the Ryan White CARE Act with adequate funding is essential to meeting those goals. I also want to point out the important work of the AIDS Foundation of Chicago and Chicago Health Outreach in this effort.

Finally, we must recognize that women and people of color represent a disproportionate number of new AIDS cases. Many of those impacted are uninsured, have no regular access to primary care services, and are unable to afford anti-HIV therapies. I am working with the Evanston Health Department and the faith community in my district to reach out to these communities and provide information on prevention and available services. Therefore, I am pleased that S. 2311 makes improvements in the Ryan White CARE Act to help eliminate disparities in access to services and outreach to underserved communities.

I urge my colleagues to support the Ryan White CARE Act reauthorization and to follow up on this action by providing full appropriation levels for its essential services.

Mr. TOWNS. Mr. Speaker, I rise in support of S. 2311, which reauthorizes ''The Ryan White CARE Act''.

HIV infection and AIDS in Brooklyn remains a difficult battle. The Centers for Disease Control found that minorities now account for more than half of all new cases in the United States. AIDS now kills more black men that gunshot wounds. And, it is also the leading cause of death for Hispanic men ages 25 to 44. This disease has equally affected women and children in minority communities. Eighty-four percent of the AIDS cases involving children, age 12 and under, can be found in the black community. And, AIDS has now become the second leading cause of death for black women and the third leading cause for Hispanic women.

I have witnessed these statistics first hand. My congressional district has the highest incidence of new AIDS cases of any area in New York City. Brownsville has more people living with AIDS than 12 States. It has the second highest number of blacks living with AIDS in all of New York City. In addition, East New York and the Ft. Greene neighborhoods have large populations of women living with AIDS.

Yet, we have not witnessed either the research or treatment and care dollars following the change in disease patterns. While Brooklyn is the epicenter of this disease in New York City, the majority of the Ryan White and NIH funds are still going to organizations which do not serve this constituency. In response to language which I worked to include in this legislation, hopefully, this trend will be halted. And, minority communities, like Brownsville, Ft. Greene and East New York, will receive their fair share of treatment dollars.

I am very pleased that with today's floor consideration of the Ryan White CARE Act we will be able to continue to bring resources to those communities and people who are impacted by AIDS and HIV infection. And, I would urge my colleagues to vote for its passage.

Mr. RUSH. Mr. Speaker, I would like to take this opportunity to commend Mr. WAXMAN and Mr. COBURN for their hard work on the reauthorization of the Ryan White CARE Act of 2000. The Ryan White CARE Act provides grants to eligible metropolitan areas that are disproportionately affected by the HIV epidemic; it provides grants to the states and territories to provide health care support services to people living with HIV/AIDS; it provides programs which support outpatient HIV early intervention services for low-income, medically underserved people in existing primary care systems; and it provides services for children, youth, women and families in a comprehensive, community-based, family-centered system of care.

I am glad to see that the Ryan White CARE Act Amendment of 2000 which I am a cosponsor, addresses the needs of people living with HIV and AIDS. As we witness the dramatic changes taking place in other world nations now confronting exploding epidemics of HIV/AIDS, we recognize that the course of the HIV epidemic is also changing.

Racial and ethnic minorities are increasingly becoming affected with this dreadful disease at an alarming rate. With adequate funding, the Ryan White CARE Act can continue providing medical services to people living with HIV/AIDS, which can help to improve their quality of life.

Mr. Speaker, I would like to thank all of my colleagues who have come to the floor today to speak on the importance of reauthorizing the Ryan White CARE Act of 2000. I am pleased that this important piece of legislation passed the House and Senate and that the leadership considered this important reauthorization before the end of this congressional session.

Mr. NADLER. Mr. Speaker, I rise in strong support of S. 2311, the Ryan White CARE Act Amendments of 2000. This is important bipartisan legislation and I am pleased to see it on the floor today on its way to swift passage. I want to thank the authors for hearing the concerns that were raised when the bill first came through the House, and I believe we have reached a good compromise.

Mr. Speaker, the AIDS epidemic has ravaged our communities throughout the country. The statistics are devastating. Through December 1998, nearly 700,000 people had been diagnosed with AIDS. Over 400,000 of these people have died. The Centers for Disease Control and Prevention estimates that over 40,000 people become infected with HIV each year with an estimated 600,000 to 900,000 people living with HIV today.

As a nation, we could have thrown up our hands and given up in the face of this terrible tragedy. But in 1990, in one of the great legislative achievements of the last decade, Congress took action to address this emergency and passed the Ryan White CARE Act. The CARE Act is a comprehensive program providing treatment and support services to those living with HIV and AIDS. It has brought hope and a little humanity to this terrifying crisis.

The CARE Act is a model of how we can accomplish great things in this chamber. By working together, we have produced a program that provides vital health services to people across the country while targeting communities most in need. It is an efficient program that has been an unqualified success.

We haven't found a cure for AIDS yet, but scientists are making promising discoveries every day, bringing hope that we may one day rid ourselves of this disease once and for all. Until then, there is the CARE Act, reaching out to people who are suffering with HIV and AIDS today and who need our help to lead healthy and productive lives. This is a humane program that deserves our strong support.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in strong support for a cause that must be sustained and implemented in America today. S. 2311, ''Ryan White CARE Act of 2000'' will reauthorize the funds for programs while also changing the formula for current distribution of Ryan White programs. Mr. Speaker, I support this measure that builds on continuing efforts to safeguard the lives of those suffering the most. Accordingly, I applaud the efforts to bring this important legislation to the floor today before the end of the 106th Congress.

Thanks to the persuasive skills by those working on behalf of those afflicted with the HIV/AIDS epidemic, the funding formula within this legislation will actually ensure that minorities are properly covered. The legislation maintains the integrity of the multistructure of the CARE Act, allowing funds to be targeted to the areas hardest hit by the HIV and AIDS epidemic. In addition, I am pleased that the legislation maintains and, in fact, strengthens the decision-making authority of local planning councils and allows resources to be used to locate and bring more individuals into the health care system. Further, I am also delighted to learn that the bill will provide more individuals with early intervention services, such as counseling and testing.

This bill will give states the option to readily extend Medicaid coverage to people living with HIV. If adopted, states will have the ability to add poor and low-income uninsured persons living with HIV to the list of persons categorically eligible for Medicaid. This is very important for people of the 18th Congressional District of Texas who deserve every opportunity to getting the proper coverage it is so critical that they receive quality care. There are HIV-infected persons in my district and across America that need some relief immediately and thus I am pleased by the Medicaid provision in the legislation.

Under current rules, most people living with HIV are ineligible for Medicaid until they have progressed to AIDS and are disabled. Yet, new treatment, such as highly active antiretrovial therapy (HAART), are successfully delaying the progression from HIV infection to AIDS. That is exciting, Mr. Speaker. We can turn this situation around. These advances, along with access to comprehensive health care, have improved the health and quality of

life for many people living with HIV. However, without access to Medicaid these advances will remain out of reach for thousands of poor and low-income uninsured people living with HIV.

Early access to HIV treatment through Medicaid, as provided by this legislation, will result in a reduction of new AIDS cases, increase the quality of life of thousands living with HIV, reduce high medical interventions such as inpatient hospitalizations and terminal care, increase tax revenues and reduce costs in the SSI and SSDI programs.

Another initiative, that effects personally my 18th district in Texas, is the establishment of a new supplementary competitive grant program for states in ''severe need''. HHS must consider the importance of HIV and AIDS, the increased need for service along with the level of unmet need. HHS also must look at disparities in the access to services for historically underserved communities. Acknowledgment of loopholes is being met and solutions being made to combat the destitute situation many underserved communities find themselves in.

Finally, I believe it is significant that the reauthorization of the Ryan White Act has the strong support of the Human Rights Campaign and AIDS Action, two organizations that has done monumental work in the promotion of better health care and other critical benefits for those afflicted with HIV/AIDS. As a result of their hard work, we have a bipartisan effort that finally begins to seek to reach out to minorities in unprecedented fashion.

Congress has long recognized the broad scope of benefits of CARE Act programs to those impacted by the HIV and AIDS. We need to continue helping those in need and redouble our efforts to eliminate the epidemic of HIV/AIDS. Mr. Speaker, I strongly urge my colleagues to strongly support this legislation.

Mr. HOLT. Mr. Speaker, I rise today to express my strong support for passing S. 2311 to reauthorize the Ryan White CARE Act.

I am proud to be a cosponsor of the House reauthorization (H.R. 4807) that we passed by voice vote on July 27, 2000. I am equally proud to stand in support of Senate bill 2311. I urge my colleagues to continue their support for these amendments by voting for S. 2311, and help ensure that those with AIDS will continue to receive the support and resources they need.

Mr. Speaker, we all know the troubling statistics. Since its inception, AIDS has claimed over 400,000 lives in the United States. An estimated 900,000 Americans are living with HIV/AIDS today. Women account for 30 percent of new infections. Over half of all new infections occur in persons under 25. As the AIDS crisis has continued year after year, it has become more and more difficult for anyone to claim that AIDS is someone else's problem.

Since 1990, the CARE Act has helped establish a comprehensive, community-based continuum of care for uninsured and under-insured people living with HIV and AIDS, including access to primary medical care, pharmaceuticals, and support services. The CARE Act provides services to people who would not otherwise have access to care.

As a result of the CARE Act, many people with HIV and AIDS are leading longer and healthier lives today.

Mr. Speaker, since my election to Congress, I have strongly supported increases in funding for medical research. As the spouse of a physician, I have a special affinity for those suffering from life-threatening illnesses. I know some believe that government is the problem and not the solution. But the truth is the opposite: in times of great human suffering and injustice, our government has acted to help our fellow citizens overcome life-threatening conditions and situations. Federal aid for the Ryan White CARE Act is a prime example of the good government can do in the face of tragedy and national danger.

By passing S. 2311, we are making clear that the AIDS epidemic in the United States will receive the attention and public health response it deserves.

By passing S. 2311 today, Mr. Speaker, we will affirm our commitment to people living with HIV/AIDS and their families. We will also be affirming our dedication to sound public policy. By reauthorizing the CARE Act, today, Mr. Speaker, we will give hope and a real chance for a better life to thousands of HIV/AIDS victims.

Mr. DINGELL. Mr. Speaker, I rise today to express my strong support for S. 2311, the Ryan White CARE Act Amendments of 2000. This is an excellent bill and it deserves our immediate consideration and support.

I want to take particular note of the way in which this bill has been developed. This bill comes to us by way of a remarkable bipartisan effort led by my good friend and colleague Representative WAXMAN and from the other side of the aisle, Representative COBURN. Given the complexity of the Ryan White program and the potentially controversial nature of the subject matter, the fact that we will pass a good bill at this time of year with a strong bipartisan vote is a tribute to them.

Our colleagues in the other body have also worked hard on this bill and are to be congratulated for their effort. Senators JEFFORDS, KENNEDY, and FRIST have been solid partners in forging the legislation before us today.

The CDC estimates that more than 900,000 persons in America are now living with HIV. Approximately one-third of these persons know they are infected and are receiving treatment. Another third know they are infected, but are not receiving treatment. Another third does not know they are infected. Another complication is that HIV infections are occurring in every region of the country and in every kind of situation. Underserved areas, such as rural areas, are having a particularly difficult time because they lack the infrastructure of proven prevention and treatment programs.

In brief, S. 2311 keeps those programs that have withstood the test of time. Just as significantly, it makes changes where they were needed. The four titles of the Ryan White CARE Act contain a variety of grants and formulas that distribute funds at the state and local levels. As we all know, changing programs of this kind is never easy. In this case, we have successfully blended the need for change with the need for continuity of care for those areas that have been especially hard hit by the HIV/AIDS epidemic. On this point, let me note the great work of our colleagues Representatives ESHOO, TOWNS and PELOSI. I note, also, that a listing of all of the changes made to the Ryan White program by this bill is set forth in the statement of managers that will be included in the record of today's proceedings.

Finally, Mr. Speaker, I wish to acknowledge the work of ranking member of the Health and Environment Subcommittee, Representative BROWN, and the Subcommittee Chairman, Representative BILIRAKIS. They have forged a solid working relationship on a variety of bills that have come before us this year and we are grateful for their hard work and cooperation.

The SPEAKER pro tempore (Mr. SIMPSON). All time for debate has expired.

Pursuant to House Resolution 611, the previous question is ordered on the Senate bill, as amended.

The question is on the third reading of the Senate bill.

The Senate bill was ordered to be read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the Senate bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. BILIRAKIS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 411, nays 0, not voting 22, as follows:

[Roll No. 512]

YEAS—411

Abercrombie	Cannon	Ehrlich
Ackerman	Capps	Emerson
Aderholt	Capuano	Engel
Allen	Cardin	English
Andrews	Carson	Etheridge
Archer	Castle	Evans
Armey	Chabot	Everett
Baca	Chambliss	Ewing
Bachus	Chenoweth-Hage	Farr
Baird	Clayton	Fattah
Baker	Clement	Filner
Baldacci	Clyburn	Fletcher
Baldwin	Coble	Foley
Ballenger	Coburn	Forbes
Barcia	Collins	Ford
Barr	Combest	Fossella
Barrett (NE)	Condit	Fowler
Barrett (WI)	Conyers	Frank (MA)
Bartlett	Cook	Frelinghuysen
Barton	Cooksey	Frost
Bass	Costello	Gallegly
Becerra	Cox	Ganske
Bentsen	Coyne	Gejdenson
Bereuter	Cramer	Gekas
Berman	Crane	Gibbons
Berry	Crowley	Gilchrest
Biggert	Cubin	Gillmor
Bilbray	Cummings	Gilman
Bilirakis	Cunningham	Gonzalez
Bishop	Danner	Goode
Blagojevich	Davis (FL)	Goodlatte
Bliley	Davis (IL)	Goodling
Blumenauer	Davis (VA)	Gordon
Blunt	Deal	Goss
Boehlert	DeFazio	Graham
Boehner	DeGette	Granger
Bonilla	Delahunt	Green (TX)
Bono	DeLauro	Green (WI)
Borski	DeLay	Greenwood
Boswell	DeMint	Gutierrez
Boucher	Deutsch	Gutknecht
Boyd	Diaz-Balart	Hall (OH)
Brady (PA)	Dickey	Hall (TX)
Brady (TX)	Dicks	Hansen
Brown (FL)	Dingell	Hastings (FL)
Brown (OH)	Dixon	Hastings (WA)
Bryant	Doggett	Hayes
Burr	Dooley	Hayworth
Burton	Doolittle	Herger
Buyer	Doyle	Hill (IN)
Callahan	Dreier	Hill (MT)
Calvert	Duncan	Hilleary
Camp	Dunn	Hilliard
Campbell	Edwards	Hinchey
Canady	Ehlers	Hinojosa

Hobson	Meeks (NY)	Schakowsky
Hoeffel	Menendez	Scott
Hoekstra	Metcalf	Sensenbrenner
Holden	Mica	Serrano
Holt	Millender-McDonald	Sessions
Hooley	Miller, Gary	Shadegg
Horn	Miller, George	Shaw
Hostettler	Minge	Shays
Houghton	Mink	Sherman
Hoyer	Moakley	Sherwood
Hulshof	Mollohan	Shimkus
Hunter	Moore	Shows
Hutchinson	Moran (KS)	Shuster
Hyde	Moran (VA)	Simpson
Inslee	Morella	Sisisky
Isakson	Myrick	Skeen
Istook	Nadler	Skelton
Jackson (IL)	Napolitano	Slaughter
Jackson-Lee (TX)	Neal	Smith (MI)
Jefferson	Nethercutt	Smith (NJ)
Jenkins	Ney	Smith (TX)
John	Northup	Smith (WA)
Johnson (CT)	Norwood	Snyder
Johnson, E.B.	Nussle	Souder
Johnson, Sam	Oberstar	Spence
Jones (NC)	Olver	Spratt
Jones (OH)	Ortiz	Stabenow
Kanjorski	Ose	Stark
Kaptur	Owens	Stearns
Kasich	Oxley	Stenholm
Kelly	Packard	Strickland
Kennedy	Pallone	Stump
Kildee	Pascrell	Stupak
Kilpatrick	Pastor	Sununu
Kind (WI)	Payne	Talent
Kingston	Pease	Tancredo
Kleczka	Pelosi	Tanner
Knollenberg	Peterson (MN)	Tauscher
Kolbe	Peterson (PA)	Tauzin
Kucinich	Petri	Taylor (MS)
Kuykendall	Phelps	Taylor (NC)
LaFalce	Pickering	Terry
LaHood	Pickett	Thomas
Lampson	Pitts	Thompson (CA)
Lantos	Pombo	Thompson (MS)
Largent	Pomeroy	Thornberry
Larson	Porter	Thune
Latham	Portman	Thurman
LaTourette	Price (NC)	Tiahrt
Leach	Pryce (OH)	Tierney
Lee	Quinn	Toomey
Levin	Radanovich	Towns
Lewis (CA)	Rahall	Traficant
Lewis (GA)	Ramstad	Turner
Lewis (KY)	Regula	Udall (CO)
Linder	Reyes	Udall (NM)
Lipinski	Reynolds	Upton
LoBiondo	Riley	Velazquez
Lofgren	Rivers	Visclosky
Lowey	Rodriguez	Vitter
Lucas (KY)	Roemer	Walden
Lucas (OK)	Rogan	Walsh
Luther	Rogers	Wamp
Maloney (NY)	Rohrabacher	Waters
Manzullo	Ros-Lehtinen	Watkins
Markey	Rothman	Watt (NC)
Martinez	Roukema	Watts (OK)
Mascara	Roybal-Allard	Waxman
Matsui	Royce	Weiner
McCarthy (MO)	Rush	Weldon (FL)
McCarthy (NY)	Ryan (WI)	Weldon (PA)
McCrery	Ryun (KS)	Weller
McDermott	Sabo	Wexler
McGovern	Salmon	Weygand
McHugh	Sanchez	Whitfield
McInnis	Sanders	Wicker
McIntyre	Sandlin	Wilson
McKeon	Sanford	Wolf
McKinney	Sawyer	Woolsey
McNulty	Saxton	Wu
Meehan	Scarborough	Wynn
Meek (FL)	Schaffer	Young (AK)

NOT VOTING—22

Berkley	Klink	Paul
Bonior	Lazio	Rangel
Clay	Maloney (CT)	Sweeney
Eshoo	McCollum	Vento
Franks (NJ)	McIntosh	Wise
Gephardt	Miller (FL)	Young (FL)
Hefley	Murtha	
King (NY)	Obey	

1151

So the Senate bill was passed.

The result of the vote was announced as above recorded.

The title of the Senate bill was amended so as to read: ''A bill to amend the Public Health Service Act to revise and extend programs established under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, and for other purposes.''.

A motion to reconsider was laid on the table.

Stated for:

Mr. MALONEY of Connecticut. Mr. Speaker, I was unavoidably detained during rollcall vote No. 512. Had I been present I would have voted ''yes.''

PROVIDING FOR CONSIDERATION OF H.R. 2941, LAS CIENEGAS NATIONAL CONSERVATION AREA IN THE STATE OF ARIZONA

Mr. HASTINGS of Washington. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 610 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 610

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 2941) to establish the Las Cienegas National Conservation Area in the State of Arizona. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Resources. After general debate the bill shall be considered for amendment under the five-minute rule. In lieu of the amendment recommended by the Committee on Resources now printed in the bill, it shall be in order to consider as an original bill for the purpose of amendment under the five-minute rule the amendment in the nature of a substitute printed in the Congressional Record and numbered 1 pursuant to clause 8 of rule XVIII. That amendment in the nature of a substitute shall be considered as read. All points of order against that amendment in the nature of a substitute are waived. During consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the Member offering an amendment has caused it to be printed in the portion of the Congressional Record designated for that purpose in clause 8 of rule XVIII. Amendments so printed shall be considered as read. The Chairman of the Committee of the Whole may: (1) postpone until a time during further consideration in the Committee of the Whole a request for a recorded vote on any amendment; and (2) reduce to five minutes the minimum time for electronic voting on any postponed question that follows another electronic vote without intervening business, provided that the minimum time for electronic voting on the first in any series of questions shall be 15 minutes. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. Any Member may demand a separate vote in the House on any amendment adopted in the Committee of the Whole to the bill or to the amendment in the nature of a substitute made in order as original text. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

The SPEAKER pro tempore. The gentleman from Washington (Mr. HASTINGS) is recognized for 1 hour.

Mr. HASTINGS of Washington. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentlewoman from New York (Ms. SLAUGHTER), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

(Mr. HASTINGS of Washington asked and was given permission to revise and extend his remarks.)

Mr. HASTINGS of Washington. Mr. Speaker, H. Res. 610 is an open rule waiving all points of order against the consideration of H.R. 2941, a bill to establish the Las Cienegas National Conservation Area in the State of Arizona.

The rule provides 1 hour of general debate to be equally divided between the chairman and ranking minority member of the Committee on Resources. The rule makes in order as an original bill for the purpose of amendment the amendment in the nature of a substitute printed in the CONGRESSIONAL RECORD and numbered 1, which shall be open for amendment at any point. The rule waives all points of order against the amendment in the nature of a substitute.

The rule also authorizes the Chair to accord priority in recognition to Members who have preprinted their amendments in the CONGRESSIONAL RECORD. The rule further allows the chairman of the Committee on the Whole to postpone votes during the consideration of the bill and to reduce voting time to 5 minutes on a postponed question if the vote follows a 15-minute vote.

Finally, the rule provides for one motion to recommit, with or without instructions.

H.R. 2941, a bill introduced by the distinguished gentleman from Arizona (Mr. KOLBE), establishes the Las Cienegas National Conservation Area in parts of Pima, Santa Cruz, and Cochise Counties in Arizona. The bill directs the Secretary of the Interior to develop a management plan for the 42,000 acre area which will conserve, protect, and enhance its resources and values.

Mr. Speaker, this legislation also authorizes the Secretary to purchase or exchange necessary acreage for the conservation area from willing sellers, both individuals and from the State of Arizona.

The bill preserves a significant amount of land that is home to an important cross-section of plants and wildlife. It also creates 142,000-plus acre planning district that is an important first step towards providing a biological corridor from the north of Tucson to Mexico for animal movements that