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Ryan White CARE Act (continued)

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U.S. Department of Health & Human Services
HEALTH RESOURCES AND SERVICES ADMINISTRATION
5600 Fishers Lane, Rm. 14-45 • Rockville, MD 20857
Contact: HRSA Press Office
Tel. 301-443-3376
Fax 301-443-1989
<http://www.hrsa.gov/newsroom>

FOR IMMEDIATE RELEASE
Tuesday, August 1, 2000

Contact: Tom Flavin
301-443-1745
HRSA-00-49

HRSA AWARDS \$18 MILLION TO IMPROVE HIV/AIDS CARE FOR WOMEN, CHILDREN AND FAMILIES

Health Resources and Services Administration Administrator Claude Earl Fox, M.D., M.P.H., today announced more than \$18 million in grants to 25 health care organizations – most in rural or underserved communities – that provide HIV/AIDS care and services to infants, youth, women and families.

“Reaching HIV-positive women, who often neglect their own needs to care for their families, is the focus of these grants,” said Dr. Fox. “These funds will help support them as they cope with HIV/AIDS and the challenges of care-giving.”

More than \$16 million is being awarded to 16 organizations that previously received grants under the Title IV Comprehensive Family Services Program of the Ryan White CARE Act. Nine new grants totaling more than \$2 million will go to organizations under the Title IV New Geographic Areas program. This program funds organizations that help achieve an equitable geographical distribution of HIV/AIDS programs across all states and territories. Funding preference is given to programs that provide services in rural or underserved communities where the number of HIV-positive and affected children, youth, women and families is increasing, and in areas that receive limited or no other CARE Act funds.

“The CARE Act Title IV program is a lifeline for women and their families who are struggling with the hardships caused by HIV/AIDS and, in many cases, extreme poverty and lack of quality care,” said Joseph F. O’Neill, M.D., M.P.H., HRSA’s associate administrator for HIV/AIDS.

In FY 2000, Congress appropriated \$51 million to support Title IV programs under the CARE Act, which provides HIV/AIDS care and supportive services for low-income, uninsured and underinsured individuals and families. Title IV programs also provide funding to increase access to clinical trials for women, children and youth.

A list of awardees is attached.

###

Note: HRSA press releases are available on the Web at <http://www.hrsa.gov/newsroom>.

Ryan White CARE Act FY 2000 Title IV Grants

Continuing Grants

Program	Amount
Children's Hospital Oakland (Oakland, Calif.)	\$1,020,000
North Broward Hospital District (Ft. Lauderdale, Florida)	1,673,638
University of Miami (Miami, Florida)	1,537,453
Hektoen Institute for Medical Research (Chicago, Ill.)	1,137,849
Children's Hospital (New Orleans, Louisiana)	1,249,587
Dimock Community Health Center (Roxbury, Mass.)	849,149
Massachusetts Dept. of Public Health (Boston, Mass.)	881,541
New Jersey Dept. of Health & Senior Services (Trenton, N.J.)	1,984,456
Columbia University (New York, N.Y.)	2,115,858
Children's Hospital -- FACES (Columbus, Ohio)	545,163
Puerto Rico Dept. of Health (San Juan, P.R.)	319,205
AIDS Care Ocean State, Inc. (Providence, R.I.)	463,434
Catholic Charities of Ft. Worth (Ft. Worth, Texas)	370,800
Houston Regional HIV/AIDS Resource Group (Houston, Texas)	483,816
University of Texas HSC San Antonio (San Antonio, Texas)	708,000
Seattle King County Dept. of Public Health (Seattle, Wash.)	653,410
Subtotal	\$16,167,536

New Geographic Areas Grants

Program	Amount
Christiana Care Health Services (Wilmington, Del.)	\$250,000
West Side Community Health Services (St. Paul, Minn.)	180,000
Southeast Mississippi Rural Health Initiative (Hattiesburg, Miss.)	250,000
University of Mississippi Medical Center (Jackson, Miss.)	210,000
Kansas City Free Health Clinic (Kansas City, Missouri)	250,000
Tri-County Community Health Council (Newton Grove, N.C.)	200,000
Medical College of Ohio (Toledo, Ohio)	250,000
Comprehensive Care Center (Nashville, Tenn.)	250,000
Inova Health Care Services (Fairfax, Virginia)	250,000
Subtotal	\$2,090,000
Total	\$18,257,536

Internal DA

DRAFT I-RWCA

House Draft F:\M6\COBURN\COBURN.081

Only includes outreach
on material received
(T1, T2)

TOP TIER ISSUES

- **CASEFINDING AND OUTREACH** Titles I and II both include casefinding and outreach activities to identify persons who have HIV disease who aren't receiving care as primary purposes of the Ryan White grants. These terms are ~~overly~~ broad, and can encompass activities ranging from ~~disease~~ surveillance and partner notification to community- or provider-level outreach. Major overlap with CDC-funded activities. (P. 18, 23)

Subtitle C - Other Provisions

Sec. 121 Use of Amounts

(a)4(B) see Senate language

(a)5(D)

Drop the word "case finding". Outreach activities that are intended to identify individuals who are aware of their HIV status and are not receiving [HIV related health service] within the delivery of primary care services. This should also be cross cited with a reference to medical points of entry.

(b)(3) Early Intervention Services

This section appears to be broad and ambiguous. The eligible sites should be identified as key points of entry in order for the grantee to fund EIS at that site.

PREFERRED

- 1) delete casefinding and leave outreach, which is inclusive of early intervention services
 - 2) retain casefinding but limit it to identifying persons aware of their HIV infection but not in services
 - 3) define casefinding as not inclusive of surveillance or partner notification activities
- **EARLY INTERVENTION SERVICES** Titles I and II define early intervention services very broadly, such that any entity receiving funds under these titles can carry out early intervention. The Administration wanted to narrow the scope of EIS by narrowing eligible entities and requiring documentation that no other funds were available for this purpose. Also lacks a requirement for follow-through referral to primary care. The community had also considered capping the amount that could be used for EIS. (P.19, 24)

PREFERRED: Take Senate language. As a fall back, strike "and all other entities" language.

SECOND TIER ISSUES

- Titles I and II lack a process for phasing in methodologies to identify HIV+ persons who are not in care, making it a requirement of grantees upon enactment. Senate bill directs Secretary to assist grantees in defining appropriate techniques for identifying these populations. (P. 4 and 28) *we rework this process language less*
- R • Comprehensive Plan / Strategy House requires Title I and II grantees to develop and implement strategy to identify (all) persons with HIV disease not receiving services. This is too broad for HRSA grantees to do -- is more appropriately a shared responsibility with CDC. **PREFERRED LANGUAGE:** limit the plan/strategy to identifying those persons who know they are HIV+ but are not in care --- important to narrow the scope, as casefinding and outreach are later linked to this strategy/plan. (P.6 and 28) *add*

Subtitle B - Type and Distribution of Grants

Sec. 111 Formula Grants

(b)(1)(A) The ability of CDC to have an HIV reporting system in place by July 1, 2004 largely depends on when States adopt HIV reporting. Some States may be not be able to determine if their HIV reporting systems are sufficient and reliable by July 1, 2004.

(D)(iii) line 6 should read as the following....

The word "appropriated" should be replaced with "authorized"

Sec. 112 Supplemental Grants

(3)(A) line 12

(1)(B) should be written as (2)(B) or subparagraph (B.)

(3)(C)(i)

Data on the current prevalence of HIV disease will not be available for all States until 2004. This date needs to be standardized. Insisting on 2004 could put some States at a disadvantage who will not have a system in place by 2001.. *ab bazi*

- Title I Supplemental grants includes HIV prevalence and rates of increase of HIV infection as criteria in the grant application. These data are not uniformly available and are problematic as a criteria in a competitive grant program. (P. 16)
PREFERRED LANGUAGE: "in accordance with"
- Oppose authorizing partner notification program in statute. (P. 43) Minimum changes that are needed:
 - p. 45 Delete lines 12-15 Stick with State law
 - p. 45 lines 21-25 delete as unnecessary, stick with State law
 - p. 46 lines 9-12 Delete as redundant of current program operating
- * Both new Title II supplementals are very open ended and require an extensive administrative process for a very small pot of money. **PREFERRED LANGUAGE:** Senate provisions. As a fall back, tailoring of the criteria and the scope would be helpful.

Subtitle A - HIV Health Services Planning Councils

Sec. 102 Duties of Councils

(a)(1-2)lines 16-24

Those requirements that are in the Senate bill are phased in and do not become effective until the Secretary formalizes the process by which to do that. See Senate bill.

(D)(i) should read as follow....

includes a strategy for identifying individuals with HIV disease who are aware of their HIV positive status and are not receiving care and for informing the individuals of and encouraging the individuals to utilize services,.....

(D)(ii) Need for Clarification from Waxman's staff

Does this make the Planning Councils responsible for dealing with substance abuse treatment and prevention or just for purposes of coordination?

THIRD TIER ISSUES

- Quality management -- no phase in time for implementing these , effective upon enactment (p.20, 24)
- Health Care Relationships - This provision is more specifically drafted in the Senate bill. House bill leaves it at "have a relationship" with appropriate entities. Senate language is preferred. (P 21, 30)

TECHNICAL

- **p. 12 line 16 should say "authorized"not appropriated**

2-2000

Danielle Glenn-Rivera
8205 Wakefield Ave. Panorama City, CA 91402
(818) 904-9764 Work # (213) 744-6462 Fax (213) 744-6373

January 10, 2000

The Honorable Donna Shalala, Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Room 615F
Washington, D.C. 20201

Dear Secretary Shalala:

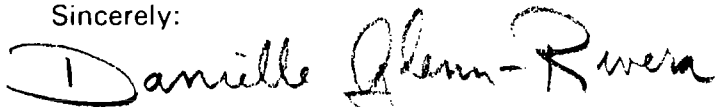
I am writing to express my dismay and outrage over the Administrations proposed .53% across the board reductions to Ryan White Care Act Program for FY 2000. These critical grant programs serving low-income, uninsured and under-insured individuals should be the first to be protected from cuts and not disproportionately shoulder the burden of discretionary HHS program reductions. A .53% reduction from Ryan White CARE Act grants would reduce FY 2000 funding by almost \$8.5 million, putting at risk thousands of vulnerable individuals living with HIV disease.

I am a member of the Osage/Cherokee tribe/s, and I'm a member of the American Indian AIDS Council in Los Angeles. We are a grassroots organization advocating for American Indians in Los Angeles. Members of our group sit on the Ryan White, CARE Act Planning Council, and on the CDC Prevention Council here in Los Angeles. We have no American Indian agencies to provide HIV/AIDS services to American Indians in Los Angeles. Our people go to non-Indian clinics for services.

Our population numbers are small compared to some of the other ethnic groups, and it is because of the small numbers that this disease can be so devastating to our people. The infection rate has decreased in Los Angeles for other groups but the infection rate has steadily increased for American Indians. If funds or services are cut, it will affect everyone.

By September 30, 2000 Congress must reauthorize the Ryan White Care Act. I am greatly concerned about the message Congress may hear as to the Administrations commitment to this important program from a decision to cut programmatic funding in 2000. I urge you to reconsider this .53% cut in funding because of its immediate negative impact on vulnerable people living with HIV, and because of its potential negative impact on the willingness of Congress to reauthorize the Act so it can continue to serve its critical role in our nation's public health system.

Sincerely:

A handwritten signature in black ink that reads "Danielle Glenn-Rivera". The signature is written in a cursive, flowing style.

Danielle Glenn-Rivera, Member
Osage/Cherokee Tribes

cc: Sandra Thurman, Office of National AIDS Policy
Kevin Thurm, HHS
John Callahan, HHS
Eric Goosby, M.D. HRSA
Claude Earl Fox M.D., HRSA
Joseph O'Neill, M.D. HRSA

AMERICAN INDIAN AIDS COUNCIL
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(818) 904-9764 Work # (213) 744-6462 Fax (213) 744-6373

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U.S. Department of Health and Human Services
200 Independence Ave, SW
Room 615F
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Dear Secretary Shalala:

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As Chairperson of the American Indian AIDS Council (AIAC) in Los Angeles, I must inform you that we are deeply distressed by this proposed reduction. AIAC is a grassroots organization consisting of members of various tribes, advocating for American Indians in Los Angeles. Members of our AIAC group sit on the Ryan White CARE Act Planning Council and on the CDC Prevention Council here in Los Angeles. We have no American Indian agencies to provide HIV/AIDS services to American Indians in Los Angeles. Our people go to non-Indian clinics for services.

In Los Angeles the infection rate has decreased for other groups, but the infection rate has steadily increased for American Indians as in other sites across the United States. Our population numbers are small compared to some of the other ethnic groups, if funds or services are cut, it could have devastating effects on American Indians.

By September 30, 2000, Congress must reauthorize the Ryan White Care Act. AIAC is greatly concerned about the message Congress may hear as to the Administrations commitment to this important program from a decision to cut programmatic funding in 2000. We urge you to reconsider this .53% cut in funding because of its immediate negative impact on vulnerable people living with HIV and because of its potential negative impact on the willingness of Congress to reauthorize the Act so it can continue to serve its critical role in our nations public health system.

Sincerely: -

A handwritten signature in black ink that reads "Danielle Glenn-Rivera". The signature is written in a cursive style with a large, looped initial "D".

Danielle Glenn-Rivera, Chair
American Indian AIDS Council (AIAC)

cc: AIAC
Sandra Thurman, Office of National AIDS Policy
Kevin Thurm, HHS
John Callahan, HHS
Eric Goosby, M.D. HRSA
Claude Earl Fox M.D., HRSA
Joseph O'Neill, M.D. HRSA

aiac/ltr/secy/12000

Called -

DRAFT -- NOT FOR RELEASE

July 21, 2000
(House)

H.R. 4807 - Ryan White CARE Act Amendments of 2000

(Rep. Coburn (R) OK and ~~150~~ cosponsors)

+ Waxman 200

The Administration strongly supports House passage of H.R. 4807, which would reauthorize appropriations for and amend the programs contained in the Ryan White CARE Act. Since its enactment in 1990, the Ryan White CARE Act has served as a lifeline in providing health care to hundreds of thousands of individuals living with HIV and AIDS in the United States. This year, the Administration requested a \$125 million increase in funding for Ryan White CARE Act programs, which represents more than a 340 percent increase in funding for these programs since the beginning of this Administration. The Administration applauds this bipartisan bill and urges its swift passage.

While the Administration strongly supports H.R. 4807, it has a few concerns with the bill and looks forward to working with Congress to address them during Conference action. Specifically, section 212 of H.R. 4807 would expand an existing grant program to authorize additional funds for HIV testing of pregnant women and newborns. The Administration supports the expansion of this program, but is concerned about the bill's provision that would establish financial incentives for States to enact mandatory HIV testing laws. In addition, H.R. 4807 would authorize a number of new prevention-focused activities that would duplicate existing programs within the Centers for Disease Control and Prevention.

The Administration commends the bipartisan efforts of the Commerce Committee in developing this important piece of legislation.

I. Ryan White
CARE Act 2000
Total Pages: 39

**EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001**

Wednesday, October 11, 2000

ENROLLED BILL FACSIMILE TRANSMITTAL

TO: Legislative Liaison Officer - See Distribution below
OMB CONTACT: Robert J. Pellicci
PHONE: (202)395-4871 FAX: (202)395-6148

SUBJECT: **ENROLLED BILL S2311**
Ryan White CARE Act Amendments of 2000

Attached is the facsimile for the above enrolled bill.

The enrolled version is also available electronically in PDF format from GPO's Web-site:

http://www.access.gpo.gov/su_docs/aces/aaces002.html

For assistance in accessing the GPO Web-site, please contact GPO Access by telephone at 1-202-512-1530 or toll free at 1-888-293-6498.

The two-day response deadline referenced in the previous request begins today. If you have previously responded to our request for your agency's views on this enrolled bill, no further response is necessary.

JAMES J. JUKES
Assistant Director for
Legislative Reference

**ENROLLED BILL FACSIMILE TRANSMITTAL
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National AIDS Policy - 456-2438

S. 2311

One Hundred Sixth Congress of the United States of America

AT THE SECOND SESSION

*Begun and held at the City of Washington on Monday,
the twenty-fourth day of January, two thousand*

An Act

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.

*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. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

- Sec. 1. Short title.
- Sec. 2. Table of contents.

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

Subtitle A—HIV Health Services Planning Councils

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

Subtitle B—Type and Distribution of Grants

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

Subtitle C—Other Provisions

- Sec. 121. Use of amounts.
- Sec. 122. Application.

TITLE II—CARE GRANT PROGRAM

Subtitle A—General Grant Provisions

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

Subtitle B—Provisions Concerning Pregnancy and Perinatal Transmission of HIV

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

Subtitle C—Certain Partner Notification Programs

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

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TITLE III—EARLY INTERVENTION SERVICES

Subtitle A—Formula Grants for States

Sec. 301. Repeal of program.

Subtitle B—Categorical Grants

Sec. 311. Preferences in making grants.

Sec. 312. Planning and development grants.

Sec. 313. Authorization of appropriations.

Subtitle C—General Provisions

Sec. 321. Provision of certain counseling services.

Sec. 322. Additional required agreements.

TITLE IV—OTHER PROGRAMS AND ACTIVITIES

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

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

Sec. 402. AIDS education and training centers.

Subtitle B—General Provisions in Title XXVI

Sec. 411. Evaluations and reports.

Sec. 412. Data collection through Centers for Disease Control and Prevention.

Sec. 413. Coordination.

Sec. 414. Plan regarding release of prisoners with HIV disease.

Sec. 415. Audits.

Sec. 416. Administrative simplification.

Sec. 417. Authorization of appropriations for parts A and B.

TITLE V—GENERAL PROVISIONS

Sec. 501. Studies by Institute of Medicine.

Sec. 502. Development of rapid HIV test.

Sec. 503. Technical corrections.

TITLE VI—EFFECTIVE DATE

Sec. 601. Effective date.

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

Subtitle A—HIV Health Services Planning Councils

SEC. 101. MEMBERSHIP OF COUNCILS.

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

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

(2) in paragraph (2)—

(A) in subparagraph (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

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(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

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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)),”;

(B) by striking the period and inserting “; 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

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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 section 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”.

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(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

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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.”.

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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—

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(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

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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 to 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

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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

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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 to 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

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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 section 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

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(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)—

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(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:

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“(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 section 2603(a)(3)(D)(i) the Secretary determines that data on cases of HIV disease are

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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)

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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 be 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

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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

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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 1,999 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 section 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 the 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 1,000, but less than 2,000, 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 section 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 the 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 1,000, 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 section 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 section 2677 to carry out part B in fiscal year

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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 1,000 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—

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(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

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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.—

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(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

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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.

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“(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.”.

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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.**—

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“(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

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“(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

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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 the 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

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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 the 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.”

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(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.”.

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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.

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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

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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.—

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(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 as "rapid HIV test").

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(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

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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.

Speaker of the House of Representatives.

*Vice President of the United States and
President of the Senate.*

Ryan White

care; treatment of

STATEMENT BY THE PRESIDENT

Today, I am very pleased to sign into law S. 2311, the "Ryan White CARE Act Amendments of 2000," which reauthorizes and expands health care and essential support services to hundreds of thousands of Americans living with HIV disease.

The reauthorization of the Ryan White CARE Act is the cornerstone of the Administration's domestic AIDS program, and one of its top legislative priorities. The reauthorization of this vital program by overwhelming bipartisan majorities in the Congress sends a clear message that this country continues to care about our fellow citizens affected by HIV disease. Under my Administration, funding for the CARE Act program has increased

nearly 350 percent since fiscal year 1993. For fiscal year 2001, I have requested an additional \$125 million for the CARE Act program. will receive more than \$1.7 billion

10 years ago, shortly after Ryan White's death, the Congress chose to build an agency in his name. As a young man, Ryan White changed the world and so the rest in his name

Today, the CARE Act has become a model for health care delivery not only in the United States, but around the world. It is a shining example of the good that can come from collaboration, coordination, and concerted action. The CARE Act has brought together Republicans and Democrats, cities and states, hospitals and community-based organizations, providers and people living with AIDS - and the results are a tribute to the power of public-private partnerships. It has created a continuum of care that is both compassionate and cost-effective - one that saves both lives and money.

When the CARE Act was originally created we were sadly unable to do much for those who were sick - and many of the services provided were designed to help people die with dignity. Thankfully, much has changed. The CARE Act is now solidly about living with HIV and AIDS. Since the last reauthorization, biomedical research has brought hope and renewed optimism with the discovery of protease inhibitors and combination therapies. But without the CARE Act, these cutting-edge therapies would have been about as meaningful to many in Selma or the South Bronx as they currently are in South Africa. The CARE Act has made the promise of biomedical research a reality in the lives of people living with HIV and AIDS in every corner of this country.

Last year alone, approximately one hundred thousand people living with HIV and AIDS received access to drug therapy because of the CARE Act. This is particularly important given that half of the people served by the Act have family incomes of less than \$10,000 a year – and the new drug “cocktails” cost more than \$12,000 annually. And we know all too well, that the drugs alone are not enough. Primary care and support services are vital to ensuring both access and adherence to these complex drug regimens. It is this comprehensive package of essential services that the CARE Act provides – and with impressive results.

The CARE Act has helped to:

- reduce both the frequency and length of expensive in-patient hospitalizations by at least 30%;
- reduce AIDS mortality by 70%;
- reduce mother-to-child transmission of HIV by 75%; and,
- enhance both the length and quality of life for people living with AIDS.

DISCUSSION

And the CARE Act goes these much in need
~~Last year, the CARE Act served an estimated half million people living with HIV and AIDS – and affected the lives of millions more. Nearly 6 in 10 of these people were poor. They were also five times more likely to be uninsured than those receiving care elsewhere, nearly 3 times more likely to be African American, and 50% more likely to be women. Clearly the CARE Act has followed the path paved by this epidemic – but challenges remain as HIV and AIDS moves deeper into underserved communities already plagued by poverty, homelessness, and substance abuse, and as treatment demands and costs continue to rise.~~

[insert this rewrite of S2311]

These individuals who
 I want to thank ~~some individuals in the Administration and in the Congress, and some~~
~~organizations~~ *embodied in the bill* for their ~~hard work and support in guiding this bill to enactment.~~ Specifically, we

on this very important bill to the community
 We all owe thanks to Secretary of Health and Human Services Donna Shalala; ~~the~~ *services* Surgeon General, *clearly*
 Dr. David Satcher; Drs. Earl Fox and Joseph O'Neill of the Health Resources Administration;
 and Sandy Thurman, Director of ~~the~~ *our* White House AIDS Office. In addition, this bill would not
 have become law without the dedication of Senators Jeffords, Kennedy, and Frist and
 Representatives Waxman and Coburn. *And finally, we* We're also particularly grateful for the assistance of the *many, many*
 National Association of Persons with AIDS; the National Minority AIDS Council; the AIDS
 Alliance for Family, Youth, and Children; the National Academy of State and Territorial AIDS
 Directors, and other organizations.

*national organizations who come together to extend the
 all American legacy of care, compassion for each other,
 families living with the disease*

The CARE Act has provided a mainstay of essential health and related support services to individuals living with HIV disease and their families. We must continue to make available quality health care and support services needed to adhere to difficult treatment regimens if we are to continue our progress against this relentless disease. Those living with this disease must be able to have access to care and services that are life saving and cost effective.

We hope that in the not-so-distant future we will have an effective vaccine and even better therapies. In the meantime, however, we are grateful to have a program such as the CARE Act, which, through its programs and services, has allowed individuals to live longer and healthier lives. The programs contained in this bill are a lifeline for individuals with HIV disease. For this reason, I am extremely pleased to sign S. 2311.

I - Ryan White

FAX COVER SHEET



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HIV/AIDS Bureau
Health Resources and Services Administration
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DATE: 10/6

TO: Cheryl

FAX: 202-456-2438

FROM: _____

SUBJECT: Barbara Harris

PAGES: 734 + Cover

NOTES: _____

NEW YORK

State CARE Act Program Profile

CARE Act Funding History Since 1996

Fiscal Year	1996	1997	1998	Total
Title I	\$96,507,343	\$97,934,015	\$101,119,686	\$295,561,044
Title II (including ADAP)	\$38,324,520	\$64,354,160	\$87,884,362	\$190,563,042
ADAP	(\$9,009,360)	(\$29,381,796)	(\$51,291,513)	(\$89,682,669)
Title III	\$11,033,443	\$12,660,451	\$12,799,351	\$36,493,245
Title IV	\$7,646,589	\$9,251,265	\$7,588,359	\$24,486,213
SPNS	\$3,248,467	\$4,040,845	\$4,292,310	\$11,581,622
AETC	\$2,116,956	\$2,074,541	\$1,503,921	\$5,695,418
Dental	\$2,999,988	\$3,065,208	\$2,965,404	\$9,030,600
Total	\$161,877,306	\$193,380,485	\$218,153,393	\$573,411,184

Number of CARE Act-funded Grantees in State (In addition to Title II and ADAP grants)

	1996	1997	1998
Title I	3	3	3
Title III	31	32	33
Title IV	10	10	9
SPNS	7	7	7
AETC (grantee or subcontractor)	11	11	11
Dental	32	32	31

AIDS Education and Training Centers: New Mexico

- ▶ Mountain Plains Regional AETC
- ▶ States Served: Colorado, Kansas, Nebraska, New Mexico, North Dakota, South Dakota, Utah and Wyoming
- ▶ Primary Grantee: University of Colorado, Denver, CO
- ▶ Subcontractors in State: Univ. of New Mexico, School of Medicine - Albuquerque

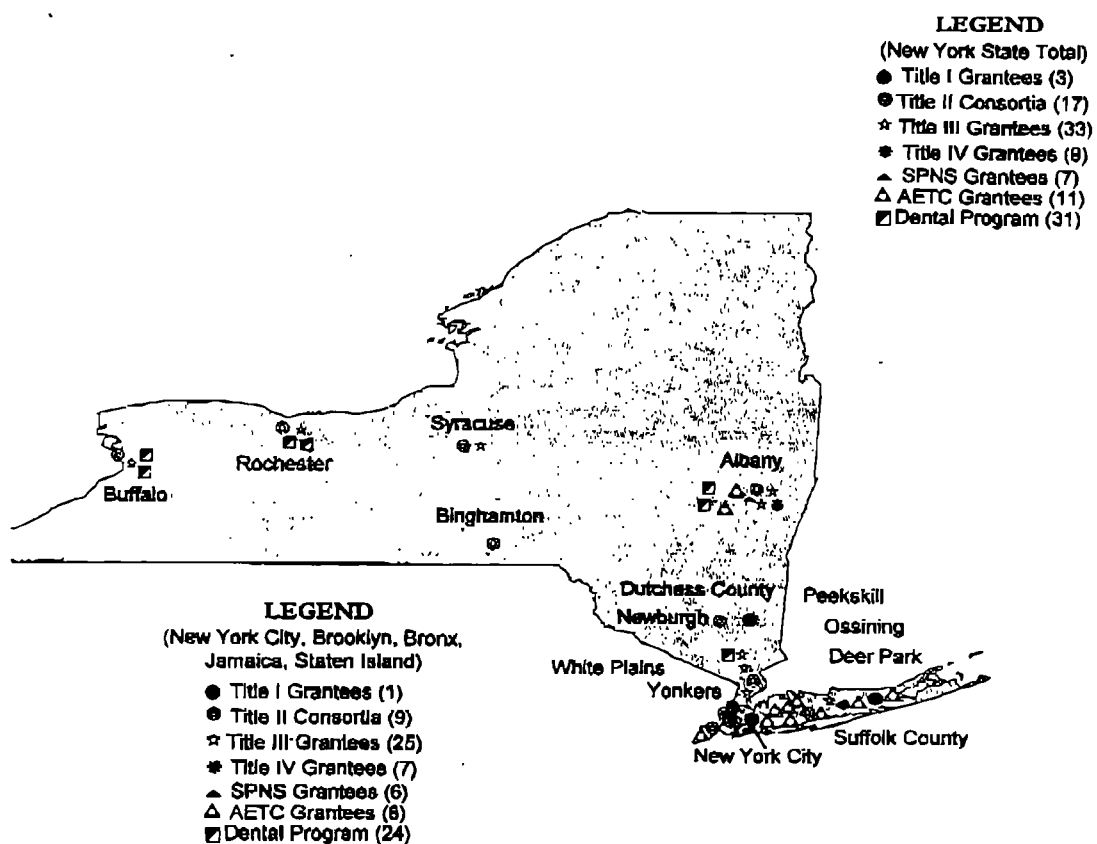
Funding History

Year	1996	1997	1998	Total
Total AETC Funding for State	\$78,429	\$58,428	\$78,527	\$215,384

Training Highlights from FY 1997

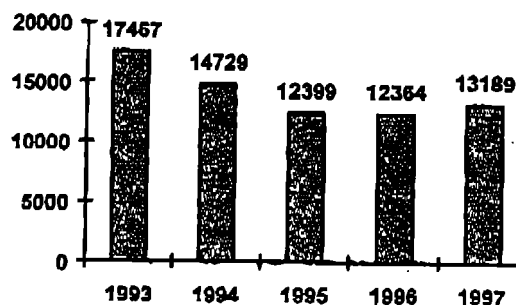
- The AETC conducted the following training: HIV Prevention, Early Intervention and Health Promotion for Rural Health Care Providers; Prevention of Perinatal Transmission of HIV; HIV/AIDS: Providing Care in the Age of HAART; Antiretroviral Resistance: Implications for Long Term Strategies; Managing Occupational Exposure to HIV in the Healthcare Setting; Pain Management in HIV Disease; and HIV in Prison Populations.
- The Colorado performance site co-sponsors the annual, two-day Rocky Mountain Regional Conference on HIV Disease and a one-day Prevention Institute (held in conjunction with the regional conference). The conference reaches between 500-700 providers and consumers.
- The AETC offers three medically focused and one dental-focused three-day clinical training programs in Denver. The programs attract providers from the entire eight-state region.
- Over 2,000 copies of an on-line and printed self-instruction module, "HIV Prevention, Early Intervention and Health Promotion: A Self-Study Module for Rural Health Care Providers" have been distributed. The AETC reports that providers have been completing the on-line module. CEUs and CMEs are offered.
- The AETC produced "HIV: A Sourcebook for the Primary Care Provider." The sourcebook has a core section and then is individualized to include resource information for each of the eight states served by the AETC.
- "AIDS Newslink," the Mountain Plains AETC newsletter, is sent to over 10,000 providers in the region three times a year. Past issues have addressed women's issues and adherence.

Location of FY 1998 CARE Act Grantees and Title II Consortia



HIV/AIDS Epidemic in the State: New York (Pop. 18,137,226)

- ▶ Persons reported to be living with AIDS through 1997: 42,100
- ▶ New AIDS Cases by Calendar Year, 1993-1997
- ▶ Persons reported to be living with HIV infection (not AIDS) through 1997:
- ▶ State reporting requirement for HIV:
No HIV reporting
- ▶ State AIDS Cases (cumulative) since 1993: 70,148 (18% of AIDS cases in the U.S.)



Demographics of AIDS Cases Reported in 1997

	State-Specific Data	National Data
Men (13 years and up):	74%	78%
Women (13 years and up):	26%	22%

	State-Specific Data	National Data
<13 years old :	1%	1%
13-19 years old :	1%	1%
20+ years old :	98%	98%

	State-Specific Data	National Data
White:	20%	33%
African American:	47%	45%
Hispanic:	31%	21%
Asian/Pacific Islander:	1%	<1%
Native American/Alaskan Native:	0%	<1%
Other, unknown or not reported:	1%	

	State-Specific Data	National Data
Men who have sex with men (MSM):	19%	35%
Injecting drug user (IDU):	33%	24%
Men who have sex with men and inject drugs (MSM/IDU):	2%	4%
Heterosexual contact:	11%	13%
Other, unknown or not reported:	35%	24%

Pediatric Cases, by exposure category

	State-Specific Data	National Data
Hemophilia/coagulation disorder:	0%	<1%
Mother with/at risk for HIV infection:	90%	91%
Receipt of blood transfusion, blood components, or tissue:	0%	<1%
Other, unknown or not reported:	10%	8%

Co Morbidities

	State Cases per 100,000 Population	U.S. Cases per 100,000 Population
Chlamydia (1996)	361.8	194.5
Gonorrhea (1996)	113.6	124.0
Syphilis (1996)	1.2	4.3
TB (1997)	12.5	7.4

Statewide Coordinated Statement of Need (SCSN)

- **Gaps:** ambulatory/outpatient care; housing; substance abuse and mental health services; case management; transportation; adoption/foster care; support groups; family-centered counseling; and food/nutrition services

State Medicaid Information

Medicaid Income Eligibility Requirements

Eligibility Category	Income
Adult Aged/Blind/Disabled*	75% FPL
Pregnant Women	185% FPL
Medically Needy	76% FPL

*Income eligibility for State's ADAP program is annual income below \$44,000.

Medicaid Prescription Drug Benefits Limits

Co-payment:	Yes
Limit on Rx per month:	No
Refill limit:	Yes
Quantity Limit:	No

Waivers

1115 waiver: Yes

Beneficiary groups: All Medicaid beneficiaries, except individuals receiving long-term care, the medically needy population, infants of incarcerated women, individuals expected to be eligible for less than six months, and individuals with access to private health insurance. Dual eligibles will initially be excluded from the demonstration, although during year two those enrolled in a Medicare risk plan may be allowed to voluntarily enroll in that plan for Medicaid services, with the state paying a capitated rate for the wrap-around services. The home relief population is also included.

1915(b) waiver(s): Yes

Title I: Dutchess County (Pop. 261,000)

► EMA: Dutchess County

AIDS Cases Reported in 1997

	EMA-Specific Data	State-Specific Data	National Data
Men (13 years and up):	85%	74%	78%
Women (13 years and up):	15%	26%	22%

	EMA-Specific Data	State-Specific Data	National Data
<20 years old:	2%	2%	2%
20+ years old:	98%	98%	98%

	EMA-Specific Data	State-Specific Data	National Data
White:	19%	20%	33%
African American:	49%	47%	45%
Hispanic:	33%	31%	21%
Asian/Pacific Islander:	0%	1%	<1%
Native American/Alaskan Native:	0%	0%	<1%
Other, unknown or not reported:	0%	1%	

	EMA-Specific Data	State-Specific Data	National Data
Men who have sex with men (MSM):	8%	19%	35%
Injecting drug user (IDU):	26%	33%	24%
Men who have sex with men and inject drugs (MSM/IDU):	0%	2%	4%
Heterosexual contact:	7%	11%	13%
Other, unknown or not reported:	59%	35%	24%

(Adults only)

Funding History

Fiscal Year	1996	1997	1998	Total
Formula	\$367,931	\$436,636	\$469,311	\$1,273,878
Supplemental	\$213,830	\$340,211	\$385,170	\$939,211
Total	\$581,761	\$776,847	\$854,481	\$2,213,089

Allocation of Funds

	1998
Health Care Services	\$204,234/24%
Medications	\$68,997/8%
Case Management	\$114,345/13%
Support Services	\$342,961/40%
Administration, Planning and Program Support	\$113,129/13%

Planning Activities

- ▶ Number of members on planning council: 22
- ▶ PLWH on planning council: 8 (36%)

Gender of Planning Council Members

Men:	64%
Women:	36%

Race/Ethnicity of Planning Council Members

White:	73%
African American:	23%
Hispanic:	5%
Asian/Pacific Islander:	0%
Native American/Alaska Native:	0%

(Note: Information taken from FY 1998 Applications. Current Planning Council composition may differ.)

Accomplishments

Clients Served (duplicated count), FY 1996:	370
Men:	51%
Women:	49%

<13 years old:	11%
13-19 years old:	5%
20+ years old:	84%

White:	49%
African American:	41%
Hispanic:	11%
Asian/Pacific Islander:	0%
Native American/Alaskan Native:	0%

Men who have sex with men (MSM):	9%
Injecting drug user (IDU):	50%
Men who have sex with men and inject drugs (MSM/IDU):	3%
Heretosexual contact:	36%
Other, unknown or not reported:	3%

► **Improved Patient Access**

- The overall census of clients who received Title I-funded primary health care services increased by more than 100% in 1997, from 40 clients in 1996 to 90 clients in 1997. Preliminary reports indicate that 110 clients were served in 1998.
- The grantee reported that 47% of those served in 1997 were African Americans with HIV disease, a proportion greater than the percentage of African Americans living within the EMA who have been reported to have AIDS.
- During FY 1997, the Hope Offers More Empowerment (HOME) Center located in the highest HIV incidence core geographic area within the EMA, provided outreach, case management and peer counseling services in addition to adult day care services, linking new clients to CARE Act-funded primary care, treatment and related services.

► **Improved Patient Outcomes**

- The grantee reported a decreasing rates of perinatal HIV transmission during FY 1997, which was attributed to CARE Act-funded initiatives to educate women of childbearing age with HIV disease about the benefits of ZDV prophylaxis.
- In addition, the client survey conducted in FY 1998 as part of the annual needs assessment process demonstrated that 72% of all respondents knew that ZDV prophylaxis reduces the risk of perinatal transmission, compared with 50% of respondents in FY 1997 and 14% in FY 1996.

► **Other Accomplishments**

- During 1997, the program coordinator and medical social worker positions were increased to full-time in order to improve access to care.

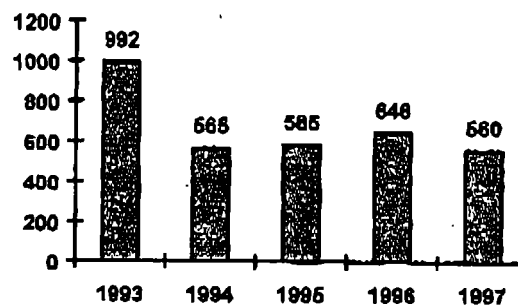
Title I: Nassau-Suffolk (Pop. 2,600,000)

▶ EMA: Nassau, Suffolk Counties

New AIDS Cases by Calendar Year, 1993-1997

▶ Estimated number of people living with AIDS at the end of 1997: 2,302

▶ AIDS Cases (cumulative) since 1993: 3,348
(5% of state cases, <1% of total U.S. cases)



AIDS Cases Reported in 1997

	EMA-Specific Data	State-Specific Data	National Data
Men (13 years and up):	74%	74%	78%
Women (13 years and up):	26%	26%	22%

	EMA-Specific Data	State-Specific Data	National Data
<20 years old:	0%	2%	2%
20+ years old:	100%	98%	98%

	EMA-Specific Data	State-Specific Data	National Data
White:	42%	20%	33%
African American:	45%	47%	45%
Hispanic:	13%	31%	21%
Asian/Pacific Islander:	1%	1%	<1%
Native American/Alaskan Native:	0%	0%	<1%

	EMA-Specific Data	State-Specific Data	National Data
Men who have sex with men (MSM):	26%	19%	35%
Injecting drug user (IDU):	34%	33%	24%
Men who have sex with men and inject drugs (MSM/IDU):	5%	2%	4%
Heterosexual contact:	13%	11%	13%
Other, unknown or not reported:	22%	35%	24%
(Adults only)			

Funding History

Fiscal Year	1996	1997	1998	Total
Formula	\$2,073,672	\$2,428,393	\$2,682,739	\$7,184,804
Supplemental	\$1,610,213	\$2,269,402	\$2,257,132	\$6,136,747
Total	\$3,683,885	\$4,697,795	\$4,939,871	\$13,321,551

Allocation of Funds

	1998
Health Care Services	\$1,839,959/37%
Medications	\$500,000/10%
Case Management	\$178,869/4%
Support Services	\$1,924,050/39%
Administration, Planning and Program Support	\$496,993/10%

Planning Activities

- ▶ Number of members on planning council: 34
- ▶ PLWH on planning council: 11 (32%)

Gender of Planning Council Members

Men:	56%
Women:	44%

Race/Ethnicity of Planning Council Members

White:	59%
African American:	32%
Hispanic:	9%
Asian/Pacific Islander:	0%
Native American/Alaska Native:	0%

(Note: Information taken from FY 1998 Applications. Current Planning Council composition may differ.)

Accomplishments

Clients Served (duplicated count), FY 1996:	3,160
Men:	51%
Women:	49%
<13 years old:	2%
13-19 years old:	1%
20+ years old:	97%
White:	41%
African American:	42%
Hispanic:	16%
Asian/Pacific Islander:	1%
Native American/Alaskan Native:	1%
Men who have sex with men (MSM):	13%
Injecting drug user (IDU):	30%
Men who have sex with men and inject drugs (MSM/IDU):	0%
Heterosexual contact:	43%
Other, unknown or not reported:	14%

► Improved Patient Access

- The grantee reports that the numbers of women, infants, and children served through the Title I-funded program have risen to 48% of the total unduplicated client count for the time period from April 1997 through February 1998. In comparison, the proportion of women of AIDS cases reported in 1997 was 26%.
- Two new substance abuse programs were established in high-need areas in the summer of 1997. One of these programs targets substance abusers that are also diagnosed with mental illness.

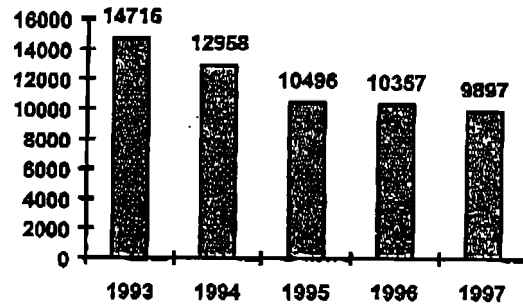
► Cost Savings

- The grantee reports that the numbers of women, infants, and children served through the Title I-funded program have risen to 48% of the total unduplicated client count for the time period from April 1997 through February 1998. In comparison, the proportion of women of AIDS cases reported in 1997 was 26%.
- Two new substance abuse programs were established in high-need areas in the summer of 1997. One of these programs targets substance abusers that are also diagnosed with mental illness.

Title I: New York City

- ▶ EMA: Bronx, Kings, New York, Putnam, Queens, Richmond, Rockland, Westchester Counties
- ▶ Estimated number of people living with AIDS at the end of 1997: 39,625
- ▶ AIDS Cases (cumulative) since 1993: 58,424 (83% of state cases, 15% of total U.S. cases)

New AIDS Cases by Calendar Year, 1993-1997



AIDS Cases Reported in 1997

	EMA-Specific Data	State-Specific Data	National Data
Men (13 years and up):	71%	74%	78%
Women (13 years and up):	29%	26%	22%

	EMA-Specific Data	State-Specific Data	National Data
<20 years old:	2%	2%	2%
20+ years old:	98%	98%	98%

	EMA-Specific Data	State-Specific Data	National Data
White:	17%	20%	33%
African American:	49%	47%	45%
Hispanic:	33%	31%	21%
Asian/Pacific Islander:	1%	1%	<1%
Native American/Alaskan Native:	0%	0%	<1%

	EMA-Specific Data	State-Specific Data	National Data
Men who have sex with men (MSM):	20%	19%	35%
Injecting drug user (IDU):	35%	33%	24%
Men who have sex with men and inject drugs (MSM/IDU):	1%	2%	4%
Heterosexual contact:	12%	11%	13%
Other, unknown or not reported:	32%	35%	24%

(Adults only)

Funding History

Fiscal Year	1996	1997	1998	Total
Formula	\$48,636,026	\$48,149,665	\$47,663,305	\$144,448,996
Supplemental	\$43,605,671	\$44,309,708	\$47,662,029	\$135,577,408
Total	\$92,241,697	\$92,459,373	\$95,325,334	\$280,026,404

Allocation of Funds

	1998
Health Care Services	\$44,199,441/46%
Medications	\$13,891,985/15%
Case Management	\$5,368,354/6%
Support Services	\$20,397,171/21%
Administration, Planning and Program Support	\$11,468,384/12%

Planning Activities

- ▶ Number of members on planning council: 45
- ▶ PLWH on planning council: 17 (38%)

Gender of Planning Council Members

Men:	53%
Women:	47%

Race/Ethnicity of Planning Council Members

White:	33%
African American:	29%
Hispanic:	27%
Asian/Pacific Islander:	9%
Native American/Alaska Native:	2%

(Note: Information taken from FY 1998 Applications. Current Planning Council composition may differ.)

Accomplishments

Clients Served (duplicated count), FY 1996:	101,510
Men:	57%
Women:	43%
Other, unknown or not reported:	1%
<13 years old:	5%
13-19 years old:	11%
20+ years old:	82%
Other, unknown or not reported:	1%
White:	15%
African American:	43%
Hispanic:	38%
Asian/Pacific Islander:	1%
Native American/Alaskan Native:	0%
Other, unknown or not reported:	3%
Men who have sex with men (MSM):	18%
Injecting drug user (IDU):	38%
Men who have sex with men and inject drugs (MSM/IDU):	2%
Heterosexual contact:	26%
Other, unknown or not reported:	16%

► Improved Patient Access

- Between 1995 and 1996 the number of office-based medical units increased by 20%, from 75,600 to over 91,000. Provider reports of new clients served in 1997 show that women, children, African Americans, and Hispanics are very well represented among Title I clients. Between April 1997 and February 1998, females comprised approximately 40% of all new clients; African Americans and Hispanics represented approximately 85% of new clients; and children and adolescents accounted for 9% of new Title I clients.
- The New York State Department of Health AIDS Institute reports that approximately 77% of all ADAP clients living in the EMA's eight counties are currently enrolled in regimens involving three or more antiretrovirals. The report showed that use of three or more antiretrovirals did not vary significantly by race/ethnicity, gender, income, or geographic residence.

► **Improved Patient Outcomes**

- The grantee reported that HIV-related deaths declined 63% between 1995 and 1997. The decline began in late 1995, just as the first protease inhibitors were approved and combination therapy became available. The primary care delivery system, developed by the Title I program, was able to respond by making state-of-the-art treatment available across all populations.

► **Other Accomplishments**

- The NYC Department of Health, HIV Training Institute developed curricula for specific categories of staff (including case managers, harm reduction staff, nutritionists, mental health staff, and others) so that Title I staff who have ongoing contact with clients understand their role in supporting adherence to therapy. Beginning in FY 1998, contracts with all Title I providers will require that they obtain treatment education for certain categories of non-clinical staff.
- Columbia University updated a questionnaire to continue the comprehensive prospective cohort study (underway since 1994) of a representative sample of 700 New Yorkers living with HIV to track their co morbidity, gauge their experiences with HIV primary care and services, and identify their unmet service needs. Outreach to replenish the sample of clients who were lost over time was conducted.

Title II: New York

Funding History

Fiscal Year	1996	1997	1998	Total
Title II Formula Grant	\$38,324,520	\$64,354,160	\$87,884,362	\$190,563,042
ADAP (included in Title II grant)	(\$9,009,360)	(\$29,381,796)	(\$51,291,513)	(\$89,682,669)
Minimum Required State Match	\$19,162,260	\$32,177,080	\$43,942,181	\$95,281,521

Allocation of Funds

	1998
Health Care (State Administered)	\$60,573,525/69%
Home and Community Care	(\$0)
Health Insurance Continuation	(\$0)
ADAP/Treatments	(\$60,573,525)
Direct Services	(\$0)
Case Management (State Administered)	\$0/0%
Consortia	\$14,094,742/16%
Health Care*	(\$6,713,373)
ADAP/Treatment	(\$0)
Case Management	(\$2,410,483)
Support Services**	(\$4,970,886)
Administration, Planning and Evaluation (Total State/Consortia)	\$12,916,095/15%

* includes: diagnostic testing, preventive care and screening, prescribing and managing medication therapy, continuing care and management of chronic conditions, and referral to specialty care.

** includes: counseling, direct emergency financial assistance, companion/buddy services, day and respite care, housing assistance, and food services.

Consortia Activities, FY 1997

Number of consortia in State: 17

Consortium Name	Location	Service Area	Title II Funding, FY 1997
Bedford-Stuyvesant/Crown Heights HIV Care Network	Brooklyn	Bedford-Stuyvesant/Crown Heights neighborhood of Brooklyn	\$2,879,982
Buffalo Region Care Network	Buffalo	Erie, Niagara, Orleans, Genesee, Wyoming, Chautauqua, Cattaraugus, and Allegany Counties	\$2,627,948
Central Harlem HIV Care Network	New York	Central Harlem neighborhood of Manhattan	\$2,108,014
East Harlem HIV Care Network	New York	East Harlem neighborhood of Manhattan	\$1,233,678
East New York-Brownsville HIV Care Network	Brooklyn	East New York neighborhood of Brooklyn	\$1,116,775
HIV Care Network of Northeastern NY	Albany	Franklin, Clinton, Essex, Hamilton, Warren, Fulton, Saratoga, Washington, Montgomery, Schenectady, Rensselaer, Albany, Schoharie, Otsego, Delaware, Greene and Columbia Counties	\$2,837,543
Jamaica/Queens HIV Care Network	Jamaica	Jamaica/Southeast Queens	\$1,902,733
Lower Hudson Region HIV Care Network	White Plains	Westchester, Putnam and Rockland Counties	\$3,490,412
Mid-Hudson Region HIV Care Network	Newburgh	Franklin, Clinton, Essex, Hamilton, Warren, Fulton, Saratoga, Washington, Montgomery, Schenectady, Rensselaer, Albany, Schoharie, Otsego, Delaware, Greene and Columbia Counties	\$2,526,125
Nassau-Suffolk HIV Care Network	Deer Park	Nassau and Suffolk Counties	\$5,560,102
New York-Penn Region HIV Care Network	Binghamton	Tioga, Broome and Chenango Counties	\$656,566
Rochester HIV CARE Network	Rochester	Monroe, Wayne, Livingston, Ontario, Yates, Seneca, Steuben, Schuyler, and Chemung Counties	\$3,091,461
South Bronx HIV Care Network	Bronx	Bronx	\$3,617,619
Staten Island HIV Care Network	Staten Island	Staten Island	\$1,126,427
Statewide AIDS Services Delivery Consortium	New York	Statewide	\$25,467,127
Syracuse HIV Care Network	Syracuse	St. Lawrence, Jefferson, Lewis, Herkimer, Oswego, Oneida, Cayuga, Onondaga, Madison, Cortland, and Tompkins Counties	\$1,757,181
Williamsburg/Greenpoint/Bushwick HIV Care Network	Brooklyn	Williamsburg/Greenpoint/Bushwick neighborhood of Brooklyn	\$1,333,767

Accomplishments

Clients Served (duplicated count), FY 1996:	70,950
Men:	68%
Women:	32%

<13 years old:	2%
13-19 years old:	5%
20+ years old:	92%
Other, unknown or not reported:	1%

White:	26%
African American:	42%
Hispanic:	29%
Asian/Pacific Islander:	1%
Native American/Alaskan Native:	26%
Other, unknown or not reported:	1%

Men who have sex with men (MSM):	21%
Injecting drug user (IDU):	32%
Men who have sex with men and inject drugs (MSM/IDU):	2%
Heterosexual contact:	31%
Other, unknown or not reported:	14%

► Improved Patient Access

- The grantee reported a large increase in 1997 in the amount of substance abuse treatment services provided, from 30,565 treatment visits in 1996 to 80,099 treatment visits in 1997, an increase of 140%.
- The grantee also reported a 27% increase in mental health services for the same period, from 36,899 visits in 1996 to 47,151 visits in 1997.
- New Medications have been added to the ADAP formulary, for a total of more than 225 drugs.
- The percentage of new enrollees in ADAP who are women has increased steadily and reached 28% in 1998.
- The percentage of African American enrollees in ADAP has increased significantly to more than 40%.

- The proportion of ADAP participants on three or more antiretroviral drugs has increased to 75% in the third quarter of 1998, and there is little variation in utilization rates among demographic cohorts, including race/ethnicity, gender, risk and geographic region.
- The State and Title I EMAs jointly support HIV service programs, including the HIV care programs for the uninsured (ADAP, ADAP Plus/Primary Care, and Home Care) and the Primary Care Development Initiative, through which access to HIV primary care services has been extended to populations in underserved areas of high seroprevalence.
- New York State has combined Title II funds with funds from other sources to implement HIV service programs designed for traditionally underserved and hard-to-reach populations, including the uninsured, racial/ethnic minorities, substance users, men of color who have sex with other men, women, children, adolescents, prisoners/prison releasees, the homeless, immigrants and migrants.

► **Cost Savings**

- Voluntary manufacturers' rebates were negotiated, averaging 15% of the manufacturer's average price for drugs that account for 92% of all filled prescriptions. The State projects estimated savings of \$12.8 million in 1998.
- New York implemented a new ADAP policy that requires entities purchasing at PHS prices to bill ADAP at acquisition cost, resulting in savings of \$600,000 annually.
- The ADAP electronic point of service (POS) claims processing system has numerous edit checks and is fully integrated with both provider and participant enrollment data systems; it is very effective and efficient in preventing waste, fraud, abuse, or duplication.

► **Other Accomplishments**

- An Advisory Council to the Title II-supported HIV Uninsured Care Programs, (ADAP, ADAP-Plus, and HIV Home CARE) is used to provide recommendations and advise the grantee on the development of new service areas and resolution of ongoing policy issues. The Council has a steering committee comprising representatives of Title I planning councils, local and State government, health care providers, agencies and associations, the infected/affected population, and representatives from the clinical subcommittee. The clinical subcommittee includes PLWH, physicians, pharmacists, and nurse specialists who actively treat individuals with HIV/AIDS. In 1997, nine of the 27 members of the steering committee and five of the 30 members of the clinical subcommittee were persons who have self-identified as living with HIV/AIDS. Both committees meet about four times a year.
- ADAP, ADAP-Plus (primary care) and Title II home care program provide a coordinated system of HIV care/treatment for uninsured and underinsured low-income persons and use a single application.
- The ADAP coordinates closely with Medicaid, checking biweekly for Medicaid eligibility and ensuring that case managers and service providers assist and monitor client applications to Medicaid.

- New York has used Title II funds to support planning and development activities associated with the implementation of managed care for persons with HIV, including planning related to the implementation of HIV Special Needs Plans (SNPs), client and provider education, and the assessment of quality issues as persons with HIV transition from fee-for-service into managed care.
- New York State and New York City jointly support the treatment adherence initiative through which innovative service delivery models are being implemented throughout the State to promote and support treatment adherence for individuals on combination therapy. The programs target those consumers at greatest risk of non-adherence.
- New York State has implemented a Quality of Care Program, through which the quality of services delivered to persons with HIV is evaluated. The program consists of several components, including the development of clinical practice guidelines, the translation of guidelines into clinical indicators for measurement, on-site quality of care reviews based on continuous quality improvement (CQI), a consultation service for providers to facilitate the development of on-site quality improvement efforts (this consultation service is a joint effort with New York City Title I), and the development of HIVQUAL, a software program for use in CQI (the development of HIVQUAL is supported through SPNS).

AIDS Drug Assistance Program (ADAP): New York

Funding History

Fiscal Year	1996	1997	1998	Total
Title II Funds	\$18,930,578	\$39,343,702	\$61,314,734	\$119,589,014
State Funds	\$8,400,000	\$5,221,000	\$11,400,000	\$25,021,000
Other: Title I	\$19,858,730	\$21,316,695	\$18,723,089	\$59,898,514
Total	\$47,189,308	\$65,881,397	\$91,437,823	\$204,508,528

(Note: Insurance and rebates are also a significant source of income for the program, \$19 million in 1998.)

Program

- ▶ Administrative Agency: Dept. of Health
- ▶ Formulary: 214 drugs, 4 protease inhibitors, 8 other antiretroviral drugs.
- ▶ Medical Eligibility
 - ▶ HIV Infected: Yes
 - ▶ CD4 Count: No
- ▶ Financial Eligibility
 - ▶ Asset Limit: Yes
 - ▶ Annual Income Cap: Yes
- ▶ Co-payment: No
- ▶ PLWH involvement in advisory capacity: The Advisory Council to the HIV Uninsured Care Programs advises the program on new service areas and policy issues. In 1997, nine of the 27 members of the steering committee were PLWH and five of the 30 of the clinical subcommittee members.
- ▶ Enrollment cap: No
- ▶ Waiting list as of 10/98: No
- ▶ Waiting list for protease inhibitors as of 10/98: No

Clients Served

Clients enrolled, 10/98:	17,000
Number using ADAP each month:	9,726
Percent of clients on protease inhibitors:	81%
Percent of active clients below 200% FPL:	69%

Client Profile, FY 1996

Men:	79%
Women:	21%

<13 years old:	1%
13-19 years old:	0%
20+ years old:	100%

White:	35%
African American:	33%
Hispanic:	30%
Asian/Pacific Islander:	1%
Native American/Alaskan Native:	0%

Title III: New York

Funding History

Fiscal Year	1996	1997	1998	Total
Number of Programs Funded in State	31	32	33	
Total Title III Funding in State	\$11,033,443	\$12,660,451	\$12,799,351	\$36,493,245

Clients Served in FY 1996 by Title III Grantees in State

(Based on programmatic information from 27 grantees in State)

- ▶ Total number of people provided HIV pre-test counseling and testing services by State's Title III-funded programs: 35,104
- ▶ Total number of people provided primary health care services by State's Title III-funded programs: 13,963
- ▶ Number of new HIV-infected patients enrolled in State's Title III-funded early intervention programs in the past year: 4,089
- ▶ New clients (adults only) in State's Title III-funded early intervention programs presenting with CD4:
 - ▶ under 200: 32%
 - ▶ from 200 to 499: 29%
 - ▶ above 500: 21%
 - ▶ unknown: 18%

Accomplishments

Clients served (primary care only), 1996:	13,963
Men:	64%
Women:	36%
<13 years old:	4%
13-19 years old:	1%
20+ years old:	96%
White:	21%
African American:	40%
Hispanic:	38%
Asian/Pacific Islander:	1%
Native American/Alaskan Native:	0%

Men who have sex with men (MSM):	19%
Injecting drug user (IDU):	32%
Men who have sex with men and inject drugs (MSM/IDU):	2%
Hemophilia/coagulation disorder:	0%
Heterosexual contact:	35%
Receipt of blood transfusion, blood components, or tissue:	1%
Other, unknown or not reported:	11%

► **Improved Patient Access**

- The Bronx Community Health Network has provided HIV primary care to over 1,000 clients in community health center settings in the Bronx.
- Through Title III funding, the Mid Hudson Care Center of the Albany Medical Center has expanded hours of operation, increased the number of annual clinic visits, and provided more integrated quality HIV care.
- Since 1995, the number of individuals accessing HIV counseling and testing services through the Elmhurst Hospital Center AIDS Program has increased by almost 500%. The HIV counseling and testing program identifies approximately 45% of all new clients and links them to care.
- Through Title III funds, the Ossining Open Door Family Medical Group expanded early intervention services to two new sites in Westchester County. As a result, the number of clients has increased by 20%, and the grantee noted a 40% increase in HIV counseling and testing services. Additionally, the grantee has developed service delivery systems sensitive to the large Hispanic population that is served.
- Of the 512 active clients of the William F. Ryan Community Health Center, 38% are women. The grantee provides a full array of women's health services on-site, including prenatal HIV counseling and testing, OB/GYN care, hysteroscopy, and sonogram.
- Through a unique program known as the Air Bridge Network, care is coordinated for people traveling between Puerto Rico and cities in the United States. As the lead agency, the William F. Ryan Community Health Center served 143 people in 1998. The Network as a whole, of which five are Title III grantees, served a total of 301 individuals.
- In 1997, Care for the Homeless provided services at 26 sites, including family residences, shelters, drop-in shelters, and soup kitchens. The grantee provided more than 1,000 primary care encounters and 850 psychosocial services to HIV-infected homeless persons in 1996. Care for the Homeless offers the only New York Citywide on-site delivery of primary health care and social services to homeless men, women, and children.
- The Erie County Medical Center, located in Buffalo, provides extensive support services for women and children, such as childcare, assistance with baby products, and case management services provided by staff trained in women's issues.

► **Improved Patient Outcomes**

- In a recent review of Bronx Community Health Network medical charts, 96% of eligible clients were receiving prophylaxis against *Pneumocystis carinii* pneumonia and over 80% of eligible clients were receiving antiretroviral therapy.
- Due to effective management of HIV disease, the Albany Medical Center has noted changes in clinical outcomes of its clients. The total number of hospital bed days has decreased by nearly 44%, and the average length of stay has decreased from 14 days to 8 days over the last three years. For clients on combination therapy, 40% have experienced a reduction in detectable viral loads and the incidence of opportunistic infections has been significantly reduced.
- Of 112 new clients entering the Elmhurst Hospital Center in 1996 receiving antiretroviral therapy, 61% had a significant rise of CD4 counts between 1996 and 1998.
- In 1997, the Montefiore Medical Center served 1,378 clients, including 483 new clients. Upon review of clinical lab data on 946 adult clients served, 88% either improved or sustained their CD4 status. The results are attributed to combination therapies that the majority of clients received.
- The total number of hospital admissions for clients enrolled in the Rochester Primary Care Network HIV Program decreased from 165 admissions in 1995 to 117 in 1997. The average length of hospital stay was also reduced from 9.6 to 7.3 days. AIDS-related deaths decreased from 47 in 1996 to 25 in 1997. The grantee noted increases in CD4 counts and decreases in viral loads as a result of combination therapy.
- All women are routinely offered HIV counseling and testing through the Erie County Medical Center. Since the ZDV protocol was initiated, no HIV-infected children have been born to women enrolled in the program.
- The total number of hospital admissions for clients of the Erie County Medical Center has decreased from 735 in 1995 to 213 in August 1997. The average length of stay also decreased from 9.9 to 8.5 days in the same time period.

► **Cost Savings**

- As a result of significant reductions in the numbers of hospital admissions, total hospital bed days and length of stay, the Albany Medical Center's early intervention program has realized substantial cost savings. The total savings from acute care in 1998 are estimated to be between \$1.8 and \$2 million. While additional expenses are incurred for primary care services, such as viral load testing and medications, the net effect has resulted in savings of approximately \$1.3 million per year.

Title III Grantees, FY 1998

Grantee Name	Location	Service Area	Type of Organization
Albany Medical College AIDS Program	Albany	Ulster, Dutchess, Orange, and Sullivan Counties	Hospital/University-based Medical Center
Betances Health Unit	New York	Southern region of New York County, Kings and Bronx Counties	Non-329/330/340 Health Center
Boriken Neighborhood Health Center	New York	New York City, Queens, Brooklyn, and the Bronx with the focus on East Harlem	Community and Migrant (329/330) Health Center
Bronx Community Health Network	Bronx	Bronx	Non-329/330/340 Health Center
Bronx Lebanon Hospital	Bronx	South Bronx	Hospital/University-based Medical Center
Brooklyn Hospital Center	Brooklyn	Kings County	Hospital/University-based Medical Center
Brooklyn Plaza Medical Ctr./Rising Heights Program	Brooklyn	Kings County	Community and Migrant (329/330) Health Center
Care for the Homeless	New York	New York, Kings, Bronx, and Queens Counties	Homeless Clinic
Community Healthcare Network	New York	Kings, Queens	Family Planning Clinic
Cumberland Neighborhood Family Care	Brooklyn	Kings County	Non-329/330/340 Health Center
Elmhurst Hospital Center	Elmhurst	Queens County	Hospital/University-based Medical Center
Erle County Medical Center	Buffalo	8 Counties	Non-329/330/340 Health Center
Joseph P. Addabbo Family Health Center	Far Rockaway	Queens County	Community and Migrant (329/330) Health Center
Lutheran Med. Ctr./Sunset Park Family Health Ctr.	Brooklyn	New York City	Community and Migrant (329/330) Health Center
Montefiore Medical Center/AIDS Ambulatory	Bronx	Primarily Bronx City	Hospital/University-based Medical Center
Morris Heights Health Center	Bronx	Bronx	Community and Migrant (329/330) Health Center
N.Y.U. Medical Center	New York	Staten Island, Manhattan	Hospital/University-based Medical Center

Grantee Name	Location	Service Area	Type of Organization
NARCO Freedom Neighborhood	Bronx	Bronx, South Bronx, Mott Haven	Non-329/330/340 Health Center
Ossining Open Door Health Center	Ossining	Westchester and Putnam Counties	Community and Migrant (329/330) Health Center
Peekskill Area Health Center	Peekskill	Westchester and Dutchess Counties	Community and Migrant (329/330) Health Center
Renaissance Health Care Network	New York	Manhattan, Brooklyn, Queens, Bronx, Staten Island	Health Department
Rochester Primary Care Network	Rochester	Monroe County	Community and Migrant (329/330) Health Center
S.T.A.R. Clinic/Health Science Center at Brooklyn	Brooklyn	Kings County	Hospital/University-based Medical Center
Settlement Health and Medical Services	New York		Community and Migrant (329/330) Health Center
St. Clare's Hospital/The Spellman Center	New York	Manhattan, Bronx, Brooklyn, Queens	Hospital/University-based Medical Center
St. Luke's - Roosevelt Hospital	New York	New York, Bronx, Kings, Queens, and Richmond Counties	Hospital/University-based Medical Center
St. Vincent's Hospital and Medical Center	New York	New York and Kings Counties	Hospital/University-based Medical Center
Suffolk Co. Department of Health Services	Hauppauge	Suffolk County, Amityville	Health Department
Syracuse Community Health Center	Syracuse	Onondago County	Community and Migrant (329/330) Health Center
Valentine Lane Family Practice	Yonkers	Westchester and Bronx Counties.	Non-329/330/340 Health Center
Whitney M. Young, Jr. Health Center	Albany		Community and Migrant (329/330) Health Center
William F. Ryan Community Health Center	New York	Manhattan	Community and Migrant (329/330) Health Center

Planning Grants

1998 - Rushville Health Center Inc - Rushville

Title IV: New York

Funding History

Fiscal Year	1996	1997	1998	Total
Number of Funded Programs	10	10	9	
Total Title IV Funding in State	\$7,646,589	\$9,251,265	\$7,588,359	\$24,486,213

HIV-infected and Affected Clients Served in 1996 by Title IV Grantees in State

Pregnant adolescents and women:	19%
Women with children:	18%
Adolescents/young adults:	11%
Children:	20%
Infants:	8%
Clients with AIDS/HIV Infection:	27%

Accomplishments

All clients served, 1996:	11,938
Men:	26%
Women:	74%
(Adolescents and adults only)	

<13 years old:	29%
13-19 years old:	11%
20+ years old:	60%

White:	5%
African American:	30%
Hispanic:	51%
Asian/Pacific Islander:	4%
Native American/Alaskan Native:	0%
Other, unknown or not reported:	9%

Men who have sex with men (MSM):	3%
Injecting drug user (IDU):	16%
Men who have sex with men and inject drugs (MSM/IDU):	1%
Hemophilia/coagulation disorder:	0%
Heterosexual contact, non IDU:	30%
Receipt of blood transfusion, blood components, or tissue:	0%
Pediatric Exposure:	24%
Other, unknown or not reported:	25%

► **Improved Patient Access**

- The eight Title IV grantees in New York State served more than 8,500 clients in 1997.
- In 1996, New York University's network of providers served 1,658 clients, of which 55% were new to care. Approximately 70% of HIV-infected children receiving care were enrolled in clinical trials in 1997.
- More than 90% of the consumers served by the Family Center and Dominican Sisters Family Health Service were either Hispanic or African American.
- The Bronx Pediatric and Adolescent AIDS Consortium of the Albert Einstein College of Medicine facilitated access to care through a variety of mechanisms: 1) expanding the total number of clinic sessions, 2) expanding services to include obstetric/gynecologic services in sites that previously did not offer this service, 3) co-locating services, and 4) expanding service hours.
- The Queens Health Network, consisting of Elmhurst and Queens Hospital Centers, screens between 450 and 500 newborns each month for HIV infection.
- Since 1987, Brooklyn Pediatric AIDS Network (BPAN) of SUNY's Pediatric AIDS Clinical Trials Group site offered over 20 clinical trials and other research to the client population and cumulatively enrolled over 300 participants in NIH-sponsored protocols. BPAN also supported the enrollment of over 270 women in the Women Infants Transmission Study.
- BPAN provided technical assistance to the Catholic Medical Center of Brooklyn and Queens and St. Vincent's Foster Care program. The technical assistance resulted in the establishment of a perinatal/pediatric HIV program at the Catholic Medical Center and the development of a free-standing clinic, which provides basic primary care and HIV management to the growing number of HIV-infected children in foster care, at St. Vincent's. BPAN also expanded its clinical care staff to support two part-time pediatricians in two network hospitals to implement HIV services in communities where none existed.
- In 1997, BPAN created a Mental Health Service division for families, children, and adolescents. Annually, this service will provide 280 comprehensive developmental evaluations to HIV-infected infants and children, serve 300 infected and affected caregivers, and provide psychological testing and therapy referrals to 10 to 15 adolescents.

- Dominican Sisters Family Health Service facilitated increased access to care by including an HIV-risk assessment in the walk-in program that serves as a social service emergency room for issues ranging from food and shelter to substance use and domestic violence.

► **Improved Patient Outcomes**

- Columbia University's Northern Manhattan network of providers consistently reports high acceptance rates of HIV counseling and testing for pregnant women. Several agencies report acceptance rates of more than 90%.
- Rates of perinatal HIV transmission have decreased across the majority of the New York Title IV programs. The rate of perinatal HIV transmission for Columbia University's Northern Manhattan network of providers ranges from less than 5% to 11%, representing a significant decrease from percentages reported in previous years. At the Children's Medical Center of Stony Brook, 15 HIV-exposed children were born to women who received prenatal care from the Stony Brook Obstetrical Department from January 1997 to October 1998. Of those, none of the infants have been infected with HIV. In 1997, all children born to HIV-infected pregnant women served by the Dominican Sisters Family Health Service tested negative for the virus.
- Over the last three years, the Lincoln Medical and Mental Health Center, an affiliate of Albert Einstein College of Medicine's Bronx Pediatric AIDS Consortium, improved the post-test counseling rates from 50% to 90%.
- In 1995, the return rate for HIV post-test counseling for adolescents seen through the Montefiore Adolescent Program was 60%. This number increased to 85% in 1998. The grantee attributes the increase to the development of youth-tested program brochures, reduction in wait time for results from two weeks to one week, and expansion of referral relationships with youth-serving agencies. The grantee directly attributes more than 25% of the HIV counseling and testing sessions to a social marketing campaign.
- Coordinated care between the pediatric clinical trials team and the HIV clinic care teams resulted in close to 100% retention of clients in clinical trials at all of the pediatric affiliates of Columbia University's Northern Manhattan Women and Children HIV Project.

► **Cost Savings**

- Columbia University's Northern Manhattan Title IV project is exploring ways of sharing resources that are not cost-effective for single agencies to provide. Specific services include regional transportation services, child life therapy, legal services, and childcare services.

Title IV Grantees, FY 1998

Grantee Name	Location	Service Area	Type of Organization
Albany Medical College	Albany		
Albert Einstein College of Medicine	Bronx	New York City and Westchester County	University/College
Columbia School of Public Health	New York	Northern Manhattan, New York City	University/College
Dominican Sisters Family Health Services	Bronx	Mott Haven in South Bronx, Bronx, New York, Queens	Home Healthcare Agency
Elmhurst Hospital Center	Elmhurst	Queens	Hospital
New York University Medical Center	New York	Staten Island, Lower Manhattan	Hospital
Research Foundation at SUNY, Brooklyn	Brooklyn	4 communities in Brooklyn	University-based Hospital
SUNY at Stoney Brook, Children's Medical Center	Stoney Brook	Suffolk County	Academic Medical Center
The Family Center	New York	New York City	Community-based Agency

Special Programs of National Significance (SPNS): New York

Funding History

Fiscal Year	1996	1997	1998	Total
Number of programs funded	7	7	7	
Total SPNS Funding in State	\$3,248,467	\$4,040,845	\$4,292,310	\$11,581,622

Project Descriptions

► Asian and Pacific Islander Coalition on HIV/AIDS

Location: New York

Project period: 10/96 - 9/01

Population Served: HIV-infected Asian/Pacific Islanders

Description of Services: Asians and Pacific Islanders (APIs) make up the fastest growing racial group in New York City. Despite their growing presence, this population has difficulty accessing HIV-related services that are culturally competent, language-appropriate, and HIV-sensitive. The BRIDGES Project seeks to remove access barriers by integrating HIV medical and social services through a system of formal linkages with comprehensive service sites, including hospitals, homeless projects, gay and lesbian community centers, and programs serving injection drug users. A Referral Services Network has also been established using bilingual providers. Training for providers in the network is being used to increase cultural competence, and bilingual peer advocates are assigned to provide language translation for APIs who speak little or no English.

Project Highlights

- APICHA has revised agreements with its six linkage sites, developed a pilot training curriculum, and recruited and trained 16 bilingual peer advocates. Training was provided to 42 staff members, including physicians, nurses, and other health care professionals.
- Bilingual peer advocates provided services to 29 HIV-positive clients to overcome language barriers and allow patients to access care. Seventy-seven HIV-positive clients were successfully enrolled in the BRIDGES Project and received comprehensive case-management services.
- Representatives from the project attended a conference in San Diego entitled, "Strengthening HIV Prevention Practice and Research Among Asians & Pacific Islanders at Risk" where the project was highlighted.
- The project opened a satellite office in Queens, New York, which facilitates further training, outreach, intake, and advocacy activities. The site includes a client recreational room.

► Columbia University**Location:** New York**Project period:** 10/96 - 9/01**Population Served:** SPNS grantees

Description of Services: Columbia University serves as the Evaluation and Technical Assistance Center (ETAC) for the Partnership Steering Committee (PSC) and provides cross-cutting multi-site evaluations of PSC grant projects. The center designs and supports systems for collecting and evaluating grantee data; helps PSC grantees develop their own evaluation capacities; provides leadership in developing collaborative evaluation strategies for innovative service delivery models; conducts evaluation analyses; and disseminates the results of multi-site evaluations. The center serves as a crucial component of the SPNS pilot-project system as it collaborates with sites and evaluates programs to determine progress and capacity for replication.

Project Highlights

- The ETAC completed the development of multi-site data elements for PSC grantees. It provided oversight to grantee projects in the development of data-submission code books and established the multi-site database, including data-management and quality-assurance systems. The center also provided extensive technical assistance to PSC grantees in the collection and evaluation of data on both a periodic and ad-hoc basis.
- ETAC conducted four workshops to train grantees in data collection and quality-assurance techniques, and ETAC received and reviewed data sets from approximately 10 grantees.
- The center also provided orientation for new grantees regarding the multi-site system and helped them develop individual evaluation plans.
- The center established a multi-site publications policy and developed concept papers for multi-site studies.

► Fortune Society, Ethics 3 Program**Location:** New York**Project period:** 10/96 - 9/01**Population Served:** Prisoners, ex-offenders and their families

Description of Services: The Ethics 3 project is developing a model to engage and retain HIV-positive ex-offenders and their families in primary and HIV-specific ambulatory medical care. An innovative, holistic, and family-focused model uses discharge planning and intensive case management along with personalized medical care, during the transition from incarceration to reentry into the community. Ethics 3 responds to the special needs that make this target population difficult to serve under traditional medical systems, resulting in episodic or discontinued involvement in care. It uses staff who are ex-offenders and in recovery themselves. It works with clients to help them stabilize their lives, addressing issues such as homelessness, substance abuse, mental illness, risk of relapse, transition from incarceration, and isolation.

Project Highlights

- Ethics 3 developed working linkages and collaborative agreements with community providers to heighten their awareness of client needs, while helping ex-offenders make the transition into the community.
- The project formed case management teams with the expertise and capacity to work with clients on discharge planning, personalized medical care, and many other co-factors, such as homelessness, substance abuse and mental illness.
- In the course of developing a holistic model, the project has provided case management, medical and support service referrals and other assistance to 89 HIV-infected clients and their families to help them overcome obstacles and engage in treatment.

► Fortune Society, Latino Discharge Program

Location: New York

Project period: 10/94 - 9/99

Population Served: HIV-infected prisoners and releasees

Description of Services: The Fortune Society's Empowerment Through HIV Information, Community and Services (ETHICS) project targets Latino HIV-positive ex-offenders who face severe barriers in accessing mainstream HIV/AIDS services upon release from prison. This population is also likely to experience feelings of isolation, depression, and powerlessness. Most lack the skills to navigate fragmented service delivery systems and are at risk for resuming previous behaviors such as substance abuse, unprotected sex, prostitution, or criminal activity. The ETHICS project responds to their needs, first, by providing culturally and linguistically appropriate discharge planning services while prisoners are still incarcerated, and second, by offering intensive case management and referral services after release. In addition to meeting clients' most urgent needs for food, shelter, clothing, and medical care, the project helps promote wellness and the pursuit of life-changing goals.

Project Highlights

- In recognition of the cultural and linguistic barriers to care faced by Latino/HIV-positive ex-offenders, the project has enlisted staff who are themselves ex-offenders and in recovery. Culturally sensitive staff are well equipped to empower clients and advocate on their behalf.
- The project has developed an effective case management model to coordinate client access to medical evaluation and care, safe and suitable short-term housing, clothing, and nutritious meals. The project has also incorporated within this model various life-affirming pursuits such as social and fitness activities, support groups, peer education, and the celebration of successes and achievements.
- The project has enrolled more than 200 HIV-positive ex-offenders and provided them with intensive case management services, including post-release counseling, entitlements, relapse prevention, and medical and social service referrals.

► Montefiore Medical Center**Location:** Bronx**Project period:** 10/96 - 9/01**Population Served:** Minorities, including non-English speaking

Description of Services: The Montefiore project targets African Americans and other ethnic and language minorities, including non-English-speaking or illiterate Latinos, to provide non-stigmatizing, culturally appropriate HIV/AIDS care. Medical, psychosocial and mental health services are specifically tailored to this population, using an integrated health care team approach. The Montefiore project conducts continuous in-service training for its team of providers, focusing on cultural competence and improvements in provider knowledge and attitudes toward different cultures. The team provides holistic, rather than compartmentalized, care and one-stop shopping. Services also include such non-traditional activities as patient self-care training, workshops on parent training and primary prevention, family field trips and psychotherapy/psychiatric care to address patient needs.

Project Highlights

- The project introduced a one-stop shopping system of health care into an underserved area, helping racial, ethnic, and linguistic minorities access culturally competent medical care and support services.
- Through continuous in-service training, the project has significantly improved providers' cultural sensitivity and ability to reach and treat minority persons with HIV/AIDS.
- The Montefiore project pioneered a well-being component to care, including a self-care training program for clients, and education in at-risk behavior and prevention.
- The pilot effort reached over 170 individuals, and 95 HIV-positive persons enrolled in the care program.
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