

112TH CONGRESS
2D SESSION

H. R. 6138

To bring an end to the spread of HIV/AIDS in the United States and
around the world.

IN THE HOUSE OF REPRESENTATIVES

JULY 18, 2012

Ms. LEE of California (for herself, Mr. MORAN, Ms. CLARKE of New York, Ms. SCHAKOWSKY, Ms. NORTON, Mr. SCHIFF, Ms. WOOLSEY, Mr. TOWNS, Mr. NADLER, Mr. CONYERS, Mr. RANGEL, Mr. HINCHEY, Mr. SERRANO, Mr. JOHNSON of Georgia, Mr. HONDA, Ms. MCCOLLUM, Mr. ENGEL, Mr. HIMES, Mr. McDERMOTT, Ms. CHU, Mr. LEWIS of Georgia, Ms. BASS of California, Mrs. CHRISTENSEN, Ms. LINDA T. SÁNCHEZ of California, Ms. WATERS, Mr. RUSH, and Mr. GRIJALVA) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Foreign Affairs, Education and the Workforce, the Judiciary, Armed Services, Financial Services, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To bring an end to the spread of HIV/AIDS in the United
States and around the world.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Ending the HIV/AIDS
5 Epidemic Act of 2012”.

1 **SEC. 2. TABLE OF CONTENTS.**

2 The table of contents of this Act is as follows:

- Sec. 1. Short title.
- Sec. 2. Table of contents.
- Sec. 3. Statement of policy.
- Sec. 4. Findings.
- Sec. 5. Nondiscrimination.

DIVISION A—ENDING HIV/AIDS IN THE UNITED STATES

TITLE I—INCREASING AND TARGETING INVESTMENT TO MAXIMIZE PREVENTION AND TREATMENT IMPACT

- Sec. 101. Additional funding for AIDS Drug Assistance Program treatments.
- Sec. 102. Enhancing the national HIV surveillance system.
- Sec. 103. Evidence-based strategies for improving linkage to and retention in appropriate care.
- Sec. 104. Improving entry into and retention in care and antiretroviral adherence for persons with HIV.
- Sec. 105. Health care professionals treating individuals with HIV/AIDS.
- Sec. 106. HIV/AIDS provider loan repayment program.
- Sec. 107. Reducing new HIV infections among injecting drug users.
- Sec. 108. Support for expansion of comprehensive sexual health and education programs.
- Sec. 109. Elimination of abstinence-only education program.

TITLE II—ENDING STIGMA AND DISCRIMINATION THAT INHIBIT ACCESS TO CARE AND MAKE PEOPLE MORE VULNERABLE

- Sec. 201. Review of all Federal and State laws, policies, and regulations regarding the criminal prosecution of individuals for HIV-related offenses.

TITLE III—ADDRESSING LEGAL AND POLICY BARRIERS TO ACCESSING HEALTH CARE

- Sec. 301. Repeal of limitation against use of funds for education or information designed to promote or encourage, directly, homosexual or heterosexual activity or intravenous substance abuse.
- Sec. 302. Expanding support for condoms in prisons.
- Sec. 303. Automatic reinstatement or enrollment in Medicaid for people who test positive for HIV before reentering communities.

TITLE IV—COORDINATING EFFORTS TO DRIVE GREATER EFFICIENCY AND IMPROVED RESULTS

- Sec. 401. Support data system review and indicators for monitoring HIV care.
- Sec. 402. Transfer of funds for implementation of National HIV/AIDS Strategy.
- Sec. 403. HIV integrated services delivery model demonstration.
- Sec. 404. Report on the implementation of the National HIV/AIDS Strategy.

DIVISION B—ENDING HIV/AIDS GLOBALLY

TITLE X—GLOBAL HIV/AIDS-FREE GENERATION STRATEGY

Sec. 1001. Global HIV/AIDS-Free Generation Strategy.

TITLE XI—USING FUNDS STRATEGICALLY TO MAXIMIZE RESULTS

Sec. 1101. Support for operations research to improve program delivery, efficiency, impact, and effectiveness.

Sec. 1102. Increasing coordination and integration of HIV/AIDS programs with development programs.

Sec. 1103. Increasing program effectiveness and sustainability to achieve successful country ownership.

TITLE XII—ADDRESSING LEGAL AND POLICY BARRIERS TO ACCESSING HEALTH CARE

Subtitle A—General Provisions

Sec. 1201. Support for laws and regulations that improve health outcomes and promote human rights.

Sec. 1202. Intensifying efforts to establish effective programs for engaging key affected populations.

Sec. 1203. Ensuring United States trade policy does not restrict access to affordable medicines.

Subtitle B—Repeal of Certain Provisions of Public Law 108–25

Sec. 1211. Repeal of “conscience clause” requirement for eligibility for assistance.

Sec. 1212. Repeal of limitation on use of funds for assistance for sex workers.

Sec. 1213. Repeal of reporting requirement on activities promoting abstinence and related activities.

Sec. 1214. Effective date.

TITLE XIII—DEFINITIONS

Sec. 1301. Definitions.

1 **SEC. 3. STATEMENT OF POLICY.**

2 It is the policy of the United States to achieve an
3 AIDS-free generation, and to—

4 (1) expand access to lifesaving antiretroviral
5 therapy for people living with HIV/AIDS and imme-
6 diately link people to continuous and coordinated
7 high-quality care when they learn they are infected
8 with HIV;

1 (2) expand targeted efforts to prevent HIV in-
2 fection using a combination of effective, evidence-
3 based approaches, including the elimination of new
4 pediatric HIV infections worldwide, routine HIV
5 screening, and universal access to HIV prevention
6 tools in the communities where HIV/AIDS is most
7 heavily concentrated;

8 (3) ensure laws, policies, and regulations do not
9 impede access to prevention, treatment, and care for
10 people living with HIV/AIDS or at risk for acquiring
11 HIV;

12 (4) accelerate research for more efficacious HIV
13 prevention and treatments tools, a cure, and a vac-
14 cine; and

15 (5) respect the human rights and dignity of
16 persons living with HIV/AIDS.

17 **SEC. 4. FINDINGS.**

18 The Congress makes the following findings:

19 (1) An estimated 34,000,000 people around the
20 world were living with HIV at the end of 2010, up
21 from 8,000,000 in 1990.

22 (2) The annual number of new HIV infections
23 has gradually declined, and due to the significant in-
24 crease in people receiving antiretroviral therapy, the
25 number of AIDS-related deaths has also declined.

1 (3) Over 1,200,000 people are estimated to be
2 living with HIV in the United States according to
3 the Centers for Disease Control and Prevention.

4 (4) One in five individuals living with HIV/
5 AIDS in the United States is unaware of being in-
6 fected, and significant disparities persist across dif-
7 ferent communities and populations with regard to
8 incidence of infection, access to treatment, and
9 health outcomes.

10 (5) Each year, 50,000 people become newly in-
11 fected with HIV in the United States.

12 (6) Among women, the rate of new HIV infec-
13 tion for African-American women is nearly 15 times
14 higher than White women, while the rate among
15 Hispanic women is nearly 4 times higher.

16 (7) In 1998, Congress created the National Mi-
17 nority AIDS Initiative to provide technical assist-
18 ance, build capacity, and strengthen outreach efforts
19 among local institutions and community-based orga-
20 nizations that serve racial and ethnic minorities liv-
21 ing with or vulnerable to HIV/AIDS.

22 (8) In the United States, the only increase in
23 HIV incidence remains among young people ages 13
24 to 29, specifically young men of color who have sex
25 with men. Additionally, only 84 percent of young

1 people report learning about HIV or AIDS in school,
2 which is fewer than in previous years.

3 (9) In 2009, the Ryan White HIV/AIDS Treat-
4 ment Extension Act of 2009 was enacted into law,
5 reauthorizing Federal HIV/AIDS care and treatment
6 programs for 4 years and making funding available
7 to United States metropolitan areas, States, and
8 service providers to assist affected families and per-
9 sons living with HIV/AIDS with health care and
10 support services.

11 (10) To combat the HIV epidemic in the United
12 States, the National HIV/AIDS Strategy (NHAS)
13 from the White House Office of National AIDS Pol-
14 icy provides a framework of increasing access to
15 care, reducing new infections, and eliminating HIV-
16 related health disparities. The vision of NHAS is:
17 “The United States will become a place where new
18 HIV infections are rare and when they do occur,
19 every person, regardless of age, gender, race/eth-
20 nicity, sexual orientation, gender identity, or socio-
21 economic circumstance, will have unfettered access
22 to high quality, life extending care, free from stigma
23 and discrimination.”.

24 (11) In recent years, several thousand people
25 across the country were waiting to receive AIDS

1 treatment through the AIDS Drug Assistance Pro-
2 gram authorized by the provisions popularly known
3 as the Ryan White CARE Act.

4 (12) The Centers for Disease Control and Pre-
5 vention has determined that increasing the propor-
6 tion of people who know their HIV status is an es-
7 sential component of comprehensive HIV/AIDS
8 treatment and prevention efforts and that early di-
9 agnosis is critical in order for people with HIV/
10 AIDS to receive life-extending therapy. Additionally,
11 the Centers for Disease Control and Prevention rec-
12 ommends recommend routine HIV screening in
13 health care settings for all patients aged 13 to 64,
14 regardless of risk.

15 (13) Advances in HIV diagnostic technology
16 (such as rapid HIV testing and, recently, the avail-
17 ability of over-the-counter HIV tests) reduce barriers
18 to testing and allow more people to know their sta-
19 tus.

20 (14) Routine HIV screening is a preventive
21 health service, and if health plans covered routine
22 HIV screenings, health providers would be more
23 likely to recommend routine HIV screening for their
24 patients.

1 (15) Requiring health plans to cover routine
2 HIV screening as a preventive health service without
3 imposing cost sharing requirements could play a
4 critical role in preventing the spread of HIV and al-
5 lowing infected individuals to receive effective treat-
6 ment.

7 (16) Developing countries continue to bear the
8 brunt of the HIV/AIDS epidemic, with sub-Saharan
9 Africa accounting for 68 percent of all adults and
10 children living with HIV/AIDS, 59 percent of whom
11 are female.

12 (17) Despite global efforts, 1,000 children
13 around the world still contract HIV each day, the
14 majority through mother-to-child transmission of
15 HIV.

16 (18) HIV prevalence among young people aged
17 15 to 24 has declined in many countries most im-
18 pacted by HIV; nevertheless, young people still ac-
19 count for 42 percent of all new infections among in-
20 dividuals aged 15 and older.

21 (19) A substantial number of HIV-positive
22 women in HIV care and treatment programs or pre-
23 vention of mother-to-child transmission (PMTCT)
24 programs experience an unplanned pregnancy.

1 (20) Making contraceptive services more widely
2 available through HIV care, treatment, and PMTCT
3 programs would make it easier for women to coordi-
4 nate their HIV-related care with their pregnancy
5 prevention goals, and at the same time, help prevent
6 mother-to-child HIV transmission.

7 (21) In 2008, the Tom Lantos and Henry J.
8 Hyde United States Global Leadership Against HIV/
9 AIDS, Tuberculosis, and Malaria Reauthorization
10 Act was enacted into law, reauthorizing the Presi-
11 dent's Emergency Plan for AIDS Relief (PEPFAR)
12 and continued United States participation and con-
13 tributions to the Global Fund to Fight AIDS, Tu-
14 berculosis and Malaria.

15 (22) The United States President's Emergency
16 Plan for AIDS Relief (PEPFAR), which represents
17 the largest commitment by any nation to combat a
18 single disease, has saved the lives of millions of peo-
19 ple around the world by establishing and expanding
20 the infrastructure necessary to deliver prevention,
21 care, and treatment services in low-resource settings.

22 (23) Over 7,000,000 people around the world
23 currently receive support for antiretroviral treatment
24 as a result of PEPFAR bilateral programs, the
25 Global Fund, or both.

1 (24) Early detection and treatment of HIV can
2 have significant positive health effects. New research
3 demonstrates conclusively that treatment of individ-
4 uals not only slows disease progression, but can also
5 reduce the risk of transmission to other individuals
6 by 96 percent.

7 (25) In most countries HIV is a disease that
8 discriminates, disproportionately affecting society's
9 most vulnerable. Even in generalized epidemics in
10 which a significant share of the wider population is
11 living with HIV/AIDS, people in vulnerable commu-
12 nities often have considerably higher rates of HIV
13 infection.

14 (26) Reaching men who have sex with men,
15 transgender people, people who inject drugs, sex
16 workers, and other vulnerable populations with effec-
17 tive HIV prevention and treatment is critical to
18 bringing the AIDS epidemic under control.

19 (27) According to the Centers for Disease Con-
20 trol and Prevention, approximately one-third of per-
21 sons with HIV are co-infected with hepatitis B virus
22 (HBV) or hepatitis C virus (HCV). About 80 per-
23 cent of injection drug users with HIV infection also
24 have HCV. HIV co-infection more than triples the

1 risk for liver disease, liver failure, and liver-related
2 death from HCV.

3 (28) The Global Commission on HIV and the
4 Law was launched in June 2010 to examine laws
5 and practices that criminalize people living with and
6 vulnerable to HIV and to develop evidence-based rec-
7 ommendations for effective HIV responses that pro-
8 mote and protect human rights.

9 (29) The 19th International AIDS Conference
10 will be held in Washington, DC, in 2012, from July
11 22 to 27, returning to the United States after a
12 nearly two-decade-long international boycott that
13 was lifted following the statutory repeal of a ban on
14 travel and immigration of people living with HIV/
15 AIDS.

16 (30) The District of Columbia, the site of the
17 XIX International AIDS Conference, has an HIV
18 prevalence rate of over 2.7 percent, which far ex-
19 ceeds the threshold that constitutes a “generalized
20 and severe” epidemic, and is comparable to the rate
21 in many parts of the developing world.

22 (31) The XIX International AIDS Conference
23 offers a unique opportunity to change the course of
24 the HIV/AIDS epidemic by informing people globally
25 about scientific advances in treatment and preven-

1 tion, building consensus to improve service delivery
2 and maximize outcomes, facilitating global civil soci-
3 ety engagement, and accelerating momentum toward
4 a cure.

5 (32) At present, 34 States and 2 United States
6 territories have criminal statutes based on “expo-
7 sure” to HIV. Most of these laws were adopted be-
8 fore the availability of effective antiretroviral treat-
9 ment for HIV/AIDS.

10 (33) Although HIV/AIDS currently is viewed as
11 a chronic, treatable medical condition, people living
12 with HIV in the United States have been charged
13 under aggravated assault, attempted murder, and
14 even bioterrorism statutes because prosecutors,
15 courts, and legislators continue to view and charac-
16 terize the blood, semen, and saliva of people living
17 with HIV as a “deadly weapon”.

18 (34) The National Alliance of State and Terri-
19 torial AIDS Directors released a statement in Feb-
20 ruary 2011 saying that “HIV criminalization under-
21 cuts our most basic HIV prevention and sexual
22 health messages, and breeds ignorance, fear and dis-
23 crimination against people living with HIV”.
24 NASTAD further “supports efforts to examine and
25 support level-headed, proven public health ap-

1 proaches that end punitive laws that single out HIV
2 over other STDs and that impose penalties for al-
3 leged nondisclosure, exposure and transmission that
4 are severely disproportionate to the actual resulting
5 harm”.

6 (35) In 2010, the President released a National
7 HIV/AIDS Strategy (NHAS), which addressed HIV-
8 specific criminal laws, stating: “[W]hile we under-
9 stand the intent behind [these] laws, they may not
10 have the desired effect and they may make people
11 less willing to disclose their status by making people
12 feel at even greater risk of discrimination. In some
13 cases, it may be appropriate for legislators to recon-
14 sider whether existing laws continue to further the
15 public interest and public health. In many instances,
16 the continued existence and enforcement of these
17 types of laws run counter to scientific evidence about
18 routes of HIV transmission and may undermine the
19 public health goals of promoting HIV screening and
20 treatment.”.

21 (36) There is a disproportionately high rate of
22 HIV/AIDS among incarcerated persons, especially
23 among minorities. The Bureau of Justice Statistics
24 (BJS) has determined that the rate of confirmed
25 AIDS cases is 2.4 times higher among incarcerated

1 persons than in the general population. Minorities
2 account for the majority of AIDS-related deaths
3 among incarcerated persons, African-American in-
4 carcerated individuals are 2.8 times more likely than
5 White incarcerated individuals and 1.4 times more
6 likely than Hispanic incarcerated individuals to die
7 from AIDS-related causes. Nearly two-thirds of
8 AIDS-related deaths are among Black, non-Hispanic
9 males.

10 (37) Studies suggest that other sexually trans-
11 mitted infections (STIs), such as gonorrhea,
12 chlamydia, syphilis, genital herpes, viral hepatitis,
13 and human papillomavirus, also exist at a higher
14 rate among incarcerated persons than in the general
15 population. For instance, researchers have estimated
16 that the rate of hepatitis C (HCV) infection among
17 incarcerated persons is somewhere between 8 and 20
18 times higher than that of the general population.

19 (38) According to the Centers for Disease Con-
20 trol and Prevention (CDC), latex condoms, when
21 used consistently and correctly, are highly effective
22 in preventing the transmission of HIV. Latex
23 condoms also reduce the risk of other STIs. Despite
24 the effectiveness of condoms in reducing the spread

1 of STIs, the Bureau of Prisons does not recommend
2 their use in correctional facilities.

3 (39) The distribution of condoms in correctional
4 facilities is currently legal in certain parts of the
5 United States and the world. The States of Vermont
6 and Mississippi, the District of Columbia, and the
7 cities of New York, San Francisco, Los Angeles,
8 Washington, DC, and Philadelphia allow condom
9 distribution in their correctional facilities. However,
10 these States and cities operate fewer than 1 percent
11 of all correctional facilities.

12 (40) Many correctional facilities in the United
13 States do not provide comprehensive testing and
14 treatment programs to reduce the spread of STIs.
15 Fewer than half of correctional facilities provide
16 counseling to HIV-positive incarcerated persons.

17 (41) Incarcerated individuals living with HIV/
18 AIDS who are eligible for Medicaid would benefit
19 from prompt and automatic enrollment upon their
20 release in order to ensure their continued ability to
21 access health services, including antiretroviral treat-
22 ment.

23 (42) Research shows that stable housing leads
24 to better health outcomes for those living with HIV.
25 Inadequate or unstable housing is not only a barrier

1 to effective treatment, but also increases the likeli-
2 hood of engaging in risky behaviors leading to HIV
3 infection. Insecure housing puts people with HIV/
4 AIDS at risk of premature death from exposure to
5 other diseases, poor nutrition, stress, and lack of
6 medical care.

7 (43) On July 16, 2012, the Food and Drug Ad-
8 ministration approved Truvada (emtricitabine/
9 tenofovir disoproxil fumarate), the first drug ap-
10 proved to reduce the risk of HIV infection in
11 uninfected individuals who are at high risk of HIV
12 infection and who may engage in sexual activity with
13 HIV-infected partners.

14 **SEC. 5. NONDISCRIMINATION.**

15 Programs funded under this Act shall not discrimi-
16 nate on the basis of actual or perceived sex, race, color,
17 ethnicity, national origin, disability, sexual orientation,
18 gender identity, or religion. Nothing in this Act shall be
19 construed to invalidate or limit rights, remedies, proce-
20 dures, or legal standards available to victims of discrimi-
21 nation under any other Federal law or any law of a State
22 or a political subdivision of a State, including title VI of
23 the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.),
24 title IX of the Education Amendments of 1972 (20 U.S.C.
25 1681 et seq.), section 504 of the Rehabilitation Act of

1 1973 (29 U.S.C. 794), the Americans with Disabilities Act
2 of 1990 (42 U.S.C. 12101 et seq.), and section 1557 of
3 the Patient Protection and Affordable Care Act (42
4 U.S.C. 18116).

5 **DIVISION A—ENDING HIV/AIDS**
6 **IN THE UNITED STATES**
7 **TITLE I—INCREASING AND TAR-**
8 **GETING INVESTMENT TO**
9 **MAXIMIZE PREVENTION AND**
10 **TREATMENT IMPACT**

11 **SEC. 101. ADDITIONAL FUNDING FOR AIDS DRUG ASSIST-**
12 **ANCE PROGRAM TREATMENTS.**

13 Section 2623 of the Public Health Service Act (42
14 U.S.C. 300ff–31b) is amended by adding at the end the
15 following:

16 “(c) ADDITIONAL FUNDING FOR AIDS DRUG AS-
17 SISTANCE PROGRAM TREATMENTS.—In addition to
18 amounts otherwise authorized to be appropriated for car-
19 rying out this subpart, there are authorized to be appro-
20 priated such sums as may be necessary to carry out sec-
21 tions 2612(b)(3)(B) and 2616 for each of fiscal years
22 2013 through 2015.”.

1 **SEC. 102. ENHANCING THE NATIONAL HIV SURVEILLANCE**
2 **SYSTEM.**

3 (a) GRANTS.—The Secretary of Health and Human
4 Services, acting through the Director of the Centers for
5 Disease Control and Prevention, shall make grants to
6 States to support integration of public health surveillance
7 systems into all electronic health records in order to allow
8 rapid communications between the clinical setting and
9 health departments, by means that include—

10 (1) providing technical assistance and policy
11 guidance to State and local health departments, clin-
12 ical providers, and other agencies serving individuals
13 with HIV to improve the interoperability of data sys-
14 tems relevant to monitoring HIV care and sup-
15 portive services;

16 (2) capturing longitudinal data pertaining to
17 the initiation and ongoing prescription or dispensing
18 of antiretroviral therapy for individuals diagnosed
19 with HIV (such as through pharmacy-based report-
20 ing);

21 (3) obtaining information—

22 (A) on a voluntary basis, on sexual orienta-
23 tion and gender identity; and

24 (B) on sources of coverage (or the lack
25 thereof) for medical treatment (including cov-
26 erage through Medicaid, Medicare, the program

1 under title XXVI of the Public Health Service
2 Act (42 U.S.C. 300ff–11 et seq.; commonly re-
3 ferred to as the “Ryan White HIV/AIDS Pro-
4 gram”), other public funding, private insurance,
5 and health maintenance organizations); and

6 (4) obtaining and using current geographic
7 markers of residence (such as current address, zip
8 code, partial zip code, and census block).

9 (b) PRIVACY AND SECURITY SAFEGUARDS.—In car-
10 rying out this section, the Secretary of Health and Human
11 Services shall ensure that appropriate privacy and security
12 safeguards are met to prevent unauthorized disclosure of
13 protected health information and compliance with the
14 HIPAA privacy and security law (as defined in section
15 3009 of the Public Health Service Act (42 U.S.C. 300jj–
16 19)) and other relevant laws and regulations.

17 (c) PROHIBITION AGAINST IMPROPER USE OF
18 DATA.—No grant under this section may be used to allow
19 or facilitate the collection or use of surveillance or clinical
20 data or records—

21 (1) for punitive measures of any kind, civil or
22 criminal, against the subject of such data or records;
23 or

1 (2) for imposing any requirement or restriction
2 with respect to an individual without the individual's
3 written consent.

4 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry
5 out this section, there are authorized to be appropriated
6 such sums as may be necessary for each of fiscal years
7 2013 through 2017.

8 **SEC. 103. EVIDENCE-BASED STRATEGIES FOR IMPROVING**
9 **LINKAGE TO AND RETENTION IN APPRO-**
10 **PRIATE CARE.**

11 (a) STRATEGIES.—The Secretary of Health and
12 Human Services, in collaboration with the Director of the
13 Centers for Disease Control and Prevention, the Adminis-
14 trator of the Substance Abuse and Mental Health Services
15 Administration, the Director of the Office of AIDS Re-
16 search, the Administrator of the Health Resources and
17 Services Administration, and the Administrator of the
18 Centers for Medicare & Medicaid Services, shall—

19 (1) identify evidence-based strategies most ef-
20 fective at addressing the multifaceted issues that im-
21 pede disease status awareness and linkage to and re-
22 tention in appropriate care, taking into consideration
23 health care systems issues, clinic and provider
24 issues, and individual psycho-social, environmental,
25 and other contextual factors;

1 (2) support the wide-scale implementation of
2 the evidence-based strategies identified pursuant to
3 paragraph (1), including through incorporating such
4 strategies into health care coverage supported by the
5 Medicaid program under title XIX of the Social Se-
6 curity Act (42 U.S.C. 1396 et seq.), the program
7 under title XXVI of the Public Health Service Act
8 (42 U.S.C. 300ff–11 et seq.; commonly referred to
9 as the “Ryan White HIV/AIDS Program”), and
10 health plans purchased through an American Health
11 Benefit Exchange established pursuant to section
12 1311 of the Patient Protection and Affordable Care
13 Act (42 U.S.C. 18031); and

14 (3) not later than 12 months after the date of
15 the enactment of this Act, submit a report to the
16 Congress on the status of activities under para-
17 graphs (1) and (2).

18 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
19 out this section, there are authorized to be appropriated
20 such sums as may be necessary for fiscal years 2013
21 through 2017.

1 **SEC. 104. IMPROVING ENTRY INTO AND RETENTION IN**
2 **CARE AND ANTIRETROVIRAL ADHERENCE**
3 **FOR PERSONS WITH HIV.**

4 (a) SENSE OF CONGRESS.—It is the sense of the Con-
5 gress that AIDS research has led to scientific advance-
6 ments that have—

7 (1) saved the lives of millions of people with
8 HIV/AIDS;

9 (2) prevented millions of people from being in-
10 fected; and

11 (3) had broad benefits that extend far beyond
12 helping people at risk for or living with HIV.

13 (b) IN GENERAL.—The Secretary of Health and
14 Human Services, acting through the Director of the Na-
15 tional Institutes of Health, shall expand, intensify, and co-
16 ordinate operational and translational research and other
17 activities of the National Institutes of Health regarding
18 methods—

19 (1) to increase adoption of evidence-based ad-
20 herence strategies within HIV care and treatment
21 programs;

22 (2) to increase HIV testing and case detection
23 rates;

24 (3) to reduce HIV-related health disparities;

1 (4) to ensure that research to improve adher-
 2 ence to HIV care and treatment programs address
 3 the unique concerns of women;

4 (5) to integrate HIV/AIDS prevention and care
 5 services with mental health and substance use pre-
 6 vention and treatment delivery systems; and

7 (6) to increase knowledge on the implementa-
 8 tion of pre-exposure prophylaxis (PrEP), including
 9 with respect to—

10 (A) who can benefit most from PrEP;

11 (B) how to provide PrEP safely and effi-
 12 ciently;

13 (C) how to integrate PrEP with other es-
 14 sential prevention methods such as condoms;
 15 and

16 (D) how to ensure high levels of adherence.

17 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
 18 out this section, there are authorized to be appropriated
 19 such sums as may be necessary for fiscal years 2013
 20 through 2017.

21 **SEC. 105. HEALTH CARE PROFESSIONALS TREATING INDI-**
 22 **VIDUALS WITH HIV/AIDS.**

23 (a) IN GENERAL.—The Secretary of Health and
 24 Human Services, acting through the Administrator of the
 25 Health Resources and Services Administration, shall ex-

1 pand, intensify, and coordinate workforce initiatives of the
2 Health Resources and Services Administration to increase
3 the capacity of the health workforce focusing primarily on
4 HIV/AIDS to meet the demand for culturally competent
5 care, and may award grants for any of the following:

6 (1) Development of curricula for training pri-
7 mary care providers in HIV/AIDS prevention and
8 care, including routine HIV testing.

9 (2) Support to expand access to culturally and
10 linguistically accessible benefits counselors, trained
11 peer navigators, and mental and behavioral health
12 professionals with expertise in HIV/AIDS.

13 (3) Training health care professionals to pro-
14 vide care to individuals with HIV/AIDS.

15 (4) Development by grant recipients under title
16 XXVI of the Public Health Service Act (42 U.S.C.
17 300ff–11 et seq.; commonly referred to as the Ryan
18 White HIV/AIDS Program) and other persons, of
19 policies for providing culturally relevant and sen-
20 sitive treatment to individuals with HIV/AIDS, with
21 particular emphasis on treatment to racial and eth-
22 nic minorities, men who have sex with men, and
23 women, young people, and children with HIV/AIDS.

24 (5) Development and implementation of pro-
25 grams to increase the use of telehealth to respond to

1 HIV/AIDS-specific health care needs in rural and
2 minority communities, with particular emphasis
3 given to medically underserved communities and in-
4 sular areas.

5 (6) Evaluating interdisciplinary medical pro-
6 vider care team models that promote high quality
7 care.

8 (7) Training health care professionals to make
9 them aware of the high rates of chronic hepatitis B
10 and chronic hepatitis C in certain adult ethnic popu-
11 lations, and the importance of prevention, detection,
12 and medical management of hepatitis B and hepa-
13 titis C and of liver cancer screening.

14 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
15 out this section, there are authorized to be appropriated
16 such sums as may be necessary for fiscal years 2013
17 through 2017.

18 **SEC. 106. HIV/AIDS PROVIDER LOAN REPAYMENT PRO-**
19 **GRAM.**

20 (a) IN GENERAL.—The Secretary may enter into an
21 agreement with any physician, nurse practitioner, or phy-
22 sician assistant under which—

23 (1) the physician, nurse practitioner, or physi-
24 cian assistant agrees to serve as a medical provider
25 for a period of not less than 2 years—

1 (A) at a Ryan White-funded or title X-
2 funded facility with a critical shortage of doc-
3 tors (as determined by the Secretary); or

4 (B) in an area with a high incidence of
5 HIV/AIDS; and

6 (2) the Secretary agrees to make payments in
7 accordance with subsection (b) on the professional
8 education loans of the physician, nurse practitioner,
9 or physician assistant.

10 (b) MANNER OF PAYMENTS.—The payments de-
11 scribed in subsection (a) shall be made by the Secretary
12 as follows:

13 (1) Upon completion by the physician, nurse
14 practitioner, or physician assistant for whom the
15 payments are to be made of the first year of the
16 service specified in the agreement entered into with
17 the Secretary under subsection (a), the Secretary
18 shall pay 30 percent of the principal of and the in-
19 terest on the individual's professional education
20 loans.

21 (2) Upon completion by the physician, nurse
22 practitioner, or physician assistant of the second
23 year of such service, the Secretary shall pay another
24 30 percent of the principal of and the interest on
25 such loans.

1 (3) Upon completion by that individual of a
2 third year of such service, the Secretary shall pay
3 another 25 percent of the principal of and the inter-
4 est on such loans.

5 (c) APPLICABILITY OF CERTAIN PROVISIONS.—The
6 provisions of subpart III of part D of title III of the Public
7 Health Service Act (42 U.S.C. 254l et seq.) shall, except
8 as inconsistent with this section, apply to the program car-
9 ried out under this section in the same manner and to
10 the same extent as such provisions apply to the National
11 Health Service Corps Loan Repayment Program.

12 (d) REPORTS.—Not later than 18 months after the
13 date of the enactment of this Act, and annually thereafter,
14 the Secretary shall prepare and submit to the Congress
15 a report describing the program carried out under this sec-
16 tion, including statements regarding the following:

17 (1) The number of physicians, nurse practi-
18 tioners, and physician assistants enrolled in the pro-
19 gram.

20 (2) The number and amount of loan repay-
21 ments.

22 (3) The placement location of loan repayment
23 recipients at facilities described in subsection (a)(1).

24 (4) The default rate and actions required.

25 (5) The amount of outstanding default funds.

1 (6) To the extent that it can be determined, the
2 reason for the default.

3 (7) The demographics of individuals partici-
4 pating in the program.

5 (8) An evaluation of the overall costs and bene-
6 fits of the program.

7 (e) DEFINITIONS.—In this section:

8 (1) The term “HIV/AIDS” means human im-
9 munodeficiency virus and acquired immune defi-
10 ciency syndrome.

11 (2) The term “nurse practitioner” means a
12 nurse with an advanced practice nursing licensure.

13 (3) The term “physician” means a graduate of
14 a school of medicine who has completed post-
15 graduate training in general or pediatric medicine.

16 (4) The term “physician assistant” means a
17 medical provider who completed an accredited physi-
18 cian assistant training program and successfully
19 passed the Physician Assistant National Certifying
20 Examination.

21 (5) The term “professional education loan”—

22 (A) means a loan that is incurred for the
23 cost of attendance (including tuition, other rea-
24 sonable educational expenses, and reasonable

1 living costs) at a school of medicine, nursing, or
2 physician assistant training program; and

3 (B) includes only the portion of the loan
4 that is outstanding on the date the physician,
5 nurse practitioner, or physician assistant in-
6 volved begins the service specified in the agree-
7 ment under subsection (a).

8 (6) The term “Ryan White-funded” means,
9 with respect to a facility, receiving funds under title
10 XXVI of the Public Health Service Act (42 U.S.C.
11 300ff–11 et seq.).

12 (7) The term “Secretary” means the Secretary
13 of Health and Human Services.

14 (8) The term “school of medicine” has the
15 meaning given to that term in section 799B of the
16 Public Health Service Act (42 U.S.C. 295p).

17 (9) The term “title X-funded” means, with re-
18 spect to a facility, receiving funds under title X of
19 the Public Health Service Act (42 U.S.C. 300 et
20 seq.).

21 (f) AUTHORIZATION OF APPROPRIATIONS.—To carry
22 out this section, there are authorized to be appropriated
23 such sums as may be necessary for fiscal years 2013
24 through 2017.

1 **SEC. 107. REDUCING NEW HIV INFECTIONS AMONG INJECT-**
2 **ING DRUG USERS.**

3 (a) SENSE OF CONGRESS.—It is the sense of the Con-
4 gress that providing sterile syringes and sterilized equip-
5 ment to injecting drug users substantially reduces risk of
6 HIV infection , increases the probability that they will ini-
7 tiate drug treatment, and does not increase drug use.

8 (b) IN GENERAL.—The Secretary of Health and
9 Human Services may provide grants and technical assist-
10 ance for the purpose of reducing the rate of HIV infections
11 among injecting drug users through a comprehensive
12 package of services for such users, including the provision
13 of sterile syringes, education and outreach, access to infec-
14 tious disease testing, overdose prevention, and treatment
15 for drug dependence.

16 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
17 out this section, there are authorized to be appropriated
18 such sums as may be necessary for fiscal years 2013
19 through 2017.

20 **SEC. 108. SUPPORT FOR EXPANSION OF COMPREHENSIVE**
21 **SEXUAL HEALTH AND EDUCATION PRO-**
22 **GRAMS.**

23 (a) SENSE OF CONGRESS.—It is the sense of Con-
24 gress that—

25 (1) federally funded sex education programs
26 should aim to—

1 (A) reduce unintended pregnancy and sex-
2 ually transmitted infections, including HIV;

3 (B) promote safe and healthy relation-
4 ships;

5 (C) use, and be informed by, the best sci-
6 entific information available;

7 (D) be built on characteristics of effective
8 programs;

9 (E) expand the existing body of evidence
10 on comprehensive sex education programs
11 through program evaluation;

12 (F) expand training programs for teachers
13 of comprehensive sex education;

14 (G) build on the personal responsibility
15 education programs funded under section 513
16 of the Social Security Act (42 U.S.C. 713) and
17 the President's Teen Pregnancy Prevention pro-
18 gram, funded under title II of the Consolidated
19 Appropriations Act, 2010 (Public Law 111-
20 117; 123 Stat. 3253); and

21 (H) promote and uphold the rights of
22 young people to information in order to make
23 healthy and responsible decisions about their
24 sexual health; and

1 (2) no Federal funds should be used for health
2 education programs that—

3 (A) deliberately withhold life-saving infor-
4 mation about HIV;

5 (B) are medically inaccurate or have been
6 scientifically shown to be ineffective;

7 (C) promote gender stereotypes;

8 (D) are insensitive and unresponsive to the
9 needs of sexually active adolescents;

10 (E) are insensitive and unresponsive to the
11 needs of lesbian, gay, bisexual, or transgender
12 youth; or

13 (F) are inconsistent with the ethical im-
14 peratives of medicine and public health.

15 (b) GRANTS FOR COMPREHENSIVE SEX EDUCATION
16 FOR ADOLESCENTS.—

17 (1) PROGRAM AUTHORIZED.—The Secretary, in
18 coordination with the Director of the Office of Ado-
19 lescent Health, shall award grants, on a competitive
20 basis, to eligible entities to enable such eligible enti-
21 ties to carry out programs that provide adolescents
22 with comprehensive sex education, as described in
23 paragraph (6).

24 (2) DURATION.—Grants awarded under this
25 subsection shall be for a period of 5 years.

1 (3) ELIGIBLE ENTITY.—In this subsection, the
2 term “eligible entity” means a public or private enti-
3 ty that focuses on adolescent health or education or
4 has experience working with adolescents, which may
5 include—

6 (A) a State educational agency;

7 (B) a local educational agency;

8 (C) a tribe or tribal organization, as de-
9 fined in section 4 of the Indian Self-Determina-
10 tion and Education Assistance Act (25 U.S.C.
11 450b);

12 (D) a State or local department of health;

13 (E) a State or local department of edu-
14 cation;

15 (F) a nonprofit organization;

16 (G) a nonprofit or public institution of
17 higher education; or

18 (H) a hospital.

19 (4) APPLICATIONS.—An eligible entity desiring
20 a grant under this subsection shall submit an appli-
21 cation to the Secretary at such time, in such man-
22 ner, and containing such information as the Sec-
23 retary may require, including the evaluation plan de-
24 scribed in paragraph (7)(A).

1 (5) PRIORITY.—In awarding grants under this
2 subsection, the Secretary shall give priority to eligi-
3 ble entities that—

4 (A) are State or local public entities, with
5 an additional priority for State or local edu-
6 cational agencies; and

7 (B) address health disparities among
8 young people that are at highest risk for not
9 less than 1 of the following:

10 (i) Unintended pregnancies.

11 (ii) Sexually transmitted infections,
12 including HIV.

13 (iii) Dating violence and sexual as-
14 sault.

15 (6) USE OF FUNDS.—

16 (A) IN GENERAL.—Each eligible entity
17 that receives a grant under this subsection shall
18 use grant funds to carry out a program that
19 provides adolescents with comprehensive sex
20 education that—

21 (i) replicates evidence-based sex edu-
22 cation programs;

23 (ii) substantially incorporates ele-
24 ments of evidence-based sex education pro-
25 grams; or

1 (iii) creates a demonstration project
2 based on generally accepted characteristics
3 of effective sex education programs.

4 (B) CONTENTS OF SEX EDUCATION PRO-
5 GRAMS.—The sex education programs funded
6 under this subsection shall include curricula
7 and program materials that address—

8 (i) abstinence and delaying sexual ini-
9 tiation;

10 (ii) the health benefits and side effects
11 of all contraceptive and barrier methods as
12 a means to prevent pregnancy and sexually
13 transmitted infections, including HIV;

14 (iii) healthy relationships, including
15 the development of healthy attitudes and
16 skills necessary for understanding—

17 (I) healthy relationships between
18 oneself and family, others, and soci-
19 ety; and

20 (II) the prevention of sexual
21 abuse, teen dating violence, bullying,
22 harassment, and suicide;

23 (iv) healthy life skills including goal-
24 setting, decisionmaking, interpersonal skills
25 (such as communication, assertiveness, and

peer refusal skills), critical thinking, self-esteem and self-efficacy, and stress management;

(v) how to make responsible decisions about sex and sexuality, including—

(I) how to avoid, and how to avoid making, unwanted verbal, physical, and sexual advances; and

(II) how alcohol and drug use can affect responsible decisionmaking;

(vi) the development of healthy attitudes and values about such topics as adolescent growth and development, body image, gender roles and gender identity, racial and ethnic diversity, and sexual orientation; and

(vii) referral services for local health clinics and services where adolescents can obtain additional information and services related to sexual and reproductive health, dating violence and sexual assault, and suicide prevention.

(7) EVALUATION; REPORT.—

(A) INDEPENDENT EVALUATION.—Each eligible entity applying for a grant under this

subsection shall develop and submit to the Secretary a plan for a rigorous independent evaluation of such grant program. The plan shall describe an independent evaluation that—

(i) uses sound statistical methods and techniques relating to the behavioral sciences, including random assignment methodologies, whenever possible;

(ii) uses quantitative data for assessments and impact evaluations, whenever possible; and

(iii) is carried out by an entity independent from such eligible entity.

(B) SELECTION OF EVALUATED PROGRAMS; BUDGET.—

(i) SELECTION OF EVALUATED PROGRAMS.—The Secretary shall select, at random, a subset of the eligible entities that the Secretary has selected to receive a grant under this subsection to receive additional funding to carry out the evaluation plan described in subparagraph (A).

(ii) BUDGET FOR EVALUATION ACTIVITIES.—The Secretary, in coordination with the Director of the Office of Adolescent

1 Health, shall establish a budget for each
2 eligible entity selected under clause (i) for
3 the costs of carrying out the evaluation
4 plan described in subparagraph (A).

5 (C) FUNDS FOR EVALUATION.—The Sec-
6 retary shall provide eligible entities who are se-
7 lected under subparagraph (B)(i) with addi-
8 tional funds, in accordance with the budget de-
9 scribed in subparagraph (B)(ii), to carry out
10 and report to the Secretary on the evaluation
11 plan described in subparagraph (A).

12 (D) PERFORMANCE MEASURES.—The Sec-
13 retary, in coordination with the Director of the
14 Centers for Disease Control and Prevention,
15 shall establish a common set of performance
16 measures to assess the implementation and im-
17 pact of grant programs funded under this sub-
18 section. Such performance measures shall in-
19 clude—

20 (i) output measures, such as the num-
21 ber of individuals served and the number
22 of hours of service delivery;

23 (ii) outcome measures, including
24 measures relating to—

1 (I) the knowledge that youth par-
2 ticipating in the grant program have
3 gained about—

4 (aa) adolescent growth and
5 development;

6 (bb) relationship dynamics;

7 (cc) ways to prevent unin-
8 tended pregnancy and sexually
9 transmitted infections, including
10 HIV; and

11 (dd) sexual health;

12 (II) the skills that adolescents
13 participating in the grant program
14 have gained regarding—

15 (aa) negotiation and commu-
16 nication;

17 (bb) decisionmaking and
18 goal-setting;

19 (cc) interpersonal skills and
20 healthy relationships; and

21 (dd) condom use; and

22 (III) the behaviors of adolescents
23 participating in the grant program,
24 including data about—

25 (aa) age of first intercourse;

- 1 (bb) number of sexual part-
- 2 ners;
- 3 (cc) condom and contracep-
- 4 tive use at first intercourse;
- 5 (dd) recent condom and con-
- 6 traceptive use; and
- 7 (ee) dating abuse and life-
- 8 time history of domestic violence,
- 9 sexual assault, dating violence,
- 10 bullying, harassment, and stalk-
- 11 ing.

12 (E) REPORT TO THE SECRETARY.—Eligi-
13 ble entities receiving a grant under this sub-
14 section who have been selected to receive funds
15 to carry out the evaluation plan described in
16 subparagraph (A), in accordance with subpara-
17 graph (B)(i), shall collect and report to the Sec-
18 retary—

- 19 (i) the results of the independent eval-
- 20 uation described in subparagraph (A); and
- 21 (ii) information about the perform-
- 22 ance measures described in subparagraph
- 23 (B).

24 (F) EFFECTIVE PROGRAMS.—The Sec-
25 retary, in coordination with the Director of the

1 Centers for Disease Control and Prevention,
2 shall publish on the Web site of the Centers for
3 Disease Control and Prevention, a list of pro-
4 grams funded under this subsection that the
5 Secretary has determined to be effective pro-
6 grams.

7 (c) GRANTS FOR COMPREHENSIVE SEX EDUCATION
8 AT INSTITUTIONS OF HIGHER EDUCATION.—

9 (1) PROGRAM AUTHORIZED.—The Secretary, in
10 coordination with the Office of Adolescent Health
11 and the Secretary of Education, shall award grants,
12 on a competitive basis, to institutions of higher edu-
13 cation to enable such institutions to provide young
14 people with comprehensive sex education, described
15 in paragraph (5)(B), with an emphasis on reducing
16 HIV, other sexually transmitted infections, and un-
17 intended pregnancy through instruction about—

18 (A) abstinence and contraception;

19 (B) reducing dating violence, sexual as-
20 sault, bullying, and harassment;

21 (C) increasing healthy relationships; and

22 (D) academic achievement.

23 (2) DURATION.—Grants awarded under this
24 subsection shall be for a period of 5 years.

1 (3) APPLICATIONS.—An institution of higher
2 education desiring a grant under this subsection
3 shall submit an application to the Secretary at such
4 time, in such manner, and containing such informa-
5 tion as the Secretary may require.

6 (4) PRIORITY.—In awarding grants under this
7 subsection, the Secretary shall give priority to an in-
8 stitution of higher education that—

9 (A) has an enrollment of needy students as
10 defined in section 318(b) of the Higher Edu-
11 cation Act of 1965 (20 U.S.C. 1059e(b));

12 (B) is a Hispanic-serving institution, as
13 defined in section 502(a) of such Act (20
14 U.S.C. 1101a(a));

15 (C) is a Tribal College or University, as
16 defined in section 316(b) of such Act (20
17 U.S.C. 1059e(b));

18 (D) is an Alaska Native-serving institution,
19 as defined in section 317(b) of such Act (20
20 U.S.C. 1059d(b));

21 (E) is a Native Hawaiian-serving institu-
22 tion, as defined in section 317(b) of such Act
23 (20 U.S.C. 1059d(b));

1 (F) is a Predominately Black Institution,
2 as defined in section 318(b) of such Act (20
3 U.S.C. 1059e(b));

4 (G) is a Native American-serving, non-
5 tribal institution, as defined in section 319(b)
6 of such Act (20 U.S.C. 1059f(b));

7 (H) is an Asian American and Native
8 American Pacific Islander-serving institution, as
9 defined in section 320(b) of such Act (20
10 U.S.C. 1059g(b)); or

11 (I) is a minority institution, as defined in
12 section 365 of such Act (20 U.S.C. 1067k),
13 with an enrollment of needy students, as de-
14 fined in section 312 of such Act (20 U.S.C.
15 1058).

16 (5) USES OF FUNDS.—

17 (A) IN GENERAL.—An institution of higher
18 education receiving a grant under this sub-
19 section may use grant funds to integrate issues
20 relating to comprehensive sex education into the
21 academic or support sectors of the institution of
22 higher education in order to reach a large num-
23 ber of students, by carrying out 1 or more of
24 the following activities:

1 (i) Developing educational content for
2 issues relating to comprehensive sex edu-
3 cation that will be incorporated into first-
4 year orientation or core courses.

5 (ii) Developing and employing
6 schoolwide educational programming out-
7 side of class that delivers elements of com-
8 prehensive sex education programs to stu-
9 dents, faculty, and staff.

10 (iii) Creating innovative technology-
11 based approaches to deliver sex education
12 to students, faculty, and staff.

13 (iv) Developing and employing peer-
14 outreach and education programs to gen-
15 erate discussion, educate, and raise aware-
16 ness among students about issues relating
17 to comprehensive sex education.

18 (B) CONTENTS OF SEX EDUCATION PRO-
19 GRAMS.—Each institution of higher education’s
20 program of comprehensive sex education funded
21 under this subsection shall include curricula
22 and program materials that address informa-
23 tion about—

24 (i) safe and responsible sexual behav-
25 ior with respect to the prevention of preg-

1 nancy and sexually transmitted infections,
2 including HIV, including through—

3 (I) abstinence;

4 (II) a reduced number of sexual
5 partners; and

6 (III) the use of condoms and con-
7 traception;

8 (ii) healthy relationships, including
9 the development of healthy attitudes and
10 insights necessary for understanding—

11 (I) relationships between oneself,
12 family, partners, others, and society;
13 and

14 (II) the prevention of sexual
15 abuse, dating violence, bullying, har-
16 assment, and suicide; and

17 (iii) referral services to local health
18 clinics where young people can obtain addi-
19 tional information and services related to
20 sexual and reproductive health, dating vio-
21 lence and sexual assault, and suicide pre-
22 vention.

23 (C) OPTIONAL COMPONENTS OF SEX EDU-
24 CATION.—Each institution of higher education’s
25 program of comprehensive sex education may

1 also include information and skills development
2 relating to—

3 (i) how to make responsible decisions
4 about sex and sexuality, including—

5 (I) how to avoid, and avoid mak-
6 ing, unwanted verbal, physical, and
7 sexual advances; and

8 (II) how alcohol and drug use
9 can affect responsible decisionmaking;

10 (ii) healthy life skills, including—

11 (I) goal-setting and decision-
12 making;

13 (II) interpersonal skills, such as
14 communication, assertiveness, and
15 peer refusal skills;

16 (III) critical thinking;

17 (IV) self-esteem and self-efficacy;

18 and

19 (V) stress management;

20 (iii) the development of healthy atti-
21 tudes and values about such topics as body
22 image, gender roles and gender identity,
23 racial and ethnic diversity, and sexual ori-
24 entation; and

1 (iv) the responsibilities of parenting
2 and the skills necessary to parent well.

3 (6) EVALUATION; REPORT.—The requirements
4 described in section 125B(g) shall also apply to eligi-
5 ble entities receiving a grant under this subsection
6 in the same manner as such requirements apply to
7 eligible entities receiving grants under section 125B.

8 (d) GRANTS FOR PRE-SERVICE AND IN-SERVICE
9 TEACHER TRAINING.—

10 (1) PROGRAM AUTHORIZED.—The Secretary, in
11 coordination with the Director of the Centers for
12 Disease Control and Prevention and the Secretary of
13 Education, shall award grants, on a competitive
14 basis, to eligible entities to enable such eligible enti-
15 ties to carry out the activities described in para-
16 graph (5).

17 (2) DURATION.—Grants awarded under this
18 subsection shall be for a period of 5 years.

19 (3) ELIGIBLE ENTITY.—In this subsection, the
20 term “eligible entity” means—

21 (A) a State educational agency;

22 (B) a local educational agency;

23 (C) a tribe or tribal organization, as de-
24 fined in section 4 of the Indian Self-Determina-

1 tion and Education Assistance Act (25 U.S.C.
2 450b);

3 (D) a State or local department of health;

4 (E) a State or local department of edu-
5 cation;

6 (F) a nonprofit institution of higher edu-
7 cation;

8 (G) a national or statewide nonprofit orga-
9 nization that has as its primary purpose the im-
10 provement of provision of comprehensive sex
11 education through effective teaching of com-
12 prehensive sex education; or

13 (H) a consortium of nonprofit organiza-
14 tions that has as its primary purpose the im-
15 provement of provision of comprehensive sex
16 education through effective teaching of com-
17 prehensive sex education.

18 (4) APPLICATION.—An eligible entity desiring a
19 grant under this subsection shall submit an applica-
20 tion to the Secretary at such time, in such manner,
21 and containing such information as the Secretary
22 may require.

23 (5) AUTHORIZED ACTIVITIES.—

24 (A) REQUIRED ACTIVITY.—Each eligible
25 entity receiving a grant under this subsection

1 shall use grant funds to train targeted faculty
2 and staff, in order to increase effective teaching
3 of comprehensive sex education for elementary
4 school and secondary school students.

5 (B) PERMISSIBLE ACTIVITIES.—Each eligi-
6 ble entity receiving a grant under this sub-
7 section may use grant funds to—

8 (i) strengthen and expand the eligible
9 entity's relationships with—

10 (I) institutions of higher edu-
11 cation;

12 (II) State educational agencies;

13 (III) local educational agencies;

14 or

15 (IV) other public and private or-
16 ganizations with a commitment to
17 comprehensive sex education and the
18 benefits of comprehensive sex edu-
19 cation;

20 (ii) support and promote research-
21 based training of teachers of comprehen-
22 sive sex education and related disciplines
23 in elementary schools and secondary
24 schools as a means of broadening student
25 knowledge about issues related to human

1 development, relationships, personal skills,
2 sexual behavior, sexual health, and society
3 and culture;

4 (iii) support the dissemination of in-
5 formation on effective practices and re-
6 search findings concerning the teaching of
7 comprehensive sex education;

8 (iv) support research on—

9 (I) effective comprehensive sex
10 education teaching practices; and

11 (II) the development of assess-
12 ment instruments and strategies to
13 document—

14 (aa) student understanding
15 of comprehensive sex education;

16 and

17 (bb) the effects of com-
18 prehensive sex education;

19 (v) convene national conferences on
20 comprehensive sex education, in order to
21 effectively train teachers in the provision of
22 comprehensive sex education; and

23 (vi) develop and disseminate appro-
24 priate research-based materials to foster
25 comprehensive sex education.

1 (C) SUBGRANTS.—Each eligible entity re-
2 ceiving a grant under this subsection may
3 award subgrants to nonprofit organizations,
4 State educational agencies, or local educational
5 agencies to enable such organizations or agen-
6 cies to—

7 (i) train teachers in comprehensive
8 sex education;

9 (ii) support Internet or distance learn-
10 ing related to comprehensive sex education;

11 (iii) promote rigorous academic stand-
12 ards and assessment techniques to guide
13 and measure student performance in com-
14 prehensive sex education;

15 (iv) encourage replication of best
16 practices and model programs to promote
17 comprehensive sex education;

18 (v) develop and disseminate effective,
19 research-based comprehensive sex edu-
20 cation learning materials;

21 (vi) develop academic courses on the
22 pedagogy of sex education at institutions
23 of higher education; or

24 (vii) convene State-based conferences
25 to train teachers in comprehensive sex edu-

1 cation and to identify strategies for im-
2 provement.

3 (e) REPORT TO CONGRESS.—

4 (1) IN GENERAL.—Not later than 1 year after
5 the date of the enactment of this Act, and annually
6 thereafter for a period of 5 years, the Secretary shall
7 prepare and submit to the appropriate committees of
8 Congress a report on the activities to provide adoles-
9 cents and young people with comprehensive sex edu-
10 cation funded under this section.

11 (2) REPORT ELEMENTS.—The report described
12 in paragraph (1) shall include information about—

13 (A) the number of eligible entities and in-
14 stitutions of higher education that are receiving
15 grant funds under subsections (b) and (c);

16 (B) the specific activities supported by
17 grant funds awarded under subsections (b) and
18 (c);

19 (C) the number of adolescents served by
20 grant programs funded under subsection (b);

21 (D) the number of young people served by
22 grant programs funded under subsection (c);
23 and

24 (E) the status of program evaluations de-
25 scribed under subsections (b) and (c).

1 (f) LIMITATION.—No Federal funds provided under
2 this section may be used for health education programs
3 that—

4 (1) deliberately withhold life-saving information
5 about HIV;

6 (2) are medically inaccurate or have been sci-
7 entifically shown to be ineffective;

8 (3) promote gender stereotypes;

9 (4) are insensitive and unresponsive to the
10 needs of sexually active youth or lesbian, gay, bisex-
11 ual, or transgender youth; or

12 (5) are inconsistent with the ethical imperatives
13 of medicine and public health.

14 (g) DEFINITIONS.—In this section:

15 (1) ESEA DEFINITIONS.—The terms “elemen-
16 tary school”, “local educational agency”, “secondary
17 school”, and “State educational agency” have the
18 meanings given the terms in section 9101 of the Ele-
19 mentary and Secondary Education Act of 1965 (20
20 U.S.C. 7801).

21 (2) AGE AND DEVELOPMENTALLY APPRO-
22 PRIATE.—The term “age and developmentally appro-
23 priate” means suitable for a particular age or age
24 group of children and adolescents, based on devel-

oping cognitive, emotional, and behavioral capacity
typical for that age or age group.

(3) ADOLESCENTS.—The term “adolescents”
means individuals who are ages 10 through 19 at
the time of commencement of participation in a pro-
gram supported under this section.

(4) CHARACTERISTICS OF EFFECTIVE PRO-
GRAMS.—The term “characteristics of effective pro-
grams” means the aspects of evidence-based pro-
grams, including development, content, and imple-
mentation of such programs, that—

(A) have been shown to be effective in
terms of increasing knowledge, clarifying values
and attitudes, increasing skills, and impacting
upon behavior; and

(B) are widely recognized by leading med-
ical and public health agencies to be effective in
changing sexual behaviors that lead to sexually
transmitted infections, including HIV, unin-
tended pregnancy, and dating violence and sex-
ual assault among young people.

(5) COMPREHENSIVE SEX EDUCATION.—The
term “comprehensive sex education” means a pro-
gram that—

1 (A) includes age- and developmentally ap-
2 propriate, culturally and linguistically relevant
3 information on a broad set of topics related to
4 sexuality including human development, rela-
5 tionships, decisionmaking, communication, ab-
6 stinence, contraception, and disease and preg-
7 nancy prevention;

8 (B) provides students with opportunities
9 for developing skills as well as learning informa-
10 tion;

11 (C) is inclusive of lesbian, gay, bisexual,
12 transgender, and heterosexual young people;
13 and

14 (D) aims to—

15 (i) provide scientifically accurate and
16 realistic information about human sexu-
17 ality;

18 (ii) provide opportunities for individ-
19 uals to understand their own, their fami-
20 lies', and their communities' values, atti-
21 tudes, and insights about sexuality;

22 (iii) help individuals develop healthy
23 relationships and interpersonal skills; and

24 (iv) help individuals exercise responsi-
25 bility regarding sexual relationships, which

1 includes addressing abstinence, pressures
2 to become prematurely involved in sexual
3 intercourse, and the use of contraception
4 and other sexual health measures.

5 (6) EVIDENCE-BASED PROGRAM.—The term
6 “evidence-based program” means a sex education
7 program that has been proven through rigorous eval-
8 uation to be effective in changing sexual behavior or
9 incorporates elements of other sex education pro-
10 grams that have been proven to be effective in
11 changing sexual behavior.

12 (7) INSTITUTION OF HIGHER EDUCATION.—The
13 term “institution of higher education” has the
14 meaning given the term in section 101 of the Higher
15 Education Act of 1965 (20 U.S.C. 1001).

16 (8) MEDICALLY ACCURATE AND COMPLETE.—
17 The term “medically accurate and complete”, when
18 used with respect to a sex education program, means
19 that—

20 (A) the information provided through the
21 program is verified or supported by the weight
22 of research conducted in compliance with ac-
23 cepted scientific methods and is published in
24 peer-reviewed journals, where applicable; or

1 (B)(i) the program contains information
 2 that leading professional organizations and
 3 agencies with relevant expertise in the field rec-
 4 ognize as accurate, objective, and complete; and

5 (ii) the program does not withhold infor-
 6 mation about the effectiveness and benefits of
 7 correct and consistent use of condoms and
 8 other contraceptives.

9 (9) SECRETARY.—The term “Secretary” means
 10 the Secretary of Health and Human Services.

11 (10) YOUNG PEOPLE.—The term “young peo-
 12 ple” means individuals who are ages 10 through 24
 13 at the time of commencement of participation in a
 14 program supported under this section.

15 (h) AUTHORIZATION OF APPROPRIATIONS.—To carry
 16 out this section, there are authorized to be appropriated
 17 such sums as may be necessary for fiscal years 2013
 18 through 2017.

19 **SEC. 109. ELIMINATION OF ABSTINENCE-ONLY EDUCATION**
 20 **PROGRAM.**

21 (a) IN GENERAL.—Title V of the Social Security Act
 22 (42 U.S.C. 701 et seq.) is amended by striking section
 23 510.

24 (b) RESCISSION.—Amounts appropriated for fiscal
 25 year 2012 under section 510(d) of the Social Security Act

1 (42 U.S.C. 710(d)) (as in effect on the day before the date
2 of enactment of this Act) that are unobligated as of the
3 date of enactment of this Act are rescinded.

4 (c) REPROGRAM OF ELIMINATED ABSTINENCE-ONLY
5 FUNDS FOR THE PERSONAL RESPONSIBILITY EDUCATION
6 PROGRAM (PREP).—Section 513(f) of the Social Security
7 Act (42 U.S.C. 713(f)) is amended by striking
8 “\$75,000,000 for each of fiscal years 2010 through 2014”
9 and inserting “\$75,000,000 for each of fiscal years 2010
10 and 2011, an amount for fiscal year 2012 equal to
11 \$75,000,000 increased by an amount equal to the unobli-
12 gated portion of funds appropriated for fiscal year 2012
13 under section 510(d) that are rescinded under section
14 109(b) of the Ending the HIV/AIDS Epidemic Act of
15 2012, and \$125,000,000 for each of fiscal years 2013
16 through 2014”.

1 **TITLE II—ENDING STIGMA AND**
2 **DISCRIMINATION THAT IN-**
3 **HIBIT ACCESS TO CARE AND**
4 **MAKE PEOPLE MORE VUL-**
5 **NERABLE**

6 **SEC. 201. REVIEW OF ALL FEDERAL AND STATE LAWS,**
7 **POLICIES, AND REGULATIONS REGARDING**
8 **THE CRIMINAL PROSECUTION OF INDIVID-**
9 **UALS FOR HIV-RELATED OFFENSES.**

10 (a) DEFINITIONS.—

11 (1) HIV AND HIV/AIDS.—The terms “HIV” and
12 “HIV/AIDS” have the meanings given to such terms
13 in section 2689 of the Public Health Service Act (42
14 U.S.C. 300ff–88).

15 (2) STATE.—The term “State” includes the
16 District of Columbia, American Samoa, the Com-
17 monwealth of the Northern Mariana Islands, Guam,
18 Puerto Rico, and the United States Virgin Islands.

19 (b) SENSE OF CONGRESS REGARDING LAWS OR REG-
20 ULATIONS DIRECTED AT PEOPLE LIVING WITH HIV/
21 AIDS.—It is the sense of the Congress that Federal and
22 State laws, policies, and regulations regarding people liv-
23 ing with HIV/AIDS—

1 (1) should not place unique or additional bur-
2 dens on such individuals solely as a result of their
3 HIV status; and

4 (2) should instead demonstrate a public health-
5 oriented, evidence-based, medically accurate, and
6 contemporary understanding of—

7 (A) the multiple factors that lead to HIV
8 transmission;

9 (B) the relative risk of HIV transmission
10 routes;

11 (C) the current health implications of liv-
12 ing with HIV;

13 (D) the associated benefits of treatment
14 and support services for people living with HIV;
15 and

16 (E) the impact of punitive HIV-specific
17 laws and policies on public health, on people liv-
18 ing with or affected by HIV, and on their fami-
19 lies and communities.

20 (c) REVIEW OF ALL FEDERAL AND STATE LAWS,
21 POLICIES, AND REGULATIONS REGARDING THE CRIMINAL
22 PROSECUTION OF INDIVIDUALS FOR HIV-RELATED OF-
23 FENSES.—

24 (1) REVIEW OF FEDERAL AND STATE LAWS.—

1 (A) IN GENERAL.—No later than 90 days
2 after the date of the enactment of this Act, the
3 Attorney General, the Secretary of Health and
4 Human Services, and the Secretary of Defense
5 acting jointly (in this paragraph and paragraph
6 (2) referred to as the “designated officials”)
7 shall initiate a national review of Federal and
8 State laws, policies, regulations, and judicial
9 precedents and decisions regarding criminal and
10 related civil commitment cases involving people
11 living with HIV/AIDS, including in regards to
12 the Uniform Code of Military Justice.

13 (B) CONSULTATION.—In carrying out the
14 review under subparagraph (A), the designated
15 officials shall ensure diverse participation and
16 consultation from each State, including with—

17 (i) State attorneys general (or their
18 representatives);

19 (ii) State public health officials (or
20 their representatives);

21 (iii) State judicial and court system
22 officers, including judges, district attor-
23 neys, prosecutors, defense attorneys, law
24 enforcement, and correctional officers;

1 (iv) members of the United States
2 Armed Forces, including members of other
3 Federal services subject to the Uniform
4 Code of Military Justice;

5 (v) people living with HIV/AIDS, par-
6 ticularly those who have been subject to
7 HIV-related prosecution or who are from
8 communities whose members have been
9 disproportionately subject to HIV-specific
10 arrests and prosecutions;

11 (vi) legal advocacy and HIV/AIDS
12 service organizations that work with people
13 living with HIV/AIDS;

14 (vii) nongovernmental health organi-
15 zations that work on behalf of people living
16 with HIV/AIDS; and

17 (viii) trade organizations or associa-
18 tions representing persons or entities de-
19 scribed in clauses (i) through (vii).

20 (C) RELATION TO OTHER REVIEWS.—In
21 carrying out the review under subparagraph
22 (A), the designated officials may utilize other
23 existing reviews of criminal and related civil
24 commitment cases involving people living with
25 HIV/AIDS, including any such review con-

1 ducted by any Federal or State agency or any
2 public health, legal advocacy, or trade organiza-
3 tion or association if the designated officials de-
4 termine that such reviews were conducted in ac-
5 cordance with the principles set forth in sub-
6 section (b).

7 (2) REPORT.—No later than 180 days after ini-
8 tiating the review required by paragraph (1), the At-
9 torney General shall transmit to the Congress and
10 make publicly available a report containing the re-
11 sults of the review, which includes the following:

12 (A) For each State and for the Uniform
13 Code of Military Justice, a summary of the rel-
14 evant laws, policies, regulations, and judicial
15 precedents and decisions regarding criminal
16 cases involving people living with HIV/AIDS,
17 including, if applicable, the following:

18 (i) A determination of whether such
19 laws, policies, regulations, and judicial
20 precedents and decisions place any unique
21 or additional burdens upon people living
22 with HIV/AIDS.

23 (ii) A determination of whether such
24 laws, policies, regulations, and judicial
25 precedents and decisions demonstrate a

1 public health-oriented, evidence-based,
2 medically accurate, and contemporary un-
3 derstanding of—

4 (I) the multiple factors that lead
5 to HIV transmission;

6 (II) the relative risk of HIV
7 transmission routes;

8 (III) the current health implica-
9 tions of living with HIV;

10 (IV) the associated benefits of
11 treatment and support services for
12 people living with HIV; and

13 (V) the impact of punitive HIV-
14 specific laws and policies on public
15 health, on people living with or af-
16 fected by HIV, and on their families
17 and communities.

18 (iii) An analysis of the public health
19 and legal implications of such laws, poli-
20 cies, regulations, and judicial precedents,
21 including an analysis of the consequences
22 of having a similar penal scheme applied to
23 comparable situations involving other com-
24 municable diseases.

1 (iv) An analysis of the proportionality
2 of punishments imposed under HIV-spe-
3 cific laws, policies, regulations, and judicial
4 precedents, taking into consideration pen-
5 alties attached to violation of State laws
6 against similar degrees of endangerment or
7 harm, such as driving while intoxicated
8 (DWI) or transmission of other commu-
9 nicable diseases, or more serious harms,
10 such as vehicular manslaughter offenses.

11 (B) An analysis of common elements
12 shared among State laws, policies, regulations,
13 and judicial precedents.

14 (C) A set of best practice recommendations
15 directed to State governments, including State
16 attorneys general, public health officials, and
17 judicial officers, in order to ensure that laws,
18 policies, regulations, and judicial precedents re-
19 garding people living with HIV/AIDS are in ac-
20 cordance with the principles set forth in sub-
21 section (b).

22 (D) Recommendations for adjustments to
23 the Uniform Code of Military Justice, as may
24 be necessary, in order to ensure that laws, poli-
25 cies, regulations, and judicial precedents re-

1 garding people living with HIV/AIDS are in ac-
2 cordance with the principles set forth in sub-
3 section (b).

4 (3) GUIDANCE.—Within 90 days of the release
5 of the report required by paragraph (2), the Attor-
6 ney General and the Secretary of Health and
7 Human Services, acting jointly, shall develop and
8 publicly release updated guidance for States based
9 on the set of best practice recommendations required
10 by paragraph (2)(C) in order to assist States dealing
11 with criminal and related civil commitment cases re-
12 garding people living with HIV/AIDS.

13 (4) MONITORING AND EVALUATION SYSTEM.—
14 Within 60 days of the release of the guidance re-
15 quired by paragraph (3), the Attorney General and
16 the Secretary of Health and Human Services, acting
17 jointly, shall establish an integrated monitoring and
18 evaluation system which includes, where appropriate,
19 objective and quantifiable performance goals and in-
20 dicators to measure progress toward statewide im-
21 plementation in each State of the best practice rec-
22 ommendations required in paragraph (2)(C), includ-
23 ing to monitor, track, and evaluate the effectiveness
24 of assistance provided pursuant to subsection (d).

1 (5) ADJUSTMENTS TO FEDERAL LAWS, POLI-
2 CIES, OR REGULATIONS.—Within 90 days of the re-
3 lease of the report required by paragraph (2), the
4 Attorney General, the Secretary of Health and
5 Human Services, and the Secretary of Defense, act-
6 ing jointly, shall develop and transmit to the Presi-
7 dent and the Congress, and make publicly available,
8 such proposals as may be necessary to implement
9 adjustments to Federal laws, policies, or regulations,
10 including to the Uniform Code of Military Justice,
11 based on the recommendations required by para-
12 graph (2)(D), either through Executive order or
13 through changes to statutory law.

14 (6) AUTHORIZATION OF APPROPRIATIONS.—

15 (A) IN GENERAL.—There are authorized to
16 be appropriated such sums as may be necessary
17 for the purpose of carrying out this subsection.
18 Amounts authorized to be appropriated by the
19 preceding sentence are in addition to amounts
20 otherwise authorized to be appropriated for
21 such purpose.

22 (B) AVAILABILITY OF FUNDS.—Amounts
23 appropriated pursuant to the authorization of
24 appropriations in subparagraph (A) are author-
25 ized to remain available until expended.

1 (d) AUTHORIZATION TO PROVIDE GRANTS.—

2 (1) GRANTS BY ATTORNEY GENERAL.—

3 (A) IN GENERAL.—The Attorney General
4 may provide assistance to eligible State and
5 local entities and eligible nongovernmental orga-
6 nizations for the purpose of incorporating the
7 best practice recommendations developed under
8 subsection (c)(2)(C) within relevant State laws,
9 policies, regulations, and judicial decisions re-
10 garding people living with HIV/AIDS.

11 (B) AUTHORIZED ACTIVITIES.—The assist-
12 ance authorized by subparagraph (A) may in-
13 clude—

14 (i) direct technical assistance to eligi-
15 ble State and local entities in order to de-
16 velop, disseminate, or implement State
17 laws, policies, regulations, or judicial deci-
18 sions that conform with the best practice
19 recommendations developed under sub-
20 section (c)(2)(C);

21 (ii) direct technical assistance to eligi-
22 ble nongovernmental organizations in order
23 to provide education and training, includ-
24 ing through classes, conferences, meetings,

1 and other educational activities, to eligible
2 State and local entities; and

3 (iii) subcontracting authority to allow
4 eligible State and local entities and eligible
5 nongovernmental organizations to seek
6 technical assistance from legal and public
7 health experts with a demonstrated under-
8 standing of the principles underlying the
9 best practice recommendations developed
10 under subsection (c)(2)(C).

11 (2) GRANTS BY SECRETARY OF HHS.—

12 (A) IN GENERAL.—The Secretary of
13 Health and Human Services, acting through the
14 Director of the Centers for Disease Control and
15 Prevention, may provide assistance to State and
16 local public health departments and eligible
17 nongovernmental organizations for the purpose
18 of supporting eligible State and local entities to
19 incorporate the best practice recommendations
20 developed under subsection (c)(2)(C) within rel-
21 evant State laws, policies, regulations, and judi-
22 cial decisions regarding people living with HIV/
23 AIDS.

1 (B) AUTHORIZED ACTIVITIES.—The assist-
2 ance authorized by subparagraph (A) may in-
3 clude—

4 (i) direct technical assistance to State
5 and local public health departments in
6 order to support the development, dissemi-
7 nation, or implementation of State laws,
8 policies, regulations, or judicial decisions
9 that conform with the set of best practice
10 recommendations developed under sub-
11 section (c)(2)(C);

12 (ii) direct technical assistance to eligi-
13 ble nongovernmental organizations in order
14 to provide education and training, includ-
15 ing through classes, conferences, meetings,
16 and other educational activities, to State
17 and local public health departments; and

18 (iii) subcontracting authority to allow
19 State and local public health departments
20 and eligible nongovernmental organizations
21 to seek technical assistance from legal and
22 public health experts with a demonstrated
23 understanding of the principles underlying
24 the best practice recommendations devel-
25 oped under subsection (c)(2)(C).

1 (3) LIMITATION.—As a condition of receiving
2 assistance through this subsection, eligible State and
3 local entities, State and local public health depart-
4 ments, and eligible nongovernmental organizations
5 shall agree—

6 (A) not to place any unique or additional
7 burdens on people living with HIV/AIDS solely
8 as a result of their HIV status; and

9 (B) that if the entity, department, or orga-
10 nization promulgates any laws, policies, regula-
11 tions, or judicial decisions regarding people liv-
12 ing with HIV/AIDS, such actions shall dem-
13 onstrate a public health-oriented, evidence-
14 based, medically accurate, and contemporary
15 understanding of—

16 (i) the multiple factors that lead to
17 HIV transmission;

18 (ii) the relative risk of HIV trans-
19 mission routes;

20 (iii) the current health implications of
21 living with HIV;

22 (iv) the associated benefits of treat-
23 ment and support services for people living
24 with HIV; and

1 (v) the impact of punitive HIV-spe-
2 cific laws and policies on public health, on
3 people living with or affected by HIV, and
4 on their families and communities.

5 (4) REPORT.—No later than 1 year after the
6 date of the enactment of this Act, and annually
7 thereafter, the Attorney General and the Secretary
8 of Health and Human Services, acting jointly, shall
9 transmit to Congress and make publicly available a
10 report describing, for each State, the impact and ef-
11 fectiveness of the assistance provided through this
12 Act. Each such report shall include—

13 (A) a detailed description of the progress
14 each State has made, if any, in implementing
15 the best practice recommendations developed
16 under subsection (c)(2)(C) as a result of the as-
17 sistance provided under this subsection, and
18 based on the performance goals and indicators
19 established as part of the monitoring and eval-
20 uation system in subsection (c)(4);

21 (B) a brief summary of any outreach ef-
22 forts undertaken during the prior year by the
23 Attorney General and the Secretary of Health
24 and Human Services to encourage States to
25 seek assistance under this subsection in order

1 to implement the best practice recommenda-
2 tions developed under subsection (c)(2)(C);

3 (C) a summary of how assistance provided
4 through this subsection is being utilized by eli-
5 gible State and local entities, State and local
6 public health departments, and eligible non-
7 governmental organizations and, if applicable,
8 any contractors, including with respect to non-
9 governmental organizations, the type of tech-
10 nical assistance provided, and an evaluation of
11 the impact of such assistance on eligible State
12 and local entities; and

13 (D) a summary and description of eligible
14 State and local entities, State and local public
15 health departments, and eligible nongovern-
16 mental organizations receiving assistance
17 through this subsection, including if applicable,
18 a summary and description of any contractors
19 selected to assist in implementing such assist-
20 ance.

21 (5) DEFINITIONS.—For the purposes of this
22 subsection:

23 (A) ELIGIBLE STATE AND LOCAL ENTI-
24 TIES.—The term “eligible State and local enti-
25 ties” means the relevant individuals, offices, or

1 organizations that directly participate in the de-
2 velopment, dissemination, or implementation of
3 State laws, policies, regulations, or judicial deci-
4 sions, including—

5 (i) State governments, including State
6 attorneys general, State departments of
7 justice, and State National Guards, or
8 their equivalents;

9 (ii) State judicial and court systems,
10 including trial courts, appellate courts,
11 State supreme courts and courts of appeal,
12 and State correctional facilities, or their
13 equivalents; and

14 (iii) local governments, including city
15 and county governments, district attorneys,
16 and local law enforcement departments, or
17 their equivalents.

18 (B) STATE AND LOCAL PUBLIC HEALTH
19 DEPARTMENTS.—The term “State and local
20 public health departments” means the fol-
21 lowing:

22 (i) State public health departments, or
23 their equivalents, including the chief officer
24 of such departments and infectious disease

1 and communicable disease specialists with-
2 in such departments.

3 (ii) Local public health departments,
4 or their equivalents, including city and
5 county public health departments, the chief
6 officer of such departments, and infectious
7 disease and communicable disease special-
8 ists within such departments.

9 (iii) Public health departments or offi-
10 cials, or their equivalents, within State or
11 local correctional facilities.

12 (iv) Public health departments or offi-
13 cials, or their equivalents, within State Na-
14 tional Guards.

15 (v) Any other recognized State or
16 local public health organization or entity
17 charged with carrying out official State or
18 local public health duties.

19 (C) ELIGIBLE NONGOVERNMENTAL ORGA-
20 NIZATIONS.—The term “eligible nongovern-
21 mental organizations” means the following:

22 (i) Nongovernmental organizations,
23 including trade organizations or associa-
24 tions that represent—

1 (I) State attorneys general, or
2 their equivalents;

3 (II) State public health officials,
4 or their equivalents;

5 (III) State judicial and court offi-
6 cers, including judges, district attor-
7 neys, prosecutors, defense attorneys,
8 law enforcement, and correctional offi-
9 cers;

10 (IV) State National Guards;

11 (V) people living with HIV/AIDS;

12 (VI) legal advocacy and HIV/
13 AIDS service organizations that work
14 with people living with HIV/AIDS;
15 and

16 (VII) nongovernmental health or-
17 ganizations that work on behalf of
18 people living with HIV/AIDS.

19 (ii) Nongovernmental organizations,
20 including trade organizations or associa-
21 tions that demonstrate a public-health ori-
22 ented, evidence-based, medically accurate,
23 and contemporary understanding of—

24 (I) the multiple factors that lead
25 to HIV transmission;

1 (II) the relative risk of HIV
2 transmission routes;

3 (III) the current health implica-
4 tions of living with HIV;

5 (IV) the associated benefits of
6 treatment and support services for
7 people living with HIV; and

8 (V) the impact of punitive HIV-
9 specific laws and policies on public
10 health, on people living with or af-
11 fected by HIV, and on their families
12 and communities.

13 (6) AUTHORIZATION OF APPROPRIATIONS.—

14 (A) IN GENERAL.—In addition to amounts
15 otherwise made available, there are authorized
16 to be appropriated to the Attorney General and
17 the Secretary of Health and Human Services
18 such sums as may be necessary to carry out
19 this subsection for each of the fiscal years 2013
20 through 2017.

21 (B) AVAILABILITY OF FUNDS.—Amounts
22 appropriated pursuant to the authorizations of
23 appropriations in subparagraph (A) are author-
24 ized to remain available until expended.

1 **TITLE III—ADDRESSING LEGAL**
2 **AND POLICY BARRIERS TO**
3 **ACCESSING HEALTH CARE**

4 **SEC. 301. REPEAL OF LIMITATION AGAINST USE OF FUNDS**
5 **FOR EDUCATION OR INFORMATION DE-**
6 **SIGNED TO PROMOTE OR ENCOURAGE, DI-**
7 **RECTLY, HOMOSEXUAL OR HETEROSEXUAL**
8 **ACTIVITY OR INTRAVENOUS SUBSTANCE**
9 **ABUSE.**

10 Section 2500 of the Public Health Service Act (42
11 U.S.C. 300ee) is amended—

12 (1) by striking subsection (c); and

13 (2) by redesignating subsection (d) as sub-
14 section (c).

15 **SEC. 302. EXPANDING SUPPORT FOR CONDOMS IN PRIS-**
16 **ONS.**

17 (a) **AUTHORITY TO ALLOW COMMUNITY ORGANIZA-**
18 **TIONS TO PROVIDE STI COUNSELING, STI PREVENTION**
19 **EDUCATION, AND SEXUAL BARRIER PROTECTION DE-**
20 **VICES IN FEDERAL CORRECTIONAL FACILITIES.—**

21 (1) **DIRECTIVE TO ATTORNEY GENERAL.—**Not
22 later than 30 days after the date of enactment of
23 this Act, the Attorney General shall direct the Bu-
24 reau of Prisons to allow community organizations to
25 distribute sexual barrier protection devices and to

1 engage in STI counseling and STI prevention edu-
2 cation in Federal correctional facilities. These activi-
3 ties shall be subject to all relevant Federal laws and
4 regulations which govern visitation in correctional
5 facilities.

6 (2) INFORMATION REQUIREMENT.—Any com-
7 munity organization permitted to distribute sexual
8 barrier protection devices under paragraph (1) must
9 ensure that the persons to whom the devices are dis-
10 tributed are informed about the proper use and dis-
11 posal of sexual barrier protection devices in accord-
12 ance with established public health practices. Any
13 community organization conducting STI counseling
14 or STI prevention education under paragraph (1)
15 must offer comprehensive sexuality education.

16 (3) POSSESSION OF DEVICE PROTECTED.—No
17 Federal correctional facility may, because of the pos-
18 session or use of a sexual barrier protection device—

19 (A) take adverse action against an incar-
20 cerated person; or

21 (B) consider possession or use as evidence
22 of prohibited activity for the purpose of any
23 Federal correctional facility administrative pro-
24 ceeding.

1 (4) IMPLEMENTATION.—The Attorney General
2 and Bureau of Prisons shall implement this section
3 according to established public health practices in a
4 manner that protects the health, safety, and privacy
5 of incarcerated persons and of correctional facility
6 staff.

7 (b) SENSE OF CONGRESS REGARDING DISTRIBUTION
8 OF SEXUAL BARRIER PROTECTION DEVICES IN STATE
9 PRISON SYSTEMS.—It is the sense of the Congress that
10 States should allow for the legal distribution of sexual bar-
11 rier protection devices in State correctional facilities to re-
12 duce the prevalence and spread of STIs in those facilities.

13 (c) SURVEY OF AND REPORT ON CORRECTIONAL FA-
14 CILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF
15 STIs.—

16 (1) SURVEY.—The Attorney General, after con-
17 sulting with the Secretary of Health and Human
18 Services, State officials, and community organiza-
19 tions, shall, to the maximum extent practicable, con-
20 duct a survey of all Federal and State correctional
21 facilities, no later than 180 days after the date of
22 enactment of this Act and annually thereafter for 5
23 years, to determine the following:

24 (A) COUNSELING, TREATMENT, AND SUP-
25 PORTIVE SERVICES.—Whether the correctional

1 facility requires incarcerated persons to partici-
2 pate in counseling, treatment, and supportive
3 services related to STIs, or whether it offers
4 such programs to incarcerated persons.

5 (B) ACCESS TO SEXUAL BARRIER PROTEC-
6 TION DEVICES.—Whether incarcerated persons
7 can—

8 (i) possess sexual barrier protection
9 devices;

10 (ii) purchase sexual barrier protection
11 devices;

12 (iii) purchase sexual barrier protection
13 devices at a reduced cost; and

14 (iv) obtain sexual barrier protection
15 devices without cost.

16 (C) INCIDENCE OF SEXUAL VIOLENCE.—
17 The incidence of sexual violence and assault
18 committed by incarcerated persons and by cor-
19 rectional facility staff.

20 (D) PREVENTION EDUCATION OFFERED.—
21 The type of prevention education, information,
22 or training offered to incarcerated persons and
23 correctional facility staff regarding sexual vio-
24 lence and the spread of STIs, including whether
25 such education, information, or training—

- 1 (i) constitutes comprehensive sexuality
- 2 education;
- 3 (ii) is compulsory for new incarcerated
- 4 persons and for new staff; and
- 5 (iii) is offered on an ongoing basis.

6 (E) STI TESTING.—Whether the correc-
7 tional facility tests incarcerated persons for
8 STIs or gives them the option to undergo such
9 testing—

- 10 (i) at intake;
- 11 (ii) on a regular basis; and
- 12 (iii) prior to release.

13 (F) STI TEST RESULTS.—The number of
14 incarcerated persons who are tested for STIs
15 and the outcome of such tests at each correc-
16 tional facility, disaggregated to include results
17 for—

- 18 (i) the type of sexually transmitted in-
19 fection tested for;
- 20 (ii) the race and/or ethnicity of indi-
21 viduals tested;
- 22 (iii) the age of individuals tested; and
- 23 (iv) the gender of individuals tested.

24 (G) PRERELEASE REFERRAL POLICY.—
25 Whether incarcerated persons are informed

1 prior to release about STI-related services or
2 other health services in their communities, in-
3 cluding free and low-cost counseling and treat-
4 ment options.

5 (H) PRERELEASE REFERRALS MADE.—

6 The number of referrals to community-based
7 organizations or public health facilities offering
8 STI-related or other health services provided to
9 incarcerated persons prior to release, and the
10 type of counseling or treatment for which the
11 referral was made.

12 (I) REINSTATEMENT OF MEDICAID BENE-

13 FITS.—Whether the correctional facility assists
14 incarcerated persons that were enrolled in the
15 State Medicaid program prior to their incarcer-
16 ation, in reinstating their enrollment upon re-
17 lease and whether such individuals receive refer-
18 rals as provided by subparagraph (G) to entities
19 that accept the State Medicaid program, includ-
20 ing if applicable—

21 (i) the number of such individuals, in-
22 cluding those diagnosed with the human
23 immunodeficiency virus, that have been re-
24 instated;

1 (ii) a list of obstacles to reinstating
2 enrollment or to making determinations of
3 eligibility for reinstatement, if any; and

4 (iii) the number of individuals denied
5 enrollment.

6 (J) OTHER ACTIONS TAKEN.—Whether the
7 correctional facility has taken any other action,
8 in conjunction with community organizations or
9 otherwise, to reduce the prevalence and spread
10 of STIs in that facility.

11 (2) PRIVACY.—In conducting the survey, the
12 Attorney General shall not request or retain the
13 identity of any person who has sought or been of-
14 fered counseling, treatment, testing, or prevention
15 education information regarding an STI (including
16 information about sexual barrier protection devices),
17 or who has tested positive for an STI.

18 (3) REPORT.—The Attorney General shall
19 transmit to Congress and make publicly available
20 the results of the survey required under paragraph
21 (1), both for the Nation as a whole and
22 disaggregated as to each State and each correctional
23 facility. To the maximum extent possible, the Attor-
24 ney General shall issue the first report no later than

1 1 year after the date of enactment of this Act and
2 shall issue reports annually thereafter for 5 years.

3 (d) STRATEGY.—

4 (1) DIRECTIVE TO ATTORNEY GENERAL.—The
5 Attorney General, in consultation with the Secretary
6 of Health and Human Services, State officials, and
7 community organizations, shall develop and imple-
8 ment a 5-year strategy to reduce the prevalence and
9 spread of STIs in Federal and State correctional fa-
10 cilities. To the maximum extent possible, the strat-
11 egy shall be developed, transmitted to Congress, and
12 made publicly available no later than 180 days after
13 the transmission of the first report required under
14 subsection (c)(3).

15 (2) CONTENTS OF STRATEGY.—The strategy
16 shall include the following:

17 (A) PREVENTION EDUCATION.—A plan for
18 improving prevention education, information,
19 and training offered to incarcerated persons
20 and correctional facility staff, including infor-
21 mation and training on sexual violence and the
22 spread of STIs, and comprehensive sexuality
23 education.

24 (B) SEXUAL BARRIER PROTECTION DEVICE
25 ACCESS.—A plan for expanding access to sexual

1 barrier protection devices in correctional facili-
2 ties.

3 (C) SEXUAL VIOLENCE REDUCTION.—A
4 plan for reducing the incidence of sexual vio-
5 lence among incarcerated persons and correc-
6 tional facility staff, developed in consultation
7 with the National Prison Rape Elimination
8 Commission.

9 (D) COUNSELING AND SUPPORTIVE SERV-
10 ICES.—A plan for expanding access to coun-
11 seling and supportive services related to STIs in
12 correctional facilities.

13 (E) TESTING.—A plan for testing incarcer-
14 ated persons for STIs during intake, during
15 regular health exams, and prior to release, and
16 that—

17 (i) is conducted in accordance with
18 guidelines established by the Centers for
19 Disease Control and Prevention;

20 (ii) includes pretest counseling;

21 (iii) requires that incarcerated persons
22 are notified of their option to decline test-
23 ing at any time;

1 (iv) requires that incarcerated persons
2 are confidentially notified of their test re-
3 sults in a timely manner; and

4 (v) ensures that incarcerated persons
5 testing positive for STIs receive post-test
6 counseling, care, treatment, and supportive
7 services.

8 (F) TREATMENT.—A plan for ensuring
9 that correctional facilities have the necessary
10 medicine and equipment to treat and monitor
11 STIs and for ensuring that incarcerated per-
12 sons living with or testing positive for STIs re-
13 ceive and have access to care and treatment
14 services.

15 (G) STRATEGIES FOR DEMOGRAPHIC
16 GROUPS.—A plan for developing and imple-
17 menting culturally appropriate, sensitive, and
18 specific strategies to reduce the spread of STIs
19 among demographic groups heavily impacted by
20 STIs.

21 (H) LINKAGES WITH COMMUNITIES AND
22 FACILITIES.—A plan for establishing and
23 strengthening linkages to local communities and
24 health facilities that—

1 (i) provide counseling, testing, care,
2 and treatment services;

3 (ii) may receive persons recently re-
4 leased from incarceration who are living
5 with STIs; and

6 (iii) accept payment through the State
7 Medicaid program.

8 (I) ENROLLMENT IN STATE MEDICAID
9 PROGRAMS.—Plans to ensure that incarcerated
10 persons who were—

11 (i) enrolled in their State Medicaid
12 program prior to incarceration in a correc-
13 tional facility are automatically re-enrolled
14 in such program upon their release; and

15 (ii) not enrolled in their State Med-
16 icaid program prior to incarceration, but
17 who are diagnosed with the human im-
18 munodeficiency virus while incarcerated in
19 a correctional facility, are automatically
20 enrolled in such program upon their re-
21 lease.

22 (J) OTHER PLANS.—Any other plans de-
23 veloped by the Attorney General for reducing
24 the spread of STIs or improving the quality of
25 health care in correctional facilities.

1 (K) MONITORING SYSTEM.—A monitoring
2 system that establishes performance goals re-
3 lated to reducing the prevalence and spread of
4 STIs in correctional facilities and which, where
5 feasible, expresses such goals in quantifiable
6 form.

7 (L) MONITORING SYSTEM PERFORMANCE
8 INDICATORS.—Performance indicators that
9 measure or assess the achievement of the per-
10 formance goals described in subparagraph (I).

11 (M) COST ESTIMATE.—A detailed estimate
12 of the funding necessary to implement the
13 strategy at the Federal and State levels for all
14 5 years, including the amount of funds required
15 by community organizations to implement the
16 parts of the strategy in which they take part.

17 (3) REPORT.—The Attorney General shall
18 transmit to Congress and make publicly available an
19 annual progress report regarding the implementation
20 and effectiveness of the strategy described in para-
21 graph (1). The progress report shall include an eval-
22 uation of the implementation of the strategy using
23 the monitoring system and performance indicators
24 provided for in subparagraphs (I) and (J) of para-
25 graph (2).

1 (e) APPROPRIATIONS.—

2 (1) IN GENERAL.—There are authorized to be
3 appropriated such sums as may be necessary to
4 carry out this section for each of fiscal years 2013
5 through 2019.

6 (2) AVAILABILITY OF FUNDS.—Amounts made
7 available under paragraph (1) are authorized to re-
8 main available until expended.

9 (f) DEFINITIONS.—For the purposes of this section:

10 (1) COMMUNITY ORGANIZATION.—The term
11 “community organization” means a public health
12 care facility or a nonprofit organization which pro-
13 vides health- or STI-related services according to es-
14 tablished public health standards.

15 (2) COMPREHENSIVE SEXUALITY EDUCATION.—
16 The term “comprehensive sexuality education”
17 means sexuality education that includes information
18 about abstinence and about the proper use and dis-
19 posal of sexual barrier protection devices and which
20 is—

- 21 (A) evidence-based;
- 22 (B) medically accurate;
- 23 (C) age and developmentally appropriate;
- 24 (D) gender and identity sensitive;

1 (E) culturally and linguistically appro-
2 priate; and

3 (F) structured to promote critical thinking,
4 self-esteem, respect for others, and the develop-
5 ment of healthy attitudes and relationships.

6 (3) CORRECTIONAL FACILITY.—The term “cor-
7 rectional facility” means any prison, penitentiary,
8 adult detention facility, juvenile detention facility,
9 jail, or other facility to which persons may be sent
10 after conviction of a crime or act of juvenile delin-
11 quency within the United States.

12 (4) INCARCERATED PERSON.—The term “incar-
13 cerated person” means any person who is serving a
14 sentence in a correctional facility after conviction of
15 a crime.

16 (5) SEXUALLY TRANSMITTED INFECTION.—The
17 term “sexually transmitted infection” or “STI”
18 means any disease or infection that is commonly
19 transmitted through sexual activity, including HIV/
20 AIDS, gonorrhea, chlamydia, syphilis, genital her-
21 pes, viral hepatitis, and human papillomavirus.

22 (6) SEXUAL BARRIER PROTECTION DEVICE.—
23 The term “sexual barrier protection device” means
24 any FDA-approved physical device which has not
25 been tampered with and which reduces the prob-

ability of STI transmission or infection between sexual partners, including female condoms, male condoms, and dental dams.

(7) STATE.—The term “State” includes the District of Columbia, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the United States Virgin Islands.

**SEC. 303. AUTOMATIC REINSTATEMENT OR ENROLLMENT
IN MEDICAID FOR PEOPLE WHO TEST POSITIVE FOR HIV BEFORE REENTERING COMMUNITIES.**

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

“(15) ENROLLMENT OF EX-OFFENDERS.—

“(A) AUTOMATIC ENROLLMENT OR REINSTATEMENT.—

“(i) IN GENERAL.—The State plan shall provide for the automatic enrollment or reinstatement of enrollment of an eligible individual—

“(I) if such individual is scheduled to be released from a public institution due to the completion of sen-

1 tence, not less than 30 days prior to
2 the scheduled date of the release; and

3 “(II) if such individual is to be
4 released from a public institution on
5 parole or on probation, as soon as
6 possible after the date on which the
7 determination to release such indi-
8 vidual was made, and before the date
9 such individual is released.

10 “(ii) EXCEPTION.—If a State makes a
11 determination that an individual is not eli-
12 gible to be enrolled under the State plan—

13 “(I) on or before the date by
14 which the individual would be enrolled
15 under clause (i), such clause shall not
16 apply to such individual; or

17 “(II) after such date, the State
18 may terminate the enrollment of such
19 individual.

20 “(B) RELATIONSHIP OF ENROLLMENT TO
21 PAYMENT FOR SERVICES.—

22 “(i) IN GENERAL.—Subject to sub-
23 paragraph (A)(ii), an eligible individual
24 who is enrolled, or whose enrollment is re-
25 instated, under subparagraph (A) shall be

1 eligible for medical assistance that is pro-
2 vided after the date that the eligible indi-
3 vidual is released from the public institu-
4 tion.

5 “(ii) RELATIONSHIP TO PAYMENT
6 PROHIBITION FOR INMATES.—No provision
7 of this paragraph may be construed to per-
8 mit payment for care or services for which
9 payment is excluded under subparagraph
10 (A), following paragraph (29), in section
11 1905(a).

12 “(C) TREATMENT OF CONTINUOUS ELIGI-
13 BILITY.—

14 “(i) SUSPENSION FOR INMATES.—Any
15 period of continuous eligibility under this
16 title shall be suspended on the date an in-
17 dividual enrolled under this title becomes
18 an inmate of a public institution (except as
19 a patient of a medical institution).

20 “(ii) DETERMINATION OF REMAINING
21 PERIOD.—Notwithstanding any changes to
22 State law related to continuous eligibility
23 during the time that an individual is an in-
24 mate of a public institution (except as a
25 patient of a medical institution), subject to

1 clause (iii), with respect to an eligible indi-
2 vidual who was subject to a suspension
3 under subclause (I), on the date that such
4 individual is released from a public institu-
5 tion the suspension of continuous eligibility
6 under such subclause shall be lifted for a
7 period that is equal to the time remaining
8 in the period of continuous eligibility for
9 such individual on the date that such pe-
10 riod was suspended under such subclause.

11 “(iii) EXCEPTION.—If a State makes
12 a determination that an individual is not
13 eligible to be enrolled under the State
14 plan—

15 “(I) on or before the date that
16 the suspension of continuous eligibility
17 is lifted under clause (ii), such clause
18 shall not apply to such individual; or

19 “(II) after such date, the State
20 may terminate the enrollment of such
21 individual.

22 “(D) AUTOMATIC ENROLLMENT OR REIN-
23 STATEMENT OF ENROLLMENT DEFINED.—For
24 purposes of this paragraph, the term ‘automatic
25 enrollment or reinstatement of enrollment’

1 means that the State determines eligibility for
2 medical assistance under the State plan without
3 a program application from, or on behalf of, the
4 eligible individual, but an individual can only be
5 automatically enrolled in the State Medicaid
6 plan if the individual affirmatively consents to
7 being enrolled through affirmation in writing,
8 by telephone, orally, through electronic signa-
9 ture, or through any other means specified by
10 the Secretary.

11 “(E) ELIGIBLE INDIVIDUAL DEFINED.—
12 For purposes of this paragraph, the term ‘eligi-
13 ble individual’ means an individual who is an
14 inmate of a public institution (except as a pa-
15 tient in a medical institution)—

16 “(i) who was enrolled under the State
17 plan for medical assistance immediately be-
18 fore becoming an inmate of such an insti-
19 tution; or

20 “(ii) is diagnosed with human im-
21 munodeficiency virus.”.

22 (b) SUPPLEMENTAL FUNDING FOR STATE IMPLE-
23 MENTATION OF AUTOMATIC REINSTATEMENT OF MED-
24 ICAID BENEFITS.—

1 (1) IN GENERAL.—Subject to paragraph (6),
2 for each State for which the Secretary of Health and
3 Human Services has approved an application under
4 paragraph (3), the Federal matching payments (in-
5 cluding payments based on the Federal medical as-
6 sistance percentage) made to such State under sec-
7 tion 1903 of the Social Security Act (42 U.S.C.
8 1396b) (excluding any increase resulting from the
9 application of section 5001 of Public Law 111–5)
10 shall be increased by 5.0 percentage points for pay-
11 ments to the State for the activities permitted under
12 paragraph (2) or a period of one year.

13 (2) USE OF FUNDS.—A State may only use in-
14 creased matching payments authorized under para-
15 graph (1)—

16 (A) to strengthen the State’s enrollment
17 and administrative resources for the purpose of
18 improving processes for enrolling (or reinstating
19 the enrollment of) eligible individuals (as such
20 term is defined in section 1902(e)(15)(E) of the
21 Social Security Act); and

22 (B) for medical assistance (as such term is
23 defined in section 1905(a) of the Social Secu-
24 rity Act) provided to such eligible individuals.

1 (3) APPLICATION AND AGREEMENT.—The Sec-
2 retary may only make payments to a State in the in-
3 creased amount if—

4 (A) the State has amended the State plan
5 under section 1902 of the Social Security Act
6 to incorporate the requirements of paragraph
7 (5)(xv) of such section;

8 (B) the State has submitted an application
9 to the Secretary that includes a plan for imple-
10 menting the requirements of section
11 1902(e)(15) of the Social Security Act under
12 the State’s amended State plan before the end
13 of the 90-day period beginning on the date that
14 the State receives increased matching payments
15 under paragraph (1);

16 (C) the State’s application meets the satis-
17 faction of the Secretary; and

18 (D) the State enters an agreement with
19 the Secretary that states that—

20 (i) the State will only use the in-
21 creased matching funds for the uses per-
22 mitted under paragraph (2); and

23 (ii) at the end of the period under
24 paragraph (1), the State will submit to the
25 Secretary, and make publicly available, a

1 report that contains the information re-
2 quired under paragraph (4).

3 (4) REQUIRED REPORT INFORMATION.—The in-
4 formation that is required in the report under para-
5 graph (3)(D)(ii) includes—

6 (A) the results of an evaluation of the im-
7 pact of the implementation of the requirements
8 of section 1902(e)(15) of the Social Security
9 Act on improving the State’s processes for en-
10 rolling of individuals who are released from
11 public institutions into the Medicaid program;

12 (B) the number of individuals who were
13 automatically enrolled (or whose enrollment is
14 reinstated) under such section 1902(e)(15) dur-
15 ing the period under paragraph (1); and

16 (C) any other information that is required
17 by the Secretary.

18 (5) INCREASE IN CAP ON MEDICAID PAYMENTS
19 TO TERRITORIES.—Subject to paragraph (6), the
20 amounts otherwise determined for Puerto Rico, the
21 United States Virgin Islands, Guam, the Northern
22 Mariana Islands, and American Samoa under sub-
23 sections (f) and (g) of section 1108 of the Social Se-
24 curity Act (42 U.S.C. 1308) shall each be increased
25 by the necessary amount to allow for the increase in

1 the Federal matching payments under paragraph
2 (1), but only for the period under such subpara-
3 graph for such State. In the case of such an increase
4 for a territory, subsection (a)(1) of such section
5 1108 shall be applied without regard to any increase
6 in payment made to the territory under part E of
7 title IV of such Act that is attributable to the in-
8 crease in Federal medical assistance percentage ef-
9 fected under paragraph (1) for the territory.

10 (6) LIMITATIONS.—

11 (A) TIMING.—With respect to a State, at
12 the end of the period under paragraph (1), no
13 increased matching payments may be made to
14 such State under this subsection.

15 (B) MAINTENANCE OF ELIGIBILITY.—

16 (i) IN GENERAL.—Subject to clause
17 (ii), a State is not eligible for an increase
18 in its Federal matching payments under
19 paragraph (1), or an increase in a cap
20 amount under paragraph (5), if eligibility
21 standards, methodologies, or procedures
22 under its State plan under title XIX of the
23 Social Security Act (including any waiver
24 under such title or under section 1115 of
25 such Act (42 U.S.C. 1315)) are more re-

1 strictive than the eligibility standards,
2 methodologies, or procedures, respectively,
3 under such plan (or waiver) as in effect on
4 the date of enactment of this Act.

5 (ii) STATE REINSTATEMENT OF ELIGI-
6 BILITY PERMITTED.—A State that has re-
7 stricted eligibility standards, methodolo-
8 gies, or procedures under its State plan
9 under title XIX of the Social Security Act
10 (including any waiver under such title or
11 under section 1115 of such Act (42 U.S.C.
12 1315)) after the date of enactment of this
13 Act, is no longer ineligible under subpara-
14 graph (A) beginning with the first calendar
15 quarter in which the State has reinstated
16 eligibility standards, methodologies, or pro-
17 cedures that are no more restrictive than
18 the eligibility standards, methodologies, or
19 procedures, respectively, under such plan
20 (or waiver) as in effect on such date.

21 (C) NO WAIVER AUTHORITY.—The Sec-
22 retary may not waive the application of this
23 subsection under section 1115 of the Social Se-
24 curity Act or otherwise.

1 (D) LIMITATION OF MATCHING PAYMENTS
2 TO 100 PERCENT.—In no case shall an increase
3 in Federal matching payments under this sub-
4 section result in Federal matching payments
5 that exceed 100 percent.

6 (c) EFFECTIVE DATE.—

7 (1) IN GENERAL.—Except as provided in para-
8 graph (2), the amendments made by subsection (a)
9 shall take effect 180 days after the date of the en-
10 actment of this Act and shall apply to services fur-
11 nished on or after such date.

12 (2) RULE FOR CHANGES REQUIRING STATE
13 LEGISLATION.—In the case of a State plan for med-
14 ical assistance under title XIX of the Social Security
15 Act which the Secretary of Health and Human Serv-
16 ices determines requires State legislation (other than
17 legislation appropriating funds) in order for the plan
18 to meet the additional requirement imposed by the
19 amendments made by this section, the State plan
20 shall not be regarded as failing to comply with the
21 requirements of such title solely on the basis of its
22 failure to meet this additional requirement before
23 the first day of the first calendar quarter beginning
24 after the close of the first regular session of the
25 State legislature that begins after the date of the en-

1 actment of this Act. For purposes of the previous
2 sentence, in the case of a State that has a 2-year
3 legislative session, each year of such session shall be
4 deemed to be a separate regular session of the State
5 legislature.

6 **TITLE IV—COORDINATING EF-**
7 **FORTS TO DRIVE GREATER**
8 **EFFICIENCY AND IMPROVED**
9 **RESULTS**

10 **SEC. 401. SUPPORT DATA SYSTEM REVIEW AND INDICA-**
11 **TORS FOR MONITORING HIV CARE.**

12 The Secretary of Health and Human Services, in col-
13 laboration with the Assistant Secretary for Health, the Di-
14 rector of the Office of HIV/AIDS and Infectious Disease
15 Policy, the Director of the Centers for Disease Control and
16 Prevention, the Administrator of the Substance Abuse and
17 Mental Health Services Administration, the Director of
18 the Department of Housing and Urban Development, the
19 Director of the Office of AIDS Research, the Adminis-
20 trator of the Health Resources and Services Administra-
21 tion, and the Administrator of the Centers for Medicare
22 & Medicaid Services, shall expand and coordinate efforts
23 to align metrics across agencies and modify Federal data
24 systems, to—

1 (1) adopt the Institute of Medicine’s clinical
2 HIV care indicators as the core metrics for moni-
3 toring the quality of HIV care, mental health, sub-
4 stance abuse, and supportive services;

5 (2) better enable assessment of the impact of
6 the National HIV/AIDS Strategy and the Patient
7 Protection and Affordable Care Act on improving
8 HIV/AIDS care and access to supportive services for
9 individuals with HIV;

10 (3) expand the demographic data elements to be
11 captured by Federal data systems relevant to HIV
12 care to permit calculation of the indicators for sub-
13 groups of the population of people with diagnosed
14 HIV infection, including—

15 (A) age;

16 (B) race;

17 (C) ethnicity;

18 (D) sex (assigned at birth);

19 (E) gender identity;

20 (F) sexual orientation;

21 (G) current geographic marker of resi-
22 dence;

23 (H) income or poverty level; and

24 (I) primary means of reimbursement for
25 medical services (including Medicaid, Medicare,

1 the Ryan White HIV/AIDS Program, private
2 insurance, health maintenance organizations,
3 and no coverage); and

4 (4) streamline data collection and systematically
5 review all existing reporting requirements for feder-
6 ally funded HIV/AIDS programs to ensure that only
7 essential data are collected.

8 **SEC. 402. TRANSFER OF FUNDS FOR IMPLEMENTATION OF**
9 **NATIONAL HIV/AIDS STRATEGY.**

10 Title II of the Public Health Service Act (42 U.S.C.
11 202 et seq.) is amended by inserting after section 241 the
12 following:

13 **“SEC. 241A. TRANSFER OF FUNDS FOR IMPLEMENTATION**
14 **OF NATIONAL HIV/AIDS STRATEGY.**

15 “(a) **TRANSFER AUTHORIZATION.**—Of the discre-
16 tionary appropriations made available to the Department
17 of Health and Human Services for any fiscal year for pro-
18 grams and activities that, as determined by the Secretary
19 of Health and Human Services, pertain to HIV/AIDS, the
20 Secretary, in coordination with the Director of the Office
21 of National HIV/AIDS Policy, may transfer up to 1 per-
22 cent of such appropriations to the Office of the Assistant
23 Secretary for Health for implementation of the National
24 HIV/AIDS Strategy.

1 “(b) CONGRESSIONAL NOTIFICATION.—Not less than
2 30 days before making any transfer under this section,
3 the Secretary shall give notice of the transfer to the Con-
4 gress.

5 “(c) DEFINITIONS.—In this section:

6 “(1) The term ‘HIV/AIDS’ has the meaning
7 given to such term in section 2689.

8 “(2) The term ‘National HIV/AIDS Strategy’
9 means the National HIV/AIDS Strategy for the
10 United States issued by the President in July 2010
11 and includes any subsequent revisions to such Strat-
12 egy.”.

13 **SEC. 403. HIV INTEGRATED SERVICES DELIVERY MODEL**
14 **DEMONSTRATION.**

15 (a) IN GENERAL.—Consistent with the National
16 HIV/AIDS Strategy for the United States and in accord-
17 ance with this section, the Secretary of Health and
18 Human Services acting through the Center for Medicare
19 & Medicaid Innovation and in cooperation with CDC,
20 HRSA, SAMHSA, and HUD, shall conduct a 3-year dem-
21 onstration project that is designed to integrate services
22 and funding under the Medicare and Medicaid programs,
23 under HIV-related programs conducted by the CDC, and
24 under the Ryan White HIV/AIDS Program, to reduce new
25 HIV infections, to increase the proportion of people who

1 know their status, to increase access to care, to improve
2 health outcomes, to reduce HIV-related health disparities
3 among Medicaid and Medicare beneficiaries, and to reduce
4 the cost of care provided to HIV positive Medicare and
5 Medicaid beneficiaries.

6 (b) OBJECTIVES.—The objectives of the demonstra-
7 tion are the following:

8 (1) To ensure the early identification of HIV
9 positive beneficiaries to reduce costly HIV-related
10 clinical conditions through HIV screening and rapid
11 linkage to high quality HIV medical care.

12 (2) To reduce new HIV infections among Med-
13 icaid and Medicare beneficiaries through routine
14 HIV testing, prevention services for HIV negative
15 beneficiaries, and intensive “prevention for positive”
16 services for HIV positive beneficiaries.

17 (3) To reduce morbidity, mortality, and high
18 cost inpatient and specialty care among HIV positive
19 beneficiaries by ensuring access to high quality HIV
20 medical care, HIV medications, and support services.

21 (4) To promote HIV treatment adherence and
22 retention in care through intensive case manage-
23 ment, treatment education, and outreach services.

24 (5) To effectively treat behavioral health condi-
25 tions among HIV positive beneficiaries that impair

1 their HIV treatment adherence and lead to sec-
2 ondary HIV infections through services funded
3 under Medicare and Medicaid and programs admin-
4 istered by SAMHSA.

5 (6) To promote independence, treatment adher-
6 ence, and stable housing for HIV positive bene-
7 ficiaries through highly coordinated HIV health,
8 housing, and support services funded by HRSA and
9 HUD.

10 (c) DEMONSTRATION DESIGN.—

11 (1) IN GENERAL.—The Secretary shall design
12 the demonstration to test both—

13 (A) the service delivery model described in
14 paragraph (2); and

15 (B) the payment model described in para-
16 graph (3).

17 (2) SERVICE DELIVERY MODEL.—

18 (A) IN GENERAL.—Under the service deliv-
19 ery model described in this paragraph, the dem-
20 onstration shall test comprehensive HIV test-
21 ing, linkage to care, HIV medical care, and an-
22 cillary services to individuals enrolled under
23 Medicare, Medicaid, or both. The service deliv-
24 ery model will integrate services furnished
25 under Medicare and Medicaid with prevention

1 services funded by CDC for HIV positive bene-
2 ficiaries, intensive case management services
3 funded by HRSA, behavioral services funded by
4 SAMHSA, and housing assistance services
5 funded through HUD.

6 (B) CORE ELEMENTS.—The model under
7 this paragraph shall have the following 8 core
8 elements:

9 (i) HIV testing services that apply the
10 CDC's 2006 recommendations for uni-
11 versal opt-out testing among Medicare and
12 Medicaid beneficiary populations.

13 (ii) Rapid linkage from HIV testing
14 settings to treatment for HIV positive
15 beneficiaries to ensure they are engaged in
16 care in a timely basis.

17 (iii) Access to high quality HIV expe-
18 rienced medical care, laboratory moni-
19 toring, HIV medications, and other re-
20 quired services.

21 (iv) Routine screening and treatment
22 for HIV-related and other chronic condi-
23 tions, including behavioral health.

24 (v) Prevention and treatment edu-
25 cation services, including an adapted Medi-

1 cation Therapy Management (MTM) pro-
2 gram model, to optimize the benefit of
3 HIV therapeutics.

4 (vi) Risk-stratified medical case man-
5 agement.

6 (vii) Provision of preventive care, in-
7 cluding counseling to prevent secondary
8 HIV infection.

9 (viii) Wrap-around support and hous-
10 ing services.

11 (3) PAYMENT MODEL.—Under the payment
12 model described in this paragraph, the demonstra-
13 tion shall test the following:

14 (A) A prepaid capitated payment model
15 that adjusts payment for HIV and behavioral
16 health acuity, to be applied under contracts
17 with managed care organizations with dem-
18 onstrated HIV experience.

19 (B) Use of funds under the Ryan White
20 HIV/AIDS Program to purchase capitated serv-
21 ices from the contracted managed care organi-
22 zations.

23 (C) Provision of additional funds to sup-
24 port services to the extent that Medicaid and
25 Medicare coverage is limited, including for serv-

1 ices such as HIV testing (for Medicaid bene-
2 ficiaries), medical case management, prevention
3 case management, treatment education, case
4 finding, behavioral health services, and housing
5 assistance.

6 (d) BENEFICIARY CRITERIA.—Beneficiaries eligible
7 for participation in the demonstration are the following:

8 (1) MEDICAID FFS BENEFICIARIES.—Fee-for-
9 service Medicaid beneficiaries 18 years of age or
10 older.

11 (2) DUAL ELIGIBLES.—Individuals who are—

12 (A) entitled to medical assistance under
13 Medicaid; and

14 (B) entitled to benefits under part A, and
15 enrolled under part B, of Medicare but are not
16 enrolled under a Medicare Advantage plan
17 under Medicare.

18 (e) ROLES AND RESPONSIBILITIES IN DEMONSTRA-
19 TION.—

20 (1) IN GENERAL.—Consistent with the National
21 HIV/AIDS Strategy for the United States, Federal
22 agencies shall coordinate their funding for the se-
23 lected States or cities covered under the demonstra-
24 tion to provide resources to fund the delivery of serv-
25 ices within the demonstration.

1 (2) HHS.—In carrying out the demonstration,
2 the Secretary shall—

3 (A) design the application process;

4 (B) solicit applications from 5 to 7 State
5 Medicaid agencies to host the demonstration;

6 (C) with respect to the service delivery
7 model described in subsection (c)(2), collaborate
8 with the CDC, HRSA, and the National Insti-
9 tutes of Health to design a minimum service de-
10 livery model that reflects the current standard
11 of care as established by the Public Health
12 Service and CDC guidelines and recommenda-
13 tions; and

14 (D) fund an evaluation of the demonstra-
15 tion to ensure collection of system, provider,
16 and beneficiary-level data to address their rou-
17 tine reporting requirements.

18 The Secretary may carry out the Secretary's author-
19 ity under this paragraph through CMMI.

20 (3) CDC.—The CDC shall collaborate with the
21 Secretary and CDC-funded HIV prevention grantees
22 in the selected States and cities to provide technical
23 assistance to design cost-effective HIV and sexually
24 transmitted infection (STI) screening and testing
25 services for Medicaid and Medicare beneficiaries, in-

1 including partner notification services and commu-
2 nicable disease reporting. CDC and CMS shall deter-
3 mine the extent to which testing funds shall be sup-
4 ported jointly or separately by these agencies.

5 (4) HRSA.—HRSA shall allocate funds avail-
6 able through the Special Projects of National Sig-
7 nificance (SPNS) Initiative Program (under subpart
8 I of part F of the Ryan White HIV/AIDS Program)
9 to support wrap-around core and support services
10 not covered under Medicare or Medicaid and shall
11 authorize the use of Ryan White HIV/AIDS Pro-
12 gram funds to purchase services through capitated
13 managed care programs that meet or exceed the
14 services covered by the Ryan White HIV/AIDS Pro-
15 gram at rates that are no greater than current per
16 capita expenditures. HRSA is authorized to use
17 funds under SPNS, and to waive such requirements
18 of SPNS as may be necessary, to carry out the dem-
19 onstration.

20 (5) SAMHSA.—SAMHSA shall allocate funds
21 through the Minority HIV/AIDS Initiative or other
22 programs to support behavioral health services not
23 covered under Medicare or Medicaid.

24 (6) HOPWA.—HUD shall directly allocate
25 funds under the Housing Opportunities for People

1 With AIDS (HOPWA) program to the States or cit-
2 ies participating in the demonstration to provide
3 supportive housing and other housing assistance to
4 beneficiaries who otherwise meet HOPWA eligibility
5 criteria. HUD is authorized to use such HOPWA
6 funds, and to waive such requirements under
7 HOPWA as may be necessary, to carry out the dem-
8 onstration.

9 (7) STATE MEDICAID AGENCIES.—Single State
10 agencies responsible for administration of the Med-
11 icaid program for individuals who are accepted to
12 participate in the demonstration shall—

13 (A) collaborate with CMS to design or re-
14 fine a prepaid capitated payment model, to allo-
15 cate and award contracts with capitated man-
16 aged care plans, to ensure such plans meet
17 State statutory or regulatory requirements, to
18 contract with a coordinating agency to organize
19 and deliver integrated HIV testing, medical
20 care, support, and housing services funded
21 under Medicare and Medicaid, other Federal,
22 State, and local government sponsors, and to
23 coordinate their activities with the State HIV/
24 AIDS program; and

1 (B) identify and contract with a coordi-
2 nating agency to organize the demonstration in
3 the State, to establish a coordinating body rep-
4 resenting State, local, and provider agencies
5 participating in the demonstration, to establish
6 systems of care that integrate HIV prevention,
7 testing, treatment, support, and housing serv-
8 ices, to establish mechanisms to gather evalua-
9 tion data for reporting to CMMI and other par-
10 ticipating Federal agencies, and to establish a
11 quality management program to monitor pro-
12 vider performance in delivering the services pro-
13 vided to participating beneficiaries under the
14 demonstration.

15 (8) MANAGED CARE ORGANIZATIONS.—
16 Capitated managed care organizations participating
17 in the demonstration shall organize and deliver serv-
18 ices as specified by the minimum service delivery
19 model established by CMMI through a network of
20 providers with demonstrated HIV experience, high
21 quality, and sufficient provider capacity.

22 (f) DEFINITIONS.—In this section:

23 (1) CDC.—The term “CDC” means the Direc-
24 tor of the Centers for Disease Control and Preven-
25 tion.

1 (2) CMMI.—The term “CMMI” means the Di-
2 rector of the Center for Medicare and Medicaid In-
3 novation.

4 (3) CMS.—The term “CMS” means the Ad-
5 ministrator of the Centers for Medicare & Medicaid
6 Services.

7 (4) DEMONSTRATION.—The term “demonstra-
8 tion” means the demonstration conducted under this
9 section.

10 (5) HRSA.—The term “HRSA” means the Ad-
11 ministrator of the Health Resources and Services
12 Administration.

13 (6) HUD.—The term “HUD” means the Sec-
14 retary of Housing and Urban Development.

15 (7) MEDICARE; MEDICAID.—The terms “Medi-
16 care” and “Medicaid” mean the programs under ti-
17 tles XVIII and XIX, respectively, of the Social Secu-
18 rity Act.

19 (8) NATIONAL HIV/AIDS STRATEGY FOR THE
20 UNITED STATES.—The term “National HIV/AIDS
21 Strategy for the United States” has the meaning
22 given such term under section 241A(b) of the Public
23 Health Service Act.

24 (9) RYAN WHITE HIV/AIDS PROGRAM.—The
25 term “Ryan White HIV/AIDS Program” means the

1 program under title XXVI of the Public Health
2 Service Act.

3 (10) SAMHSA.—The term “SAMHSA” means
4 the Substance Abuse and Mental Health Services
5 Administration.

6 (11) SECRETARY.—The term “Secretary”
7 means the Secretary of Health and Human Services,
8 acting through CMMI.

9 **SEC. 404. REPORT ON THE IMPLEMENTATION OF THE NA-**
10 **TIONAL HIV/AIDS STRATEGY.**

11 (a) REPORT REQUIRED.—The President, in consulta-
12 tion with the heads of all relevant agencies including the
13 Department of Education, the Department of Health and
14 Human Services, the Department of Housing and Urban
15 Development, the Department of Justice, the Department
16 of Labor, the Department of Veterans Affairs, and the So-
17 cial Security Administration, shall enter an arrangement
18 not later than 6 months after the date of the enactment
19 of this Act with the Institute of Medicine of the National
20 Academies (or, if the Institute declines to enter into such
21 an arrangement, another appropriate entity)—

22 (1) to prepare a report on the status of the im-
23 plementation of the National HIV/AIDS Strategy;
24 and

1 (2) to transmit such report to the Congress and
2 make publicly available a report.

3 (b) CONTENTS.—The report required by subsection
4 (a) shall include a description, analysis, and evaluation
5 of—

6 (1) key steps taken by the Federal Government
7 toward the achievement of the goals of the National
8 HIV/AIDS Strategy, including the goals of—

9 (A) reducing the number of people who be-
10 come infected with HIV;

11 (B) increasing access to care and opti-
12 mizing health outcomes for people living with
13 HIV; and

14 (C) reducing HIV-related health dispari-
15 ties;

16 (2) the extent to which the National HIV/AIDS
17 Strategy has improved coordination of efforts to
18 maximize the effective delivery of HIV/AIDS preven-
19 tion, care, and treatment services at the community
20 level, including coordination—

21 (A) within and among Federal agencies
22 and departments;

23 (B) between the Federal Government and
24 State and local governments and health depart-
25 ments;

1 (C) between the Federal Government and
2 nonprofit foundations and civil society organiza-
3 tions, including community- and faith-based or-
4 ganizations focused on addressing the issue of
5 HIV/AIDS; and

6 (D) between the Federal Government and
7 private businesses;

8 (3) efforts by the Federal Government to edu-
9 cate, involve, and establish and strengthen partner-
10 ships with civil society organizations, including
11 community- and faith-based organizations, in order
12 to implement the National HIV/AIDS Strategy and
13 achieve its goals;

14 (4) how Federal resources are being deployed to
15 implement the Strategy, including—

16 (A) the amount of funding used to date, by
17 each Federal agency and department, to imple-
18 ment the National HIV/AIDS Strategy;

19 (B) a brief summary for each Federal
20 agency and department of the number and
21 function of all Federal employees assisting in
22 implementing the Strategy; and

23 (C) an estimate of the amount of funding
24 necessary to implement the National HIV/AIDS

1 Strategy, by each Federal agency and depart-
2 ment, for the next fiscal year; and

3 (5) what additional steps, if any, are necessary
4 to fully implement the National HIV/AIDS Strategy,
5 including—

6 (A) whether any existing statutory laws,
7 policies, or regulations are impeding the imple-
8 mentation of the National HIV/AIDS Strategy,
9 at the Federal, State, or local level, and wheth-
10 er any changes to such laws, policies, or regula-
11 tions are necessary or recommended; and

12 (B) whether any Federal agencies or de-
13 partments require additional statutory authority
14 to effectively carry out their duties as part of
15 the National HIV/AIDS Strategy.

16 (c) USE OF PREVIOUSLY APPROPRIATED FUNDS.—
17 Funding for the report required under subsection (a) shall
18 be derived from discretionary funds of the departments
19 and agencies specified in such subsection.

1 **DIVISION B—ENDING HIV/AIDS**
2 **GLOBALLY**

3 **TITLE X—GLOBAL HIV/AIDS-**
4 **FREE GENERATION STRATEGY**

5 **SEC. 1001. GLOBAL HIV/AIDS-FREE GENERATION STRAT-**
6 **EGY.**

7 (a) STRATEGY.—The President, acting through the
8 Coordinator of United States Government Activities to
9 Combat HIV/AIDS Globally, shall establish a comprehen-
10 sive, integrated, 5-year strategy to expand and improve
11 efforts to combat global HIV/AIDS, while promoting effi-
12 ciency and maximizing results. The strategy shall be re-
13 ferred to as the “Global HIV/AIDS-Free Generation
14 Strategy”.

15 (b) CONTENTS.—The strategy shall—

16 (1) accelerate progress toward achieving the
17 United States goal of an AIDS-free generation;

18 (2) establish a limited number of measurable
19 targets to accelerate reductions in HIV incidence
20 and HIV/AIDS-related morbidity and mortality;

21 (3) strengthen existing and future compacts
22 and framework agreements authorized under section
23 104A(d)(8) of the Foreign Assistance Act of 1961
24 (22 U.S.C. 2151b–2(d)(8));

1 (4) strengthen engagement with diplomatic ef-
2 forts at all levels of government to—

3 (A) continue to identify and promote link-
4 ages between efforts to combat HIV/AIDS and
5 other health development issues and human
6 rights issues;

7 (B) encourage and assist national govern-
8 ments to pursue policies and legal frameworks
9 that facilitate and enable effective responses to
10 HIV prevention, care, and treatment services;
11 and

12 (C) increase financial accountability;

13 (5) provide a plan to—

14 (A) support early diagnosis and initiation
15 of HIV treatment to achieve accelerated reduc-
16 tions of incidence and morbidity;

17 (B) eliminate vertical transmission of HIV
18 from mother to child and support early diag-
19 nosis and initiation of HIV treatment in infants
20 and children;

21 (C) intensify efforts to expand access to
22 voluntarily medical male circumcision, male and
23 female condoms and other proven-effective HIV
24 prevention interventions, in combination with

1 other evidence-based modalities and structural
2 interventions;

3 (D) reduce the risk of HIV infection and
4 address the HIV-related needs of sex workers,
5 men who have sex with men, transgender peo-
6 ple, and people who inject drugs;

7 (E) increase gender equity in HIV/AIDS
8 programs and services, including access to vol-
9 untary family planning and reproductive health
10 services and reducing violence and coercion;

11 (F) expand partnership with implementers,
12 researchers, and academic organizations to im-
13 prove the science that guides the global re-
14 sponse to HIV/AIDS;

15 (G) provide capacity development support
16 to increase meaningful engagement of civil soci-
17 ety, especially local indigenous organizations,
18 that work in the areas of human rights, wom-
19 en's and young people's health and rights, and
20 gay, lesbian, bisexual, and transgender rights,
21 in the development, implementation, moni-
22 toring, and evaluation of United States-funded
23 programs;

24 (H) advance the efforts of developing coun-
25 tries to develop health systems capable of man-

1 aging their epidemics, respond to broader
2 health needs impacting affected communities,
3 and address new and emerging health concerns;
4 and

5 (I) defend, protect, and fulfill the human
6 rights of people living with HIV and those most
7 at risk of HIV infection.

8 (c) CONSULTATION.—In developing the strategy, the
9 President, acting through the Coordinator of United
10 States Government Activities to Combat HIV/AIDS Glob-
11 ally, shall consult with—

12 (1) each executive branch agency administering
13 United States foreign assistance related to—

14 (A) improving global health;

15 (B) strengthening financial management
16 systems; and

17 (C) monitoring and promoting human
18 rights and democracy;

19 (2) personnel at United States embassies and
20 country missions involved in the administration of
21 the types of United States foreign assistance de-
22 scribed in paragraph (1);

23 (3) the appropriate congressional committees
24 with jurisdiction over the agencies described in para-
25 graph (1);

1 (4) civil society and nongovernmental organiza-
2 tions engaged in improving health care and health
3 outcomes in developing countries, including indige-
4 nous community and faith-based organizations;

5 (5) international organizations engaged in im-
6 proving health care and health outcomes in devel-
7 oping countries and of which the United States is a
8 voting member, with which the United States coordi-
9 nates the delivery of foreign assistance, or to which
10 the United States contributes funding for the pur-
11 pose of providing such assistance;

12 (6) academic organizations, private foundations,
13 businesses, and other organizations engaged in im-
14 proving health care and health outcomes in devel-
15 oping countries and not receiving United States
16 funding for such purposes;

17 (7) other donor nations engaged in improving
18 health care and health outcomes in developing coun-
19 tries;

20 (8) countries receiving health-related United
21 States foreign assistance; and

22 (9) any other global, regional, or subregional
23 organizations or partnerships engaged in improving
24 health care and health outcomes in developing coun-
25 tries.

1 (d) REPORT.—Not later than 1 year after the date
2 of the enactment of this Act, the President shall submit
3 to Congress a report that sets forth the strategy described
4 in this section.

5 **TITLE XI—USING FUNDS STRA-**
6 **TEGICALLY TO MAXIMIZE RE-**
7 **SULTS**

8 **SEC. 1101. SUPPORT FOR OPERATIONS RESEARCH TO IM-**
9 **PROVE PROGRAM DELIVERY, EFFICIENCY,**
10 **IMPACT, AND EFFECTIVENESS.**

11 (a) SENSE OF CONGRESS.—It is the sense of the Con-
12 gress that there is a need and urgency to expand the range
13 of interventions for preventing the transmission of HIV,
14 including behavioral prevention research, operations re-
15 search to optimize combination HIV prevention, and re-
16 search on medical technology to prevent HIV infection, in-
17 cluding microbicides, cost-effective female condoms, Pre-
18 Exposure Prophylaxis (PrEP), multipurpose technologies
19 for the prevention of HIV and unintended pregnancy, and
20 vaccines.

21 (b) STATEMENT OF POLICY.—It should be the policy
22 of the United States to ensure that efforts to combat HIV/
23 AIDS globally should expand, intensify, and coordinate
24 operations research to improve the quality, delivery, and
25 impact of programming, including with respect to—

1 (1) services appropriate for men who have sex
2 with men, transgender people, people who inject
3 drugs, and sex workers;

4 (2) structural interventions to remove barriers
5 that inhibit effective implementation of HIV/AIDS-
6 related foreign assistance, including the analysis of
7 laws and policies that have a negative health impact
8 and put individuals at increased risk of HIV infec-
9 tion;

10 (3) scalable combination of prevention and
11 treatment approaches to HIV/AIDS;

12 (4) prevention and management of co-
13 morbidities such as tuberculosis, malaria, and viral
14 hepatitis; and

15 (5) identification and follow up of HIV-positive
16 infants and children in resource-limited settings to
17 increase the proportion of children accessing HIV
18 treatment and care services.

19 **SEC. 1102. INCREASING COORDINATION AND INTEGRATION**
20 **OF HIV/AIDS PROGRAMS WITH DEVELOP-**
21 **MENT PROGRAMS.**

22 (a) STATEMENT OF POLICY.—It should be the policy
23 of the United States to ensure that efforts to combat HIV/
24 AIDS globally should maximize efficiencies and the inte-
25 gration of services and programs to achieve reduction in

1 HIV transmission rates and the burden of HIV-related
2 morbidity and mortality, by means that include—

3 (1) ensuring that women and adolescent girls
4 with HIV or who are at risk of HIV infection and
5 who do not wish to become pregnant have access to
6 voluntary contraceptive services, including a range of
7 contraceptive options, and voluntary counseling to
8 plan families, either directly or through meaningful
9 referrals to existing United States Agency for Inter-
10 national Development or local family planning pro-
11 grams that provide counseling and a range of con-
12 traceptive options;

13 (2) integrating tuberculosis interventions with
14 HIV services, including case-finding and tuberculosis
15 treatment, expanding tuberculosis preventive ther-
16 apy, and reducing other opportunistic infections that
17 accompany HIV/AIDS;

18 (3) ensuring young people with HIV are pro-
19 vided with confidential and affordable access to
20 youth-friendly comprehensive sexual and reproduc-
21 tive health services and supplies, including male and
22 female condoms for the prevention of pregnancy and
23 sexually transmitted diseases, as relevant; and

24 (4) working to promote and protect the human
25 rights of people living with HIV, including men who

1 have sex with men, transgender people, people who
2 inject drugs, sex workers, and other vulnerable popu-
3 lations, including indigenous people, migrants, inter-
4 nally displaced people, young people, incarcerated
5 populations, and people with disabilities.

6 (b) REPORT.—Not later than 180 days after the date
7 of the enactment of this Act, the Secretary of State shall
8 submit to the appropriate congressional committees a re-
9 port describing the utilization of efficiencies in the delivery
10 of HIV/AIDS treatment services within and between
11 United States-funded bilateral and multilateral programs
12 and partner countries, including to the extent that such
13 gains in efficiencies are being exhausted.

14 **SEC. 1103. INCREASING PROGRAM EFFECTIVENESS AND**
15 **SUSTAINABILITY TO ACHIEVE SUCCESSFUL**
16 **COUNTRY OWNERSHIP.**

17 (a) STATEMENT OF POLICY.—It should be the policy
18 of the United States to ensure that efforts to combat HIV/
19 AIDS globally should help developing countries signifi-
20 cantly decrease the burden of HIV, strengthen and im-
21 prove their health systems, help build country ownership,
22 and increase financial accountability to ensure sustain-
23 ability and equitable access to health services, including
24 by—

1 (1) assisting developing countries create,
2 strengthen, and implement their own evidence-based
3 national HIV/AIDS strategies, by means that in-
4 clude—

5 (A) supporting early diagnosis and initi-
6 ation of HIV and tuberculosis treatment to
7 achieve accelerated reductions of incidence and
8 morbidity;

9 (B) eliminating the vertical transmission of
10 HIV from mother to child and supporting early
11 diagnosis and initiation of HIV treatment in in-
12 fants and children;

13 (C) intensifying efforts to expand access to
14 voluntary medical male circumcision, male and
15 female condoms, harm reduction services, and
16 other proven-effective HIV prevention interven-
17 tions, in combination with other evidence-based
18 modalities, including structural interventions;

19 (D) intensifying efforts to eliminate HIV
20 infections among populations that are often at
21 greatest risk, including sex workers, men who
22 have sex with men, and people who inject
23 drugs, and addressing the HIV-related needs,
24 including access to ART, of those already in-
25 fected;

1 (E) ensuring young people are provided
2 with comprehensive knowledge, skill-building
3 programs, in and out of school, to make in-
4 formed and responsible decisions for their sex-
5 ual health, and are provided with confidential
6 and affordable access to youth-friendly com-
7 prehensive sexual and reproductive health serv-
8 ices and supplies, including male and female
9 condoms;

10 (F) ensuring women with HIV or who are
11 at risk of HIV infection and who do not wish
12 to become pregnant have access to voluntary
13 contraceptive services and commodities, and
14 women who desire pregnancy have access to
15 family planning counseling and maternal health
16 services free of judgment and discrimination;
17 and

18 (G) encouraging policy changes to elimi-
19 nate discriminatory and stigmatizing policies
20 that stand in the way of access to health serv-
21 ices by marginalized and poor populations in-
22 cluding punitive laws against HIV exposure and
23 potential transmission, sex work, same-sex be-
24 havior, drug use, and gender expression;

1 (2) supporting meaningful community involve-
2 ment and participation, inclusive of poor, vulnerable,
3 or marginalized populations and their representative
4 indigenous and civil society organizations, in deci-
5 sionmaking related to national HIV/AIDS strategies
6 and the delivery of health services, including in deci-
7 sions related to the adoption of health policies and
8 the total amount and distribution of health funding;

9 (3) assisting countries to coordinate, regulate,
10 and harmonize the delivery of health services pro-
11 vided by the United States and nongovernmental or-
12 ganizations, including community and faith-based
13 organizations, private foundations, international or-
14 ganizations, and other donors, and to coordinate or
15 integrate such services with the health system to the
16 maximum extent practicable;

17 (4) using, to the maximum extent practicable,
18 local and regional entities for the provision of tech-
19 nical assistance, and where the capacity of such enti-
20 ties is insufficient, supporting capacity building to
21 enable such entities to provide such assistance;

22 (5) strengthening procurement and supply
23 chain logistics to help prevent drug and commodity
24 stock outs, including male and female condom short-

1 ages, and to help ensure the eventual provision of
2 microbicides for HIV prevention; and

3 (6) providing technical assistance and support
4 to national ministries of health, or their equivalents,
5 and other relevant ministries in overseeing the
6 health systems of their countries and monitoring and
7 evaluating the effectiveness of such systems in re-
8 ducing mortality and improving health outcomes, in-
9 cluding preparing for the provision of HIV/AIDS,
10 voluntary family planning, non-communicable dis-
11 eases, and reproductive health services in emergency
12 situations.

13 (b) REPORT.—Not later than 180 days after the date
14 of the enactment of this Act, the Secretary of State shall
15 submit to the appropriate congressional committees a re-
16 port identifying benchmarks that are directly relevant to
17 significantly decreasing the burden of the epidemic in each
18 country receiving HIV-related foreign assistance and pro-
19 vide context for helping countries and civil society to build
20 country ownership.

1 **TITLE XII—ADDRESSING LEGAL**
2 **AND POLICY BARRIERS TO**
3 **ACCESSING HEALTH CARE**
4 **Subtitle A—General Provisions**

5 **SEC. 1201. SUPPORT FOR LAWS AND REGULATIONS THAT**
6 **IMPROVE HEALTH OUTCOMES AND PROMOTE**
7 **HUMAN RIGHTS.**

8 It should be the policy of the United States to ensure
9 that United States foreign assistance should encourage
10 and assist national governments of developing countries
11 to pursue policies and legal frameworks that improve
12 health outcomes, including policies and legal frameworks
13 that—

14 (1) are medically accurate and evidence-based
15 and adhere to the latest global public health stand-
16 ards for prevention, treatment, and care;

17 (2) promote and improve the status of women
18 and youth, ensuring their ability to access and use
19 health services without fear or risk of gender-based
20 violence, reprisal, discrimination, stigmatization, ar-
21 rest, or other mistreatment;

22 (3) work to remove criminalization of, stig-
23 matization of, and discrimination against poor, vul-
24 nerable, or marginalized populations and enact laws

1 and policies to promote and protect the rights of
2 such populations;

3 (4) avoid, to the maximum extent possible, reli-
4 ance on criminal laws and sanctions to address
5 health issues;

6 (5) incorporate relevant policy guidance that
7 addresses structural barriers to accessing health
8 care; and

9 (6) prioritize the creation of a legal, political,
10 and social environment that enables access to health
11 services by all members of the population.

12 **SEC. 1202. INTENSIFYING EFFORTS TO ESTABLISH EFFEC-**
13 **TIVE PROGRAMS FOR ENGAGING KEY AF-**
14 **FECTED POPULATIONS.**

15 It should be the policy of the United States to ensure
16 that efforts to combat HIV/AIDS globally should intensify
17 efforts to establish effective programs for engaging men
18 who have sex with men, transgender people, people who
19 inject drugs, and sex workers in HIV prevention, care, and
20 treatment initiatives, by means that include—

21 (1) ensuring those eligible for treatment receive
22 antiretroviral treatment;

23 (2) providing sterile syringes, education, and
24 outreach and treatment for drug dependence for in-

1 jecting drug users through a comprehensive package
2 of services;

3 (3) providing sexual health services, condoms,
4 and other HIV prevention services to sex workers,
5 their clients, and partners; and

6 (4) defending human rights and inherent dig-
7 nity by addressing laws and practices that prevent
8 people from accessing services and providing legal
9 and social services to individuals and communities to
10 facilitate access to services and to reduce violence,
11 stigma, and discrimination.

12 **SEC. 1203. ENSURING UNITED STATES TRADE POLICY DOES**
13 **NOT RESTRICT ACCESS TO AFFORDABLE**
14 **MEDICINES.**

15 In administering title III of the Trade Act of 1974
16 (19 U.S.C. 2411 et seq.), the United States Government
17 shall not seek, through negotiation or otherwise, the rev-
18 ocation or revision of any intellectual property law or pol-
19 icy of a low- or middle-income country that regulates HIV
20 and opportunistic infection pharmaceuticals or medical
21 technologies if the law or policy of the country—

22 (1) promotes access to affordable HIV and op-
23 portunistic infection pharmaceuticals or medical
24 technologies for affected populations in that country;
25 and

1 (2) provides intellectual property protection
 2 consistent with the Agreement on Trade-Related As-
 3 pects of Intellectual Property Rights referred to in
 4 section 101(d)(15) of the Uruguay Round Agree-
 5 ments Act (19 U.S.C. 3511(d)(15)).

6 **Subtitle B—Repeal of Certain**
 7 **Provisions of Public Law 108–25**

8 **SEC. 1211. REPEAL OF “CONSCIENCE CLAUSE” REQUIRE-**
 9 **MENT FOR ELIGIBILITY FOR ASSISTANCE.**

10 Section 301 of the United States Leadership Against
 11 HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22
 12 U.S.C. 7631) is amended by striking subsection (d).

13 **SEC. 1212. REPEAL OF LIMITATION ON USE OF FUNDS FOR**
 14 **ASSISTANCE FOR SEX WORKERS.**

15 Section 301 of the United States Leadership Against
 16 HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22
 17 U.S.C. 7631), as amended by section 711 of this Act, is
 18 further amended by striking subsections (e) and (f).

19 **SEC. 1213. REPEAL OF REPORTING REQUIREMENT ON AC-**
 20 **TIVITIES PROMOTING ABSTINENCE AND RE-**
 21 **LATED ACTIVITIES.**

22 Section 403(a)(2) of the United States Leadership
 23 Against HIV/AIDS, Tuberculosis, and Malaria Act of
 24 2003 (22 U.S.C. 7673(a)(2)) is amended—

1 (1) by striking “(2) PREVENTION STRATEGY.—
 2 ” and all that follows through “In carrying out para-
 3 graph (1)” and inserting “(2) PREVENTION STRAT-
 4 EGY.—In carrying out paragraph (1)”; and
 5 (2) by striking subparagraph (B).

6 **SEC. 1214. EFFECTIVE DATE.**

7 This subtitle and the amendments made by this sub-
 8 title—

9 (1) take effect on the date of the enactment of
 10 this Act; and

11 (2) apply with respect to funds made available
 12 to carry out the United States Leadership Against
 13 HIV/AIDS, Tuberculosis, and Malaria Act of 2003
 14 or any amendment made by that Act on or after
 15 such date of enactment.

16 **TITLE XIII—DEFINITIONS**

17 **SEC. 1301. DEFINITIONS.**

18 In this division:

19 (1) APPROPRIATE CONGRESSIONAL COMMIT-
 20 TEES.—The term “appropriate congressional com-
 21 mittees” means—

22 (A) the Committee on Foreign Affairs and
 23 the Committee on Appropriations of the House
 24 of Representatives; and

1 (B) the Committee on Foreign Relations
2 and the Committee on Appropriations of the
3 Senate.

4 (2) AIDS.—The term “AIDS” means the ac-
5 quired immune deficiency syndrome.

6 (3) HIV.—The term “HIV” means the human
7 immunodeficiency virus, the pathogen that causes
8 AIDS.

9 (4) HIV/AIDS.—The term “HIV/AIDS”
10 means, with respect to an individual, an individual
11 who is infected with HIV or living with AIDS.

○