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RYAN WHITE CARE REAUTHORIZATION ACT OF 1995

APRIL 3 (legislative day, MARCH 27, 1995.—Ordered to be printed)

Mrs. KASSEBAUM, from the Committee on Labor and Human Resources, submitted the following

REPORT

[To accompany S. 641]

The Committee on Labor and Human Resources, to which was referred the bill (S. 641), to amend title XXVI of The Public Health Service Act, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

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I. SUMMARY OF THE BILL

As reported by the committee, the bill reauthorizes title XXVI programs to ensure that individuals living with HIV and AIDS receive appropriate services. The legislation contains formulae, authorization for appropriation, and programmatic changes to ensure that CARE Act programs are consistent with demands created by the changing HIV and AIDS epidemic.

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

Title I: Provides emergency relief grants to eligible metropolitan areas (EMA's) disproportionately affected by the HIV

epidemic. One-half of the title I funds are distributed by formula; the remaining one-half is distributed competitively.

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

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

Title IV: Provides grants for research and services for children and families.

2. A single appropriation for title I grants to eligible metropolitan areas and title II grants to states is authorized for fiscal year 1996.

A single appropriation should help unify the interest of grantees in assuring funding for all individuals living with AIDS, regardless of whether they live in EMA's or states.

The appropriation is divided between the two titles based on the ratio of fiscal year 1995 appropriations for each title. Sixty-four percent is designated for title I in fiscal year 1996. The Secretary is authorized to develop and implement a method to adjust the ratio of funding for title I and title II to account for new title I cities and other relevant factors for fiscal year 1997 through fiscal year 2000. If the Secretary does not implement such a method, separate appropriations for titles I and II are authorized, beginning in fiscal year 1997 and extending through fiscal year 2000.

3. New formulas are authorized for titles I and II based on an estimation of the number of individuals living with AIDS and the costs of providing services.

The present distribution formulas have led to disparity in funding for individuals living with AIDS based on where they live. This is due to: a caseload measure which is cumulative, the absence of any measure of service costs, and the counting of EMA cases by both the titles I and II formulas.

The new formulas will include an estimate of living cases of AIDS. This estimate is calculated by applying a different weight to each year of cases reported to the Centers for Disease Control and Prevention over the most recent 10 year period. A cost index is determined by using the average Medicare hospital wage index for the 3 year period immediately preceding the grant award. Over a 5 year period, hold-harmless floors for the formulas are provided in order to assure that no entity receives less than 92.5 percent of its 1995 allocation. The phase-in is provided to avoid disruption of services to beneficiaries, while still allowing for the redistribution of funds.

4. The addition of new title I cities will be limited.

The current designation criteria for title I cities was developed to target emergency areas. Five years after the initial enactment of the Ryan White CARE Act, the epidemic persists. However, the needs of potentially new title I cities are not the

same as the original cities. Title II funding has been used to develop infrastructure in many of these metropolitan areas, decreasing the relative need for new cities to receive emergency title I funding.

To maintain the emergency nature of title I the eligibility definition is refined to include only those areas which have a population of at least 500,000 individuals and a cumulative total of more than 2,000 cases of AIDS in the preceding 5 years. To allow a transition period, this requirement will not apply to any area that is deemed eligible before fiscal year 1998.

5. A priority for the title I supplementary grants is established.

The severity of illness has a major impact on the delivery of services. The reauthorization establishes a priority for the distribution of funds which accounts for co-morbid conditions. Such conditions include sexually transmitted diseases, substance abuse, tuberculosis, severe mental illness, and homelessness.

6. The Special Projects of National Significance (SPNS) and the AIDS Education and Training Centers are included in a new title V.

Currently, SPNS is funded by a 10 percent title II set-aside. The reauthorization bill provides that the SPNS program will receive a 3 percent set-aside from each of the other four titles. The SPNS project will address the needs of special populations, assist in the development of essential community-based service infrastructure, and ensure the availability of services for Native American communities.

The AIDS Education and Training Centers program is transferred from Federal health professions education legislation. This program provides funding for the training of health personnel in the diagnosis, treatment, and prevention of HIV disease. Its purpose is to assure the availability of a cadre of trained individuals for the CARE Act programs.

7. A statewide coordination and planning process is created to improve coordination of services, including services in title I cities and title II States.

8. Representation on the title I planning councils is changed to more accurately reflect the demographics of the HIV epidemic, and to adequately reflect appropriate communities, subpopulations and providers.

9. Guidelines for a minimum State drug formulary are authorized.

Therapeutics improve the quality of life of patients with HIV disease and minimize the need for costly inpatient medical care. The medical state of the art is constantly changing. The guidelines will help ensure that Food and Drug Administration approved therapies are available to people living with HIV disease.

10. Administrative caps for titles I and II are extended to contractors and subcontractors.

Administrative costs for grantees and subcontractors are tightly defined and limited. This limitation will maximize the

amount of funding available to provide services for people living with AIDS.

II. BACKGROUND AND NEED FOR LEGISLATION

GENERAL BACKGROUND

In March 1990, Congress enacted the Ryan White CARE Act, honoring Ryan White, a young man who taught the Nation to respond to the AIDS epidemic with hope and action rather than fear. By the spring of 1990, over 128,000 people had been diagnosed with AIDS in the United States; 78,000 had died of the disease.

Today, more than 440,000 cases of AIDS have been reported to the Centers for Disease Control and Prevention (CDC). More than 243,000 men, women and children have died as the epidemic has encompassed more of the Nation over the last 15 years. More than 100 people in the United States die every day of AIDS—one every 15 minutes.

The Nation continues to experience rapid growth in the number of individuals diagnosed with AIDS. The first 100,000 AIDS cases in the United States were diagnosed over an 8 year period. The second 100,000 cases were reported in a 2 year period. In the last year alone over 80,000 AIDS cases have been reported—more than 220 a day. AIDS has become the leading killer of Americans aged 25–44.

The epidemic continues to grow, touching larger numbers of people and more and more segments of our society. The heterosexual transmission rate continues to increase; women, teenagers, and minorities are even more at risk. One of every two HIV infections now occurs in people under age 25. Suburban and rural areas of the country are now feeling the full impact of the epidemic. Those areas must now confront the same social, economic and personal devastation that the original urban epicenters have been battling since 1981.

The continued expansion of the AIDS epidemic in America is a certainty. Yet, diagnosed AIDS cases measure only a fraction of the problem. The National Commission on AIDS reported that, based on CDC estimates, at least 1 million Americans were already infected with HIV by 1993. Hundreds of thousands of these Americans will require health care services in the future. This crisis will severely challenge the Nation's health care system well into the next century.

While a cure for HIV disease remains a distant hope, science has made significant progress in developing treatments for HIV disease. Therapies now exist that can help slow the progression of HIV and fend off many of the opportunistic infections associated with AIDS. In addition, prenatal administration of AZT has also been shown to reduce the intrauterine transmission of HIV. These developments have resulted in longer survival rates for people diagnosed with AIDS and have highlighted the importance of early intervention and early treatment.

Public policy should adapt to the expanding epidemic and the increase in scientific and medical information regarding HIV. Effective policy should address the increasing service needs that the epidemic creates and integrate the advances in knowledge and under-

standing of the disease. In 1993, for example, the Centers for Disease Control and Prevention revised the AIDS case definition to more accurately reflect the physiological progression of HIV disease. This change has contributed to the 111 percent increase in AIDS diagnoses over those reported in 1992, because people living with HIV are now diagnosed earlier in the course of their disease.

The Ryan White CARE Act was originally introduced in 1990 in response to the need for HIV primary care and support services. The major focus of public policy prior to the CARE Act was on research, public education, surveillance and prevention. These activities are still a necessary priority. In addition, the CARE Act has helped people with HIV and AIDS to obtain services to improve the quality of their lives.

The public health and economic burden of the AIDS epidemic has not been reduced since the CARE Act was passed. While the CARE Act has been a lifeline of support to many people, need for services continues to grow faster than the resources available to meet them. In fact, the steady expansion and changed demographics of the epidemic and the increasing survival rates for people living with AIDS has in some areas increased the stress on local health care systems. This strain is felt in both urban centers where the epidemic continues to rage, and in smaller cities and rural areas, where the epidemic is expanding rapidly.

In response, the committee ordered favorably reported the Ryan White CARE Reauthorization Act of 1995. This reauthorization provides accessible HIV primary care and support services to the increasing number of people who need them. That care, often begun in acute care facilities, is generally very expensive and often goes un-reimbursed. The demand for this type of expensive service can be reduced, however, as people receive needed services in Ryan White funded community-based, neighborhood health clinics and social service agencies. Americans who might otherwise become ill and burden our already overcrowded hospital emergency rooms will remain healthy, working and productive members of our society.

HIV IN RURAL AREAS

While the AIDS epidemic continues in urban areas of the country, the number of new cases diagnosed in small urban centers, suburban, and rural areas is reaching alarming levels. According to the HIV/AIDS Surveillance Reports published by the Centers for Disease Control and Prevention, the proportion of all AIDS cases reported in areas with under 500,000 population has grown from 9.5 percent to 17 percent. However, as the epidemic has grown everywhere, the demand for medical and support services in suburban and rural areas has also grown.

Some of the problems created by HIV disease in rural areas are similar to those being confronted in large cities. The lack of trained primary care providers, absence of long-term-care facilities, scarcity of resources, and a scattered population are a few of the obstacles that may be faced in developing coordinated outpatient services programs.

Small rural hospitals and other rural providers may not be able to provide the highly specialized services often required by some persons with HIV disease. Primary care services are also not often

available, requiring some individuals and families to travel very long distances to receive necessary care.

Some of these problems might be alleviated if rural hospitals and practitioners were better linked to the urban centers with specialty and sub-specialty clinical services. Some states have supported such linkages as HIV disease has become prevalent in areas outside the original epicenters of the epidemic. The demand and need for such linkages will only continue to rise in the coming years.

HIV DISEASE IN URBAN AREAS

While the expansion of the epidemic into suburban and rural areas is clear, 42 eligible metropolitan areas (EMA's) currently receive title I funding, compared to only 16 when the CARE Act was originally passed. In fiscal year 1996, nearly 50 cities are expected to be eligible. Seventy two percent of the new AIDS diagnoses are reported in the current EMA's.

The epidemic in urban areas continues as it expands to other parts of the country. These urban areas must address not only the epidemic, but other co-morbid factors, including tuberculosis, homelessness, substance abuse, mental illness, and other STD's. These interrelationships vastly complicate the treatment of HIV/AIDS and demand that support services respond to many social ills.

HIV-specific problems and general health care delivery issues continue to challenge public health officials. Municipal hospitals continue to bear a disproportionate share of the AIDS burden. People with HIV disease are drawn to these essentially urban facilities even as other pressures are being placed on them. Private hospitals, for example, continue to cut back on charity care, and the large public hospitals are now forced to deal with the HIV epidemic in the setting of many urban tragedies.

CHILDREN AND FAMILIES WITH HIV DISEASE

As HIV spreads rapidly among intravenous drug users and their sexual partners, entire families become infected and need a full range of HIV health care and support services. As of July 1994, nearly 5,000 children had received an AIDS diagnosis. AIDS will be the fifth leading cause of death for all children in this decade and a major cause of mental retardation.

Minority communities have been particularly hard hit by the expanding epidemic. Although African Americans and Latinos represent 15 percent of the population, they comprise 45 percent of all reported AIDS cases—and 75 percent of all women, children and youths with AIDS.

Many families find that obtaining access to essential services can be a complicated and frustrating process. Women with perinatally infected children, often ill and still addicted to drugs, may have difficulty advocating effectively for their children and have the most limited access to health care for themselves as any group infected with HIV. The availability of health care and support services for HIV infected women and children "under one roof" is critical.

Essential to the success of this "one-stop shopping" model is a family centered system of case management. The committee heard eloquent testimony to that effect from Anna, a 32-year-old Miami woman who, along with her twin 7-year-old boys have been strug-

gling through a maze of treatment and support services since 1989 when they discovered they were all living with HIV. Anna described the life saving support, encouragement and assistance she received from Kim, her CARE Act funded case manager. Kim helped Anna to assess her needs, plan for the future, coordinate services and make referrals. Through Kim's help, Anna testified that she learned to access "the system" to get her own and her children's medical needs met. "Kim was the only person at the time who understood and empowered me", Anna told the committee.

FORMULA ISSUES

There is a need as well to modify the titles I and II formula provisions to take into account the changing face of the HIV epidemic, which is documented above. The need for these changes was first acknowledged in an April 1994 report of the Department of Health and Human Services Inspector General (IG). The IG stated "Concerns about the funding formulas were raised by many people we talked to as we designed the study * * * We expect the formulas to be an important focus for discussion during reauthorization." At the request of Senators Kassebaum and Brown, the General Accounting Office (GAO) completed a thorough review of the funding formulas to determine if they resulted in an equitable distribution of limited Federal resources.

There are large disparities in the current distribution of CARE Act funding. For instance, the GAO notes that "* * * EMA's that were first eligible to receive title I funds were funded at about \$1,500 per case, on average, in fiscal year 1994. In contrast, during this same time EMA's that recently became eligible to receive these funds were funded at only \$1,000 per case—one-third less than the older EMA's." In addition, "* * * per case funding was \$1,000 in States without an EMA, \$1,700 in States where less than half the state caseload lived in an EMA, and \$2,200 in States where more than half of the State's caseload lived in and EMA."

According to the letter sent by the GAO to The Honorable Nancy L. Kassebaum on February 14, 1995, disparities in both formulas exist for the following reasons:

Both titles I and II include in their formulas individuals living in EMA's (eligible metropolitan areas). Because not all States have an EMA, counting EMA cases for both titles can penalize States that do not have EMA's, and to a lesser extent, States whose EMA's contain a relatively small share of the State's total caseload.

The title I formula uses the cumulative number of AIDS cases reported since 1981 as a caseload measure. Since two-thirds of these cases are deceased, this factor may penalize States and EMA's that have recently experienced the most rapid growth in caseloads.

Neither the formula for title I nor II includes a factor to reflect differences in EMA and State costs of providing services to persons with AIDS. As a consequence, EMA's and States that must pay more for personnel and office space may not receive a level of funding to purchase serv-

ices comparable to those that lower cost areas are able to purchase.

The title I formula uses AIDS incidence rates (cases per capita) to measure EMAs' funding capacity but does not consider their local tax bases. The AIDS incidence rate factor was adopted as a means of targeting more aid to EMA's whose funding capacity has been adversely affected by high concentrations of AIDS cases. However, not considering their tax bases can result in overstating the funding capability of such EMA's that have more limited tax bases.

Conversely, the title II formula uses per capita income to measure the States' funding capacity, but it does not measure the impact that a high concentration of AIDS cases has on the funding capability of a State. This can result in overstating the funding capability of States with high concentrations of AIDS cases.

To remedy these problems, the GAO recommended new formulas for titles I and II based on an estimation of the number of individuals currently living with AIDS and the costs of providing services. In addition, GAO recommended an adjustment to offset statewide case counts, when such States also include title I cities.

To estimate the number of individuals living with AIDS, the GAO recommended applying different weights to the number of AIDS cases identified by the Centers for Disease Control and Prevention during each of the most recent 10-year period. Developed with input from the CDC, the GAO suggested applying the following weights: .06 for the first and second year during such period, .08 during the third year, .10 during the fourth year, .16 during the fifth and sixth year, .24 during the seventh year, .40 during the eighth year, .57 during the ninth year, and .88 during the tenth year.

The GAO recommended using the medicare average hospital wage index. This index would provide a proxy to determine relative differences in the cost of providing services to people with AIDS in different portions of the country. In addition, GAO recommended that 30 percent of the cost factor should be constant to reflect the fact that drug prices across different regions of the country are relatively stable.

The committee worked to identify which portion of title II funding is similar in purpose to title I funding. All of title I funding is devoted to medical and support services; while for fiscal year 1995, 57 percent of title II funding is devoted to medical and support services. To address funding differences between States with and without EMA's, the committee adopted a title II formula with two separate components. One portion of the formula is based on the number of individuals living in EMA and non-EMA areas. The remaining portion is based on the number of individuals living in non-EMA areas only.

AUTHORIZATION OF APPROPRIATIONS FOR TITLES I AND II

The committee received comments from many interested individuals and groups indicating that the current separate authorization structure for titles I and II sets up a competitive process for titles

I and II grantees which disrupts the unity of interests for people living with AIDS. For these reasons, S. 641 includes a single authorization for the two titles.

THE NEED FOR S. 641

The CARE Act was originally passed in 1990 to address some of the most pressing problems in health services delivery raised by the HIV epidemic. Today, S. 641 represents the continuation of that comprehensive approach.

The HIV epidemic is one major problem which has compromised the health and health care infrastructure of this country. Our Nation's health care system was totally unprepared for the advent of AIDS and HIV. Even when the full scope and severity of the epidemic began to be reported, the planning and funding that would be required to mount an appropriate response lagged.

The Ryan White CARE Act of 1990 was designed and passed with near unanimity in the Senate to address those planning and funding shortfalls. Two national commissions recommended and supported the principles underlying the CARE Act as the most effective means to address the burgeoning needs of people living with HIV/AIDS. Title I of the act addresses the needs of the metropolitan areas where HIV disease is most heavily concentrated. Title II addresses the HIV epidemic on a statewide basis, with a special emphasis on the needs of smaller cities and rural areas and on services to families and children with HIV disease. Title II also provides a basis for hard-hit urban and nonurban areas to build an effective continuum of care.

In considering reauthorizing the CARE Act, the committee has received input from a wide variety of sources. Dr. June Osborn, chair of the National Commission on AIDS from 1989-93, testified before the committee that the structure of the CARE Act has worked over the last 5 years and that it provides a solid basis on which to build an effective response to the changing epidemic over the next 5 years. National AIDS organizations including the AIDS Action Council, the Campaign for Fairness, the CAEAR Coalition, the National Association of State and Territorial AIDS Directors, and National Organizations Responding to AIDS, have also provided input. These groups, as well as mayors, governors, Federal, State and local public health officials, CARE Act funded service providers and, most important, people living with HIV disease are all in agreement that the CARE Act has been a success and a lifeline of support to hundreds of thousands of people.

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

Witnesses also testified regarding the problems associated with the existing CARE Act. Funding disparities exist among EMA's and

among states. Title I EMA's have often been pitted against title II States in a competition for scarce resources.

The epidemic has grown and it has changed. The witnesses agreed that the reauthorized CARE Act should change to address the needs of these newly affected groups.

The original CARE Act has demonstrated that alternatives to inpatient care can alleviate some of the burden that both urban and rural hospitals face. Examples of CARE Act success are plentiful:

In Massachusetts, the average length of hospitalization for people with AIDS in the State declined from 11.8 days before CARE Act implementation to 9.4 days after CARE Act implementation. During the same period, the average length of stay for all other diagnoses actually increased from 6.6 days to 7.0 days.

In Miami, the average length of stay for people with HIV at Mercy Hospital was reduced from 14 days in 1991 to 8.4 days in 1994, through CARE Act funded discharge planning, case management and outpatient medical and support services.

In South Carolina, CARE Act funds supported the opening of a primary care clinic in 1993 staffed with HIV-trained nurses and physicians to serve patients without Medicaid or other private health insurance. The existence of the clinic significantly reduced the use of hospital emergency rooms in Columbia.

In Missouri, CARE Act funds enabled the State through its consortia to develop a network of 116 primary care physicians to provide care to patients living in rural areas. Uninsured patients are able to receive timely medical care that costs less than if they had to travel long distances to an urban center.

Evidence from four States (Florida, Hawaii, Minnesota and Wisconsin) suggests that title II Health Insurance Continuation Programs (HICP) have resulted in significant cost savings. The four States estimated a savings of \$1.3 million over a 1 year period, or \$9,384 per HICP client per year.

Title III(b) of the CARE Act has provided vital primary care and other support services through health centers in underserved areas which face an increasing demand for HIV care. Services supported by title III(b) reach 40,000 people with or at risk for HIV disease.

Under title IV of the CARE Act, services for women, youth, infants and children are available in 26 States and are delivered through 199 affiliated clinical service sites. Title IV serves 11,900 HIV positive or affected women and children.

S. 641 has preserved and improved upon the best aspects of the original CARE Act. At the same time, in recognition of the changes that have taken place over the last 5 years, the committee has also made some necessary alterations. These changes focus on the funding formulae used to distribute resources to cities and States. The purpose of these changes is to assure a more equitable allocation of funding, based on where people with the illness are currently living.

While difficult to negotiate, these changes ultimately have received the support of national AIDS organizations, public health officials, and people with AIDS. With any formula change, there is

always the concern about the potential for disruption of services to individuals now receiving them. To address this concern, the bill maintains hold-harmless floors designed and phased-in to assure that no entity receives less than 92.5 percent of its 1995 allocation over the next 5 years.

The committee has also recognized a need to establish a single authorization of appropriations for title I and title II. Such an appropriation would be divided based on the ratio of fiscal year 1995 appropriations to each of these two titles. Thus 64 percent would be allocated to title I in fiscal year 1996.

A single appropriation is needed because it would compel cities and States to work collaboratively in the future and produce a sense on the part of grantees that their interests are unified rather than competitive. It would also disregard geographic interests. As such, funding priorities would focus on the service needs of people living with HIV/AIDS nationwide, rather than by jurisdictions, cities, or States.

III. LEGISLATIVE HISTORY AND COMMITTEE ACTION

S. 641 was introduced on March 28, 1995 by Senators Kassebaum, Kennedy, Hatch, Jeffords, Frist, Pell, Dodd, Simon, and Coats. The bill was referred to the Committee on Labor and Human Resources.

In the executive session of the Committee on Labor and Human Resources held on Wednesday March 29, 1995, S. 641 was brought up for consideration. The bill was unanimously adopted and favorably reported to the full Senate.

IV. COMMITTEE VIEWS ¹

PART A

Through part A of S. 641, the committee intends that urgently needed financial relief to health care facilities and other service agencies and institutions continue to be directed to those areas of the country that have been severely affected by the HIV epidemic. The AIDS epidemic with its associated co-morbid factors (including tuberculosis, sexually transmitted diseases, substance abuse, homelessness, and severe mental illness) pose profound challenges in meeting the needs of people living with HIV and AIDS.

The original purpose of the CARE Act to function as emergency relief for high-incidence areas continues to be important. The epidemic's impact on institutional and organizational resources continues to place stress on the health care infrastructure in areas with large number of AIDS cases, affecting not only services available to people with HIV but also to all citizens.

The overall guidance of the committee to areas receiving emergency support under the reauthorized CARE Act is that part A funds be used to both reduce individual and societal stresses resulting from AIDS and the frequently associated co-morbid urban, social and public health problems. CARE Act funds should continue to be focused on individuals with HIV disease and support the improvement and availability of quality, community-based medical

¹ Public Health Service Act section sites and parts are utilized for the purposes of this section.

and support services which can contribute to reduced utilization of in-patient hospitalization.

The changes made to existing law by the reauthorizing legislation reflect the committee's understanding of the epidemiological changes that have taken place over the last 5 years as presented by experts in the HIV/AIDS field, including epidemiologists, medical and support service providers, and people living with HIV disease. Similarly, the committee recommends changes to existing law based on 5 years of Federal, State and local administration of CARE Act programs.

Section 2601. Establishment of program of grants

It is the committee's intent to continue to direct sufficient resources to cities with the greatest need by limiting the time period within which AIDS cases are counted in eligibility determinations and by limiting part A grants to cities with a population of at least 500,000. This includes those areas with a rapid growth of the epidemic and a large enough population and sufficient health planning function to utilize the planning council model to for planning the delivery of health and support services for people with HIV disease.

These limitations identify true epidemic emergencies but avoid the marked increases in the number of EMA's seen during the reauthorization period. This restructuring is necessary, to avoid a significant reduction in the amount of funding available to any one city. Future eligibility based on current law would dilute the act's purpose of providing "emergency relief," given that many of these newly eligible areas have been receiving part B funds for 5 years. The committee feels that, as the epidemic progresses, the term "emergency" should denote a more rapid increase in AIDS cases—an absolute threshold of 2,000 people with AIDS over a 5 year period. Cities that experience this dramatic increase would certainly be experiencing an emergency similar to that envisioned in the original act. The committee intends that once an EMA becomes eligible, it will remain eligible regardless of changes in eligibility criteria or case counts. Furthermore to allow for a period of transition, this change will not become effective until FY 1998.

Section 2602. Administration and planning council

The committee believes that the planning council mechanism can assure that part A moneys are effectively allocated and administered. The community-based planning model represented by the planning councils is a successful model of delivering health care to vulnerable populations. The committee is confident of the ability of the part A model to rapidly provide appropriate HIV care services to people in the urban communities hardest hit by the epidemic and strongly supports the continuation of this model.

In carrying out its duty of establishing priorities for the allocation of funds, it is the intent of the committee that the planning council consider the effectiveness of various service delivery mechanisms in terms of cost and outcome (i.e., number of people served, reduction in hospital length-of-stays, et cetera). It is not the intent of the committee to require planning councils to research and document such measurements in order to justify funding a certain pri-

ority. To the extent that data are reasonably available, the planning council should consider these factors. The committee does not intend that planning councils use an excessive amount of resources to implement this provision which would be better utilized to provide services under the CARE Act. The committee affirms its commitment to the local determination of the planning council and the allocation of scarce resources in accordance with unmet need of groups and subpopulations.

HRSA should support planning councils in their role of assessing and addressing local administrative mechanisms that may impede rapid allocation of funds and the effectiveness of services in meeting need in an eligible metropolitan area. HRSA should also assure that planning councils adhere to reasonable and appropriate policies regarding conflict of interest. Such policies should, at a minimum, assure that decisions about vendor selection, are not undertaken by anyone associated with, or who has a financial relationship to such vendors. The reauthorization legislation continues to provide that the grantee be responsible for activities to ensure program effectiveness, including activities such as: vendor development (ensuring that community-based organizations are supported in the provision of culturally and linguistically appropriate services to their communities); assuring these programs are fulfilling the needs of people living with HIV/AIDS identified by the planning council; and assuring that persons living with HIV disease are satisfied with the care they are receiving under those conditions.

The reauthorization legislation also grants authority to the planning council, at its discretion, to engage in activities to assess program effectiveness, to contract out this function, to delegate this function to the grantee, or to perform this function in conjunction with the grantee or the grantee's administrative agency. Should the planning council choose to contract out the program effectiveness function, the grantee must provide all necessary information and support to accomplish the function.

The bill further provides that, should this function be delegated to the grantee, the grantee is bound to execute this function within the 5 percent administrative cap unless the planning council provides additional funding for this purpose. The legislation grants authority to the planning council to allocate such funding if the planning council determines that to further the goal of program effectiveness the grantee requires additional resources.

The legislation makes clear that each planning council should be reflective of the demographics of the HIV epidemic within its EMA, with a particular emphasis placed on communities which are disproportionately affected and historically underserved groups and subpopulations. The legislation also clearly states that the planning council membership include representatives of affected communities. Nominations for council membership shall be identified through an open process and selected based on publicized criteria which will include a conflict-of-interest standard for each nominee.

The representation of people living with HIV/AIDS and consumers of Ryan White services is of importance to the effectiveness of the planning council process. People living with HIV/AIDS on the planning council should, themselves, reflect the range of affected

communities. The committee seeks to give a voice to the various groups and subpopulations affected by HIV.

The committee strongly believes that HRSA should monitor the policies of all EMA's regarding representation of disproportionately affected communities at all levels of decision-making in the planning council. In addition, the committee recommends that HRSA establish a guidance standard for all EMA's for the membership on the planning council by people living with HIV/AIDS.

Effective participation in decision-making processes requires more than just filling a designated slot on the planning council. HRSA should monitor the effectiveness of planning councils in fostering the active and meaningful participation of people living with HIV/AIDS, and actively address noncompliance with representation requirements through its administrative authority. The committee encourages planning councils to facilitate less cumbersome participation in the planning council process for people living with HIV/AIDS by addressing such practical considerations as travel reimbursements, travel vouchers and child care. The committee also encourages planning councils to provide adequate orientation for all persons serving on the council, including persons living with HIV/AIDS to facilitate their effective participation on the planning council.

The committee intends that provider representatives on the planning council have a history of delivering services to affected communities and people with HIV. The committee has added planning council membership of other Federal HIV programs in order to maximize coordination and integration of services. For the purposes of this section, other Federal HIV programs include HOPWA programs and AIDS dental reimbursement programs.

Section 2603. Type and distribution of grants

Formula

The committee intends that the Secretary implement the formula developed by the General Accounting Office as such formula is codified. Interpretation of the legislative language should be accomplished with the input of the General Accounting Office based on the methodology developed by the GAO for the committee.

Supplemental Grants

The committee feels that an external review of applications is the most effective means of distributing supplemental grant funds.

The committee intends that, in awarding supplemental grants to eligible grantees, the Secretary give priority (added weight) to the criteria of severe need and ability to expend resources to meet that need. The Secretary may consider other definitions of severe need but, within the review criteria, should consider high rates of co-morbidities (as defined in the legislation), people with AIDS previously unknown to the area, and homelessness as the most appropriate measurements of such need. The committee does not intend that the planning council conduct resource-intensive documentation of these co-morbidities at the individual level, but may document the existence of these public health problems more generally in the local population.

It is the intent of the committee that the Secretary designate 50 percent of the amounts available for part A awards for supplemental grants in each fiscal year. Of the 50 percent designated for supplemental grants, the Secretary shall reserve such sums as necessary to fund the hold-harmless provisions built into the allocation formula for the 50 percent of part A funds designated for formula grants. The caps on losses in the formula grant awards shall be achieved by providing additional sums to those cities that fall below the annually designated floor, rather than putting additional sums through the allocation formula.

Regarding the evaluation of supplemental grant applications, the committee expects that HRSA will develop a process which includes an evaluation of the ability of grantees and subcontractors to spend resources quickly and efficiently. To the extent possible, this evaluation should include review of financial reports and other relevant data on grantee expenditures.

Section 2604. Use of amounts

The committee wishes to stress that capacity building is an important and legitimate expenditure of funds under part A of the Ryan White CARE Act. Part A is intended to enhance the capacity of existing or new organizations to provide and improve services for people living with HIV/AIDS. Capacity building may include the provision of technical assistance in order to improve the ability of organizations to provide or expand services. Planning councils should expect a direct relationship between capacity building and expansion, quality, or improvement of services.

The determinative authority of the planning councils must be maintained so that they can assess gaps in essential services as well as address these gaps. The planning council should evaluate the needs of a community and the availability of culturally, linguistically and geographically appropriate services. Planning councils are uniquely positioned to identify the need to develop the capacity of HIV/AIDS services for historically underserved groups and subpopulations.

It is the intent of the committee that substance abuse treatment and mental health service programs for people with HIV disease be eligible for funding under part A. Substance abuse treatment includes all modalities, including detoxification, outpatient counseling, and methadone maintenance. Mental health services similarly include outpatient mental health services (including individual counselling, health care, assessment, and psychotherapy), and support groups (including group therapy). Consistent with the act, Ryan White funds continue to serve as the funding of last resort when other resources are inadequate or unavailable.

Section 2605. Single application and grant award

It is the understanding of the committee that the current mechanism of distributing part A awards in separate formula and supplemental grants has created additional and unnecessary administrative burdens at the Federal and local levels. Grantees must complete two separate applications and track the expenditures of two separate grants. In meeting two sets of administrative demands, service providers (some of whom receive two contracts for the same

service under the current distribution mechanism) must also devote more time and resources than necessary to nonservice related responsibilities.

To minimize these administrative burdens, the committee gives authority to the Secretary to develop administrative mechanisms at the Federal level to award both the formula and supplemental awards as a single grant based on the submission of a single grant application. Any changes made by the Secretary should not result, however, in grantees receiving their grants any later than 90 days after the appropriations bill is signed. In addition, such a process should be phased in, in order to minimize potential local or administrative complications and to ensure that no gap in funding will occur.

Section 2606. Technical assistance

The committee believes that HRSA should provide an effective technical assistance network, including peer-based technical assistance, for all eligible metropolitan areas that are able to address issues of inclusion and representation, epidemiology, community planning, development of needs assessments and conflict resolution. The committee also encourages HRSA to conduct semiannual or annual meetings for information sharing, technology transfer, skills building and strategic advice. Participants in such meetings should include representatives from city and county health departments (grantees), planning council co-chairs, consumers and administrative agencies.

Peer-based technical assistance in conjunction with planning grants should be provided to communities newly eligible for Part A funding. The committee believes that EMA's that have effectively implemented the program have a great deal of expertise to offer those seeking to work through similar issues. New EMA preparation includes: implementation of community-wide needs assessments; a plan for the rapid distribution of funds as required by law; the development of community representation on planning councils; the creation of effective by-laws, organizational structures and procedures, including conflict resolution; and fostering productive working relationships with affected communities, local administrative agencies and the local health department.

HRSA should include all planning council chairs, (co)chairs and/or vice-chairs, or other council leadership, along with the grantees, in all HRSA information dissemination, including mailings, telefacsimile and other communication, to facilitate better communication and information flow.

The committee believes that HRSA should provide a greater level of technical assistance to the planning councils and grantees on such issues such as inclusion of communities of color, women, persons living with HIV/AIDS on the planning council, and process and outcome evaluations.

PART B

The committee views the current structure of the part B program as an effective means for states to direct CARE Act resources where they see the greatest need. The changes made to the formula distribution of part B funds to States should not be construed as

a restriction on the State's flexibility in determining how to allocate its resources or that States must spend a certain amount of part B dollars in any one area. The entire amount of part B funds allocated to a State can be expended on any combination of the 4 programs as outlined in the legislation, except that the 50 percent consortia requirement for States with more than 1 percent of all AIDS cases remains in effect.

In establishing a formula which includes distributing 50 percent of the amounts available for part B grants based on non-EMA cases, the committee intends to increase the resources available to States that have not benefited from direct funding to cities. The committee intends that States would continue to address the needs of individuals in EMA's and non-EMA areas with the flexibility currently afforded States under the CARE Act of 1990. The committee expects that HRSA will continue to work with part A and B grantees to collaborate on allocating resources appropriately across the entire State.

Section 2612. General use of grants

The Committee has retained the provision in section 2612(b), regarding a set-aside of 15 percent of funding under title II for services for infants, children, women and families, as authorized under current law. The Committee urges HRSA to monitor compliance to ensure that the purposes of this provision are fully met.

Section 2616. Provision of treatments

The committee feels strongly that people living with HIV should have access to life-prolonging therapies and encourages States to do all they can to maximize such access. The committee acknowledges that the costs of AIDS drug therapies are expensive and that discretionary Ryan White funding alone will never meet the need.

It is the intent of the committee that the Secretary work with States, providers, and affected communities to develop a recommended minimum formulary for the provision of FDA-approved pharmaceutical drug therapies. Prophylactic therapies for certain opportunistic infections are widely recognized to be cost-effective means to reduce inpatient costs. States are expected to document the progress made, either through the drug assistance program or other public program, in meeting the recommended minimum formulary.

Section 2617. Statewide coordinated statement of need

Although the CARE Act provides the opportunity for the development of plans specific to States and to local areas, the committee believes that improved coordination among the various efforts mandated under the Act is necessary. To that end, the committee has provided for the development of a Statewide Coordinated Statement of Need (SCSN). The committee emphasizes that the purpose of the SCSN is to define need, not allocate resources. In addition, the committee believes that the SCSN should build on and not supplant the needs assessment processes conducted by the planning councils. The committee seeks to maximize coordination, integration, and effective linkage, not duplicate processes which are already in place and working well. The SCSN process is not meant

to affect part A planning councils discretion in making resource allocation decisions.

Should the part B grantee fail to convene the SCSN process or should that process fail to accomplish a statewide coordinated statement of need, no penalty will result to other grantees under this part as long as representatives of such grantees have participated in the process in good faith as required by the statute. The requirement that grantees participate in the SCSN process shall take effect in the first year following enactment. However, the requirement that programs provided by grantees be consistent with the SCSN does not take effect until fiscal year 1997, the first year that such consistency will be possible.

The legislation makes clear that part B grantees are not required to fund participation in the Statewide Coordinated Statement of Need (SCSN) process. Nonetheless, the committee strongly encourages grantees under part B to provide the funds necessary to assure adequate and broad, statewide participation of people living with HIV/AIDS and other representatives of historically underserved communities and subpopulations in the SCSN process. The committee wishes to stress, as well, that grantees under part B are required to make every effort to assure the representation from each part A planning council within its jurisdiction and grantees under part C, D, and F. Finally, in order to maximize the potential for coordination and collaboration, States are encouraged to include other major providers of HIV health care and support services that may not receive funding under the CARE Act.

Section 2618. Amount of CARE grants

The committee intends that the Secretary implement the formula developed by the General Accounting Office as such formula is codified. Interpretation of the legislative language should be accomplished with the input of the General Accounting Office on the methodology developed by the GAO for the committee.

The legislation states that 50 percent of amounts available for part B grants shall be distributed based on a 10-year cumulative weighted case count of AIDS cases in the State outside of EMA's. For EMA's that cross state boundaries, it is the intent of the committee that, for the purposes of counting non-EMA State AIDS cases, the cases within such an EMA be apportioned to the appropriate State. For example, the Philadelphia, PA, EMA includes counties in the State of New Jersey. To calculate the non-EMA cases in Pennsylvania, the total statewide count shall be reduced by those Philadelphia EMA cases residing in Pennsylvania. Similarly, the statewide count for New Jersey shall be reduced by the number of Philadelphia cases living in New Jersey (as well as the cases living in other New Jersey EMA's).

The legislation also includes a ratable reduction provision in the event that amount appropriated for part B is less than the amount appropriated in FY 1995. It is the intent of the committee that the loss limit in the given fiscal year be multiplied by the percentage of appropriations available compared to FY 1995. For example, if in FY 1997 the appropriations for part B were reduced by 10 percent, the loss limit would be changed from 97 percent to 87.3 percent [i.e., $(97 \text{ percent}) \times (90 \text{ percent}) = 87.3 \text{ percent}$].

Unfortunately, the committee is not able to protect any State against loss resulting from a reduced appropriation. Those States whose awards are reduced in order to ensure meeting the loss cap may experience a loss (compared to FY 1995) of up to the percentage of appropriations available compared to FY 1995. For example, if appropriations are reduced by 10 percent in FY 1997, those states whose awards are higher than their FY 1995 award are proportionately reduced in order to ensure that each State receives 87.3 percent of its FY 1995 award. In this hypothetical example, States experiencing such a proportional deduction cannot receive less than 90 percent of their FY 1995 award.

Additionally, the legislation increases the administrative expense limitation for states. This change is included because the committee recognizes that additional resources are needed to administer this program in the many diverse areas of each state. Additionally, this change is included because the committee recognizes the added administrative costs required to manage the four different title II component programs.

Section 2621. Grievance procedures

The committee notes that, elsewhere in the legislation regarding part A grantees, planning councils are required to develop local procedures to address grievances, disputes and conflicts of interest. HRSA should work with part B grantees to develop similar local procedures and processes. To build on this locally based conflict resolution system, the reauthorization bill directs HRSA to work with members of the CARE Act community to jointly develop an appropriate Federal role in the event that these local procedures fail.

In carrying out section 2621, it is the intent of the committee that HRSA engage in a process with grantees, planning councils and consumers to jointly develop a grievance procedure for addressing allegations of egregious violations of the letter of the act. In developing that procedure, participants should consider mechanisms to: determine whether a violation has occurred, confirm that locally developed procedures have been exhausted, mediate and arbitrate a solution and, ultimately, impose appropriate sanctions, including the reduction of grant awards. Participants should consider the use of a peer review committee as a possible mechanism to carry out these functions.

PART C—SUBPART II

The committee wishes to underscore the need for linkages to exist between grantees and other HIV/AIDS providers operating in the area to be served by the grantee. The committee encourages HRSA to monitor a grantees demonstrated linkages to other HIV/AIDS Service resources in the area to be served.

The committee acknowledges the need for adequate input from people living with HIV/AIDS in the development of a continuum of HIV care services. The committee encourages HRSA to monitor such participation for each grantee.

Part C grants are administered through the Bureau of Primary Health Care (BPHC) at HRSA. The committee also encourages HRSA to coordinate meetings and other opportunities for coordina-

tion among all parts of the legislation, particularly those carried out by the Division of HIV Services.

The committee supports efforts currently underway to centralize oversight of the part C programs within the BPHC at HRSA and requests that this centralization be completed by FY 1996. The committee directs the regional program managers to report to the director of the BPHC so that part C programs can benefit from the expertise located in BPHC and HRSA generally.

Section 2651. Provision of primary care services

The committee directs HRSA to convene a process, utilizing current and prospective grantees, in order to draft guidelines designed to articulate the necessary role of primary care services to people living with HIV/AIDS served with funds provided under this part. Early intervention services, the primary focus of part C grants, are expected to include a continuum of services, including, but not limited to: HIV primary care, prophylaxis, therapeutics, acute care and treatment monitoring. For current grantees with the capacity to provide direct services, the committee expects that people living with HIV/AIDS be afforded full access to such services. The committee recognizes that some part C grantees operate as a consortia of services specifically designed for HIV/AIDS. These programs and the guidelines developed must meet the needs of people living with HIV/AIDS and assure that direct services are provided consistent with the needs of consumers.

Section 2654. Planning grants

It is the intent of the committee that the preferences for rural and underserved areas apply only to planning grants. It is the view of the committee that rural areas are in particular need of such system development. The committee also recognizes that underserved communities continue to exist in urban and suburban areas of the country. Health care programs for populations with unique needs are lacking. The purpose of the planning grants is to assist providers in developing HIV primary care delivery systems.

PART D

Section 2671. Grants for coordinated services and access to research for children, youth, and families

Part D was enacted to provide funds for coordinated health and social services in association with voluntary participation in research programs. Through this section the committee affirms its commitment to the provision of innovative comprehensive HIV care systems for children, youth, and families with or affected by HIV. Grants made through this section to public and not-for-profit entities provide or arrange for coordinated HIV services to the public for the purpose of supporting or maintaining comprehensive, community-based, culturally competent, family or youth centered HIV care systems. Projects facilitate the voluntary participation of children, youth, and women with HIV disease in qualified research protocols. The committee understands that participation of children, youth, and pregnant women in HIV research programs has been successful when projects were convenient to women and chil-

dren with HIV disease, when they were sensitive to nontraditional services such as child care and transportation costs and when the research was conducted within an established, comprehensive HIV care system.

Comprehensive care systems

It is the intent of the committee for this program to be flexible but to organize, coordinate and support a broad range of HIV services linking institutional and community-based providers. Grantees may provide a wide range of health services and may make referrals for or provide for services to facilitate access to care. Five percent of the funds appropriated under this section may be used to provide training and technical assistance to projects. This assistance may include the development of innovative models of care, new therapies, outreach to minority communities advance provider training and improve the coordination with research programs.

Patient participation in research protocols

The committee intends for this program to be administrated by the Secretary, acting through the Administrator of HRSA, in consultation with the Director of the National Institutes of Health. The committee expects that this collaboration will result in improved research results, improved access for people who might not have otherwise participated in research and in better use of research dollars by coordination of ancillary services. It is the committee's goal to bridge the gap between the patients and research through the title IV programs and not to recreate arrangements that are already in place. The committee intends that these resources are not to be used to directly fund research.

It is the committee's intent for all patients to be offered research opportunities, but it is not the intent of the committee to have patients forced into study participation. The committee believes that well-designed and accessible research will attract participants. Occasional patients are expected to refuse the opportunity to enroll in research programs. However, if substantial rates of refusal do occur, then grantees should review the available research opportunities and determine if they are appropriate for its patients.

Part D of this Act requires that the Secretary constitute an independent panel to review existing research protocols which have either been approved by the National Institutes of Health or approved by other for-profit or non-profit entities. The panel shall review these protocols and approve those which it determines provide greater benefit to children, youth, and pregnant women. For the purpose of this section, the committee also intends that all protocols approved by the National Institutes of Health shall be deemed to be approved by the independent panel.

The committee expects that the panel will rule not only on the scientific merits of the project, but also the feasibility of the program to be performed in outpatient community sites. The committee has also provided for the panel to review each protocol's potential clinical benefit but it does not intend that this standard of potential benefit be interpreted narrowly. Rather, it must be realized that research may offer little guaranteed benefit for study partici-

pants, but such research does offer potential clinical benefit to study participants if research success is achieved.

The committee intends that each grantee under this section affiliate itself with no less than one protocol approved by this independent panel. However, each grantee may also affiliate itself with protocols which are not approved by the independent panel. Furthermore, the committee does not intend that study participants participate only in the protocols approved by the independent panel. Rather, they may participate in other protocols offered by the grantee.

The Secretary is allowed discretion to fund programs that are not in noncompliance on a limited basis. The committee agrees that waivers of compliance may be needed as part of research arrangements. In such instances the committee intends for programs to develop remedial measures expeditiously and to seek new research opportunities for patients. The committee also recognizes that both profit-making, and nonprofit private research entities can contribute to the AIDS research effort. The committee believes that the facilitation of children, youth, and women in all approved programs will improve the chance of research success and increase the access to state-of-the-art trials.

PART F

Section 2691. Special projects of national significance

It is the intent of the committee that 3 percent of the total amounts appropriated for parts A, B, C, and D be calculated in determining the amount of funding available for these projects.

The committee recognizes the successful results of Special Projects of National Significance in areas such as mental health services, advocacy services, services to youth, and services to Native Americans. The committee intends that part A and part B grantees shall have the ability to fund projects begun as a Special Project of National Significance (either under the original act or the reauthorization legislation) in order to continue and replicate successful and innovative service models.

APPROPRIATION FOR PART A AND PART B

Section 2677. Authorization of appropriations

This section would create a single appropriation for part A and part B. For fiscal year 1996, the committee intends that 64 percent of the appropriation would be allocated for the purposes of part A. The committee intends that part A and part B continue to function separately from each other. Grants for part A would still be allocated directly to EMA's and for part B would be allocated to States. Furthermore, the Secretary shall maintain funding for part A and part B as separate accounts once the single appropriation has been divided based on the set-aside ratios.

Because the relative needs for funding under part A and B may change over time, the committee intends to have the Secretary adjust the set-aside ratios based on a method developed by the Secretary. In developing the method, the Secretary should consider the impact of the addition of new title I cities and other relevant fac-

tors. In developing the methodology, the Secretary should receive the input of affected communities, organizations, and other experts.

If the Secretary determines that this methodology is not feasible, then the committee intends that there should be two separate appropriations for fiscal year 1997 through fiscal year 2000.

GENERAL

The Committee notes that funds are not authorized under this Act for any program that includes distribution, exchange, or preparation for the distribution or exchange of needles to any person for the purpose of using illicit intravenous drugs.

The Committee also notes that the primary purpose of the CARE act is to make health and support services available to individuals with HIV disease. The Committee urges HRSA to monitor the amount of funds used for administration, planning, and evaluation and for non-health related services, such as housing, to ensure that the primary purposes of the Act are met.

In general, the Committee encourages public and private partnerships to address the service needs of individuals living with HIV and AIDS. Such partnerships would complement the limited Federal resources available to care for such individuals.

V. COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 3, 1995.

Hon. NANCY LANDON KASSEBAUM,
Chairman, Committee on Labor and Human Resources, U.S. Senate, Washington, DC.

DEAR MADAM CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 641, the Ryan White CARE Reauthorization Act of 1995.

Enactment of S. 641 would not affect direct spending or receipts. Therefore, pay-as-you-go procedures would not apply to the bill.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JAMES L. BLUM
(For June E. O'Neill, Director).

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 641.
2. Bill title: The Ryan White CARE Reauthorization Act of 1995.
3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources on March 29, 1995.
4. Bill purpose: S. 641 would reauthorize various programs established pursuant to the Ryan White CARE Act of 1990. In addition, the bill would make changes in requirements for some of the programs.
5. Estimated cost to the Federal Government: The following table summarizes the estimated authorizations and outlays that would result from this bill under two different sets of assumptions. The

first includes the effects of the program changes proposed by the bill and adjusts the estimated amounts for projected inflation after 1995. The second makes no allowance for projected inflation.

[By fiscal year, in millions of dollars]

	Projected Under S. 641					
	1995	1996	1997	1998	1999	2000
Estimated Authorizations of Appropriations—assuming program changes and adjustments for projected inflation						
Emergency relief	357	368	381	395	409	423
CARE grants	198	205	212	220	228	236
Early intervention grants	52	57	59	61	63	65
Grants for coordinated services	26	27	28	29	30	31
AIDS education and training	16	17	17	18	19	19
Special projects	(¹)	25	25	25	25	25
Total estimated authorizations	647	699	723	748	773	799
Estimated outlays from authorizations in S. 641	NA	336	643	742	767	794
Estimated outlays from appropriations in 1995 and previous years	597	331	71			
Total estimated outlays	597	667	714	742	767	794
Estimated Authorizations of Appropriations—assuming continued funding at the 1995 level, adjusted for program changes						
Total estimated authorizations	647	677	677	677	677	677
Total estimated outlays	597	656	674	677	677	677

Notes: Details may not add to totals because of rounding NA=Not applicable.

¹ Special projects authorization amount for 1995 is included in the CARE grants total.

The costs of this bill fall within budget function 550.

6. Basis of estimate: S. 641 reauthorizes funding for Ryan White CARE Act programs at such sums as may be necessary for fiscal years 1996 through 2000. Because the bill changes the requirements for some of the programs, CBO estimated the changes in funding that would be necessary to meet the requirements of the bill.

Emergency relief grants

The bill would limit eligibility for emergency relief grants to metropolitan areas with more than 500,000 residents, but would exempt areas that were eligible as of March 31, 1995, from this requirement. The bill also would limit eligibility for the grants to cities with a cumulative 5-year total of more than 2000 cases of AIDS, beginning in fiscal year 1997. According to the Department of Health and Human Services (HHS), these limitations would prevent growth in the number of eligible grantees. The estimated authorization levels in the above table are based on the 1995 appropriations of \$357 million. Under the assumption that appropriations are increased to reflect projected inflation, estimated authorization amounts would increase to \$368 million in fiscal year 1996, and to \$423 million in fiscal year 2000.

CARE grants

S. 641 would reauthorize and make several changes to the program to provide grants for the operation of HIV service delivery consortia under Title II of the Ryan White CARE Act. CBO esti-

mated the authorization levels for fiscal years 1996 through 2000 by adjusting the amount appropriated for fiscal year 1995, \$198 million, for the effects of changes to the current program as explained below. Taking into account all these elements and assuming that appropriations are increased to reflect projected inflation, CBO estimates authorization amounts for Title II programs as amended by the bill at \$205 million in fiscal year 1996, increasing to \$236 million in fiscal year 2000.

The bill would remove the authorization for special projects of national significance in Title II. This program is currently authorized at a maximum of 10 percent of Title II funding. In the past three years, this program was funded at an average of 4.3 percent of Title II funding. CBO estimated the decrease in authorization amounts resulting from removal of this program by applying the average percentage to estimated authorization levels for Title II for fiscal years 1996 through 2000. The estimated savings are \$9 million to \$11 million a year.

The bill would increase the maximum percentage of funding for such grants that can be used for administrative, planning, and evaluation functions from 10 percent to 15 percent of grant amounts. CBO estimates that an additional \$10 million to \$11 million each year would be required to maintain current service levels.

Early intervention grants

The bill would reauthorize early intervention grants and increase the maximum percentage of funding for such grants that can be used for administrative functions from 5 percent to 10 percent of grant amounts. This change would require additional funding to maintain current service levels. The program is funded at \$52 million in fiscal year 1995. CBO estimates that this provision would require \$3 million in additional funding in each fiscal year. After allowing for this change and assuming that appropriations are increased to reflect projected inflation, CBO estimates the authorization amount as \$57 million for 1996, growing to \$65 million by 2000.

Grants for coordinated services

S. 641 would reauthorize funding for grants to coordinate systems of care for women and children at such sums as may be necessary for fiscal years 1996 through 2000. The estimated authorization levels in the above table are based on the 1995 appropriation of \$26 million in fiscal year 1995. Under the assumption that appropriations are increased to reflect projected inflation, estimated authorization amounts would increase to \$27 million in fiscal year 1996, and to \$31 million in 2000.

AIDS education and training centers

S. 641 would reauthorize funding to train health practitioners in treatment of individuals who are HIV-positive. The estimated authorization amounts in the above table are based on the 1995 appropriation of \$16 million. Assuming that appropriations are increased to reflect projected inflation, estimated authorization amounts would increase to \$17 million in 1996, and to \$19 million in 2000.

Special projects

The bill would authorize funding for programs for the care and treatment of individuals who are HIV-positive at a maximum of \$25 million each year for fiscal years 1996 through 2000.

This estimate assumes that all authorizations are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spending rates computed by CBO on the basis of recent program data.

7. Pay-as-you-go considerations: None.

8. Estimated cost to State and local governments: The Ryan White Act requires states that receive funding under Titles II and III of the act to provide non-federal matching contributions and specifies the amount of such contributions. Non federal funds could come from state and local governments.

9. Estimate comparison: None.

10. Previous CBO estimate: None.

11. Estimate prepared by: Connie Takata.

12. Estimate approved by: Robert A. Sunshine for Paul N. Van de Water; Assistant Director for Budget Analysis.

VI. REGULATORY IMPACT

The committee has determined that there will be no increase in the regulatory burden of paperwork as the result of this bill.

VII. SECTION-BY-SECTION ANALYSIS

SECTION 1. SHORT TITLE

The short title is the "Ryan White CARE Reauthorization Act of 1995."

SECTION 2. REFERENCES

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

SECTION 3. GENERAL AMENDMENTS

(a) Establishment of grant program

Amended section 2601. The ending date for determining EMA eligibility will be March 31, 1995 for fiscal year 1996 and December 31 of the most recent calendar year thereafter. The EMA qualifying factor of 2,000 or more cumulative AIDS cases is changed to 2,000 or more cumulative cases for the most recent 5 year period and the qualifying factor based on incidence is eliminated. A new criteria is established requiring an area to have 500,000 or more in population, except for areas eligible as of March 31, 1994. EMA's currently receiving grants will remain eligible.

Amended section 2602. Specifies that HIV Health Services Planning Councils (HHSPC) will reflect the demographics of the epidemic in the involved area, with particular consideration given to disproportionately affected and historically underserved groups. Nominations for membership will be identified through an open process based on locally delineated and publicized criteria, including a conflict-of-interest standard for each nominee. Provides that

an HHSPC may not be chaired solely by an employee of the grantee. Further provides that HHSPC priorities for the allocation of funds will be based on documented needs, cost and outcome effectiveness, priorities of the targeted HIV-infected community, and availability of other resources. Requires that a HHSPC participate in the development of a Statewide Coordinated Statement of Need. Requires the establishment of specific HHSPC dispute resolution procedures and for the development of methods for community input on needs and priorities. Allows a HHSPC the discretion to assess the effectiveness of services in meeting identified needs. Makes technical changes to the required categories of HHSPC representatives and adds categories for organizations serving children, women, youth, and families and for grantees under other Federal HIV programs.

Amended section 2603. Extends grant authority and provides that a grantee must successfully demonstrate inclusive HHSPC membership and that proposed services are consistent with the Statewide Coordinated Statement of Need. Provides that priority for supplemental grants will be based on prevalence of diseases which affect the impact of HIV disease, of homelessness, and of cases in individuals previously unknown to the area. Adds a grant schedule ensuring maintenance of 1995 EMA grant amounts, on a gradually descending basis, through the year 2000 and requires the Secretary to reserve a percentage of the amount appropriated under part A for that purpose.

Amended section 2604. Adds substance abuse treatment, mental health treatment, treatment education, and prophylactic treatment for opportunistic infections to language on grant purpose. Includes substance abuse treatment programs, mental health programs, and private for-profit entities among entities eligible for financial assistance. Private for-profit entities may become eligible when no other provider of quality HIV care exists in the area. Specifies that entities receiving allocations from the grantee will not use in excess of 12.5 percent for administration and further specifies permissible administrative activities.

Amended section 2605. Specifies that political subdivisions must assure maintenance of expenditures equal to those in the preceding fiscal year, rather than for the 1-year fiscal period preceding the original grant. Updates application requirements language to include participation in the Statewide Coordinated Statement of Need process. Provides that the Secretary may phase in a single application requirement and single grant award for grants under part A.

Amended section 2606. Requires (rather than permits) the Administrator of the Health Resources Services Administration (HRSA) to provide technical assistance, including peer based assistance to new EMA's establishing planning councils. Allows the Administrator to make planning grants to projected newly eligible EMA's, not to exceed \$75,000 per area or a total of 1 percent of the part A appropriation for the fiscal year. Provides that such grant amounts will be deducted from first year formula amounts for the involved area.

(b) CARE grant program

Amended section 2613. Allows private for-profit entities that are the only available source of care to participate in HIV Care consortia. Adds substance abuse treatment, mental health treatment, prophylactic treatment for opportunistic infections, and treatment education to the services that may be provided through a consortium. Includes youth centered care as part of the application planning requirement and includes community-based providers and organizations with a history of serving children, youth, women, and families in the entities that must be consulted for consortium planning.

Amended section 2616. Requires the Secretary to review the status of State drug reimbursement programs and assess barriers to availability of prophylactic treatments for opportunistic infections (including active tuberculosis). Requires the Secretary to establish a recommended minimum formulary of drug therapies. The State will be required to document progress in treatment availability and to develop plans for full implementation of the formulary.

Amended section 2617. Requires at least one annual meeting of specified grantee representatives for the purpose of developing the Statewide coordinated statement of need. Adds to the State application requirement a description of how allocation and utilization are consistent with the Statewide Coordinated Statement of Need.

Amended section 2618. Increases limits on the portion of grants that a State may use for planning and evaluation and for administration to 10 percent each, or 15 percent in total; specifies that entities receiving grant funds from a State will be limited to 12.5 percent for administration. Provides that a State receiving the minimum allotment may not use more than an amount required to support one full-time-equivalent employee for those purposes.

Amended section 2619. Requires (rather than permits) the Secretary to provide technical assistance for grant activities, including the development and implementation of the Statewide Coordinated Statements of Need.

New section 2621. Requires HRSA to establish grievance procedures within 90 days to address allegations of egregious violations under each part of title XXVI. The procedures will include an appropriate enforcement mechanism.

New section 2622. Requires that the Secretary ensure coordination between HRSA, the Centers for Disease Control and Prevention, and the Substance Abuse and Mental Health Services Administration regarding planning and implementation of Federal HIV programs. The Secretary will be required to submit periodic reports to relevant congressional committees on integration and coordination of efforts at the Federal, State, and local levels and addressing Federal barriers to program integration.

(c) Early intervention services

Amended section 2651. Adds requirement that at least 50 percent of the grant be used to provide a continuum of HIV primary medical care, including appropriate dental services, to individuals confirmed to be living with HIV. Requires most grantees to use at least 50 percent of grants to provide testing, counseling and treatment services at sites where other primary care services are rendered. Requires family planning and hemophilia centers to ensure

services through linkage with primary care providers. Allows for participation of private for-profit entities when such entities are the only available provider of quality HIV care in the area.

Amended section 2652. Updates minimum qualification for participation of private for-profit entities when such entities are the only available provider of quality HIV care in the area.

Amended section 2654. Provides that the Secretary may provide planning grants not to exceed \$50,000 to develop primary care delivery systems. Specifies that preference is granted to entities that would provide primary care services in rural or underserved communities and limits planning expenditures to 1 percent of a fiscal year's appropriation.

Amended section 2655. Authorizes appropriations of such sums as may be necessary through fiscal year 2000.

Amended section 2664. The limit of 5 percent for administrative expenses is increased to 10 percent for planning, evaluation, and technical assistance. Specifies that a grantee must demonstrate consistency with the Statewide coordinated statement of need and agree to participate in ongoing revisions of that statement.

(d) Grants

Amended section 2671. Renames this section the "Grants for Coordinated Services and Access to Research for Children, Youth, and Families." Replaces pediatric demonstration grants with grants to public and private nonprofit entities to provide outpatient health care and support services for children, youth, and women with HIV disease and their families; to support the provision of such care with HIV prevention and research programs; and to facilitate voluntary participation of children, youth, and women in qualified research protocols. Requires assurances that grants will be used primarily for children, youth, and women and that grantees will facilitate voluntary research participation, will coordinate services with other title XXVI providers and providers under the Maternal and Child Health block grant, and will participate in the Statewide Coordinated Statement of Need. Establishes procedures for protection of research participants. Allows the Secretary to use up to 5 percent of appropriations for training and technical assistance. Requires annual evaluations, which may include recommendations for improved access and participation. Allows the Secretary discretion to grant temporary waivers of required assurances. Authorizes appropriations of such sums as may be necessary for fiscal years 1996 through 2000. Renames Part D "Grants for Coordinated Services and Access to Research for Children, Youth, and Families."

(e) Demonstration and training

Establishes a new PART F entitled "Demonstration and Training." Subparts under the new part are, "Subpart I—Special Projects of National Significance" and "Subpart II—AIDS Education and Training Centers."

New section 2691. The Secretary shall use the greater of \$20 million or 3 percent of the amount appropriated for each of parts A, B, C, and D, not to exceed \$25 million, for grants to public and nonprofit private entities for special programs related to innovative treatment models for the care and treatment of individuals with

HIV disease, including models to address the needs of special populations, to assist in developing essential community-based service delivery infrastructure, to ensure the availability of services for Native Americans, and for other specified purposes. Projects must be consistent with the Statewide Coordinated Statement of Need. The Secretary must disseminate information on successful models and may provide peer-based technical assistance for that purpose.

(f) HIV/AIDS Communities, Schools, Centers

New section 2692. Transfers authority for AIDS education and training centers from title VII (Health Professions Education) to title XXVI and makes technical corrections. Authorizes appropriations of such sums as may be necessary for fiscal years 1996 through 2000.

SECTION 4. AMOUNT OF EMERGENCY RELIEF GRANTS

Amended section 2603. Changes the Part A formula distribution factor. The new distribution factor will equal the estimated number of living AIDS cases in the area multiplied by a cost index for the eligible area based on the Medicare area wage index for hospitals. Specifies that the estimated number of living AIDS cases will be calculated by multiplying cases reported over the most recent 10 year period by a percentage schedule representing estimated survival rates. Establishes the cost index for eligible areas in Puerto Rico, Guam, and the Virgin Islands at 1.0. Allows the Secretary to adjust a fiscal year EMA grant to reflect unexpended funds from the preceding year.

SECTION 5. AMOUNT OF CARE GRANTS

Amended section 2618. Changes the distribution factor for part B to the average of the State distribution factor and the non-EMA distribution factor. The State distribution factor will be determined by multiplying the number of estimated living AIDS cases by the State or territory cost index. The non-EMA distribution factor will be determined by multiplying the number of estimated living AIDS cases (less the estimated number of living AIDS cases within an eligible area) by the State or territory cost index. Estimated living AIDS cases and the cost index would be determined as in section 4, except that a method for computing a statewide hospital wage index is specified. Allows the Secretary to adjust the grant for a fiscal year to reflect unexpended funds from the preceding years grant. Sets minimum grant amounts for States through the year 2000 based on 1995 grant levels; reduces the minimums if appropriations for a year are below the 1995 level. Provides for a proportionate reduction in grants to States receiving more than their 1995 levels, so long as the reduction does not bring any such State's grant below the 1995 level. Further specifies the minimum allotment as \$100,000 for States (or the District of Columbia) with less than 90 living cases and as \$250,000 for States (or the District of Columbia) with more than 90 living cases.

SECTION 6. CONSOLIDATION OF AUTHORIZATIONS OF APPROPRIATIONS

New section 2677. Authorizes a combined appropriation for parts A and B of such sums as may be necessary for fiscal years 1996 through 2000, and provides that 64 percent of appropriations will be allocated to part A, 36 percent to part B. Requires the Secretary to develop and implement a methodology for adjusting these part A and B percentages in fiscal years 1997 through 2000 based on grants to newly eligible EMA's and other relevant factors and requires the Secretary to submit a report on the methodology to appropriate committees of Congress. Authorizes continued separate appropriations if the Secretary fails to implement this methodology.

SECTION 7. EFFECTIVE DATE

Provides that amendments are effective October 1, 1995, except that changes in the time period used to establish caseloads for EMA eligibility and in permissible uses for EMA grants are effective on enactment and changes in the caseload criteria for EMA eligibility are effective October 1, 1997.

VIII. CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

* * * * *

PUBLIC HEALTH SERVICE ACT

RYAN WHITE CARE REAUTHORIZATION ACT OF 1995

* * * * *

SEC. 2601. ESTABLISHMENT OF PROGRAM OF GRANTS.

(a) **ELIGIBLE AREAS.**—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall, subject to subsection (b), make grants in accordance with section 2603 for the purpose of assisting in the provision of the services specified in 2604 2 in any metropolitan area for which, as of June 30, 1990, in the case of grants for fiscal year 1991, and as of **March 31 of the most recent fiscal year** *March 31, 1995, and December 31 of the most recent calendar year thereafter* for which such data is available in the case of a grant for any subsequent [fiscal year—

[(1) there has been reported to and confirmed by the Director of the Centers for Disease Control and Prevention a cumulative total of more than 2,000 cases of acquired immune deficiency syndrome; or

[(2) the per capita incidence of cumulative cases of such syndrome (computed on the basis of the most recently available data on the population of the area) is not less than 0.0025.] *fiscal year, there has been reported to and confirmed by, for the 5-year period*

prior to the fiscal year for which the grant is being made, the Director of the Centers for Disease Control and Prevention a cumulative total of more than 2,000 cases of acquired immune deficiency syndrome.

* * * * *

(c) *POPULATION OF ELIGIBLE AREAS.*—The Secretary may not make a grant to an eligible area under subsection (a) after the date of enactment of this subsection unless the area has a population of at least 500,000 individuals, except that this subsection shall not apply to areas that are eligible as of March 31, 1994. For purposes of eligibility under this title, the boundaries of each metropolitan area shall be those in effect in fiscal year 1994.

(d) *CONTINUED FUNDING.*—A metropolitan area that has received a grant under this section for the fiscal year in which this subsection is enacted, shall be eligible to receive such a grant in subsequent fiscal years.

SEC. 2602. ADMINISTRATION AND PLANNING COUNCIL.

* * * * *

(b) HIV HEALTH SERVICES PLANNING COUNCIL.—

(1) *ESTABLISHMENT.*—To be eligible for assistance under this part, the chief elected official described in subsection (a)(1) shall establish or designate an HIV health services planning council that shall include representatives of—

[(A) health care providers;

[(B) community-based and AIDS service organizations;

[(C) social service providers;

[(D) mental health care providers;

[(E) local public health agencies;

[(F) hospital planning agencies or health care planning agencies;

[(G) affected communities, including individuals with HIV disease;

[(H) non-elected community leaders;

[(I) State government;

[(J) grantees under subpart II of part C; and;

[(K) the lead agency of any Health Resources and Services Administration adult and pediatric HIV-related care demonstration project operating in the area to be served.] reflect in its composition the demographics of the epidemic in the eligible area involved, with particular consideration given to disproportionately affected and historically underserved groups and subpopulations. Nominations for membership on the council shall be identified through an open process and candidates shall be selected based on locally delineated and publicized criteria. Such criteria shall include a conflict-of-interest standard for each nominee.

(2) *REPRESENTATION.*—The HIV health services planning council shall include representatives of—

(A) health care providers, including federally qualified health centers;

(B) community-based organizations serving affected populations and AIDS service organizations;

(C) social service providers;

- (D) mental health and substance abuse providers;
- (E) local public health agencies;
- (F) hospital planning agencies or health care planning agencies;
- (G) affected communities, including people with HIV disease or AIDS and historically underserved groups and sub-populations;
- (H) nonelected community leaders;
- (I) State government (including the State medicaid agency and the agency administering the program under part B);
- (J) grantees under subpart II of part C;
- (K) grantees under section 2671, or, if none are operating in the area, representatives of organizations with a history of serving children, youth, women, and families living with HIV and operating in the area; and
- (L) grantees under other Federal HIV programs.

[(2)] (3) METHOD OF PROVIDING FOR COUNCIL.—

* * * * *

(C) *CHAIRPERSON.*—A planning council may not be chaired solely by an employee of the grantee.

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

(A) establish priorities for the allocation of funds within the eligible **[area]**; area based on the—

- (i) documented needs of the HIV-infected population;
- (ii) cost and outcome effectiveness of proposed strategies and interventions, to the extent that such data are reasonably available, (either demonstrated or probable);
- (iii) priorities of the HIV-infected communities for whom the services are intended; and
- (iv) availability of other governmental and non-governmental resources;

(B) develop a comprehensive plan for the organization and delivery of health services described in section 2604 that is compatible with any existing State or local plan regarding the provision of health services to individuals with HIV disease; [and]

(C) assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area**[.]** and at the discretion of the planning council, assess the effectiveness, either directly or through contractual arrangements, of the services offered in meeting the identified needs;

(D) participate in the development of the Statewide coordinated statement of need initiated by the State health department;

(E) establish operating procedures which include specific policies for resolving disputes, responding to grievances, and minimizing and managing conflict-of-interests; and

(F) establish methods for obtaining input on community needs and priorities which may include public meetings, conducting focus groups, and convening ad-hoc panels.

SEC. 2603. TYPE AND DISTRIBUTION OF GRANT.**(a) GRANTS BASED ON RELATIVE NEED OF AREA.—**

* * * * * * *

(2) EXPEDITED DISTRIBUTION.—**[Not later than—**

[(A) 90 days after an appropriation becomes available to carry out this part for fiscal year 1991; and

[(B) 60 days after an appropriation becomes available to carry out this part for each of fiscal years 1992 through 1995; the Secretary shall,] *Not later than 60 days after an appropriation becomes available to carry out this part for each of the fiscal years 1996 through 2000, the Secretary shall, except in the case of waivers granted under section 2605(c), disburse 50 percent of the amount appropriated under section [2608] 2677 for such fiscal year through grants to eligible areas under section 2601(a), in accordance with paragraph (3). The Secretary shall reserve an additional percentage of the amount appropriated under section 2677 for a fiscal year for grants under part A to make grants to eligible areas under section 2601(a) in accordance with paragraph (4).*

* * * * * * *

[(3) AMOUNT OF GRANT.—**[(A) IN GENERAL.—**

[(i) Subject to the extent of amounts made available in appropriations Acts, a grant made for purposes of this paragraph to an eligible area shall be made in an amount equal to the product of—

[(I) an amount equal to the amount available for distribution under paragraph (2) for the fiscal year involved; and

[(II) the percentage constituted by the ratio of the distribution factor for the eligible area to the sum of the respective distribution factors for all eligible areas.

[(ii) For purposes of clause (i)(II), the term “distribution factor” means the sum of—

[(I) an amount equal to the product of 3 and the amount determined under subparagraph (B) for the eligible area involved; and

[(II) an amount equal to the product of the amount determined under subparagraph (B) for the eligible area and the amount determined under subparagraph (C) for the area.

[(B) Amount relating to cumulative number of cases.—The amount determined in this subparagraph in an amount equal to the ratio of—

[(i) an amount equal to the cumulative number of cases of acquired immune deficiency syndrome in the eligible area involved, as indicated by the number of such cases reported to and confirmed by the Director of the Centers for Disease Control and Prevention by the applicable date specified in section 2601(a); to

[(ii) an amount equal to the sum of the respective amounts determined under clause (i) for each eligible area for which an application for a grant for purposes of this paragraph has been approved.

[(C) Amount relating to per capita incidence of cases.—The amount determined in this subparagraph is an amount equal to the ratio of—

[(i) the per capita incidence of cumulative cases of acquired immune deficiency syndrome in the eligible area involved (computed on the basis of the most recently available data on the population of the area); to

[(ii) the per capita incidence of cumulative such cases in all eligible areas for which applications for grants for purposes of this paragraph have been approved (computed on the basis of the most recently available data on the population of the areas).]

(3) AMOUNT OF GRANT.—

(A) IN GENERAL.—Subject to the extent of amounts made available in appropriations Acts, a grant made for purposes of this paragraph to an eligible area shall be made in an amount equal to the product of—

(i) an amount equal to the amount available for distribution under paragraph (2) for the fiscal year involved; and

(ii) the percentage constituted by the ratio of the distribution factor for the eligible area to the sum of the respective distribution factors for all eligible areas.

(B) DISTRIBUTION FACTOR.—For purposes of subparagraph (A)(ii), the term “distribution factor” means the product of—

(i) an amount equal to the estimated number of living cases of acquired immune deficiency syndrome in the eligible area involved, as determined under subparagraph (C); and

(ii) the cost index for the eligible area involved, as determined under subparagraph (D).

(C) ESTIMATE OF LIVING CASES.—The amount determined in this subparagraph is an amount equal to the product of—

(i) the number of cases of acquired immune deficiency syndrome in the eligible area during each year in the most recent 120-month period for which data are available with respect to all eligible areas, as indicated by the number of such cases reported to and confirmed by the Director of the Centers for Disease Control and Prevention for each year during such period; and

(ii) with respect to—

- (I) the first year during such period, .06;
- (II) the second year during such period, .06;
- (III) the third year during such period, .08;
- (IV) the fourth year during such period, .10;
- (V) the fifth year during such period, .16;
- (VI) the sixth year during such period, .16;
- (VII) the seventh year during such period, .24;

(VIII) the eighth year during such period, .40;
 (IX) the ninth year during such period, .57; and
 (X) the tenth year during such period, .88.

(D) *COST INDEX*.—The amount determined in this subparagraph is an amount equal to the sum of—

(i) the product of—

(I) the average hospital wage index reported by hospitals in the eligible area involved under section 1886(d)(3)(E) of the Social Security Act for the 3-year period immediately preceding the year for which the grant is being awarded; and

(II) .70; and

(ii) .30.

(E) *UNEXPENDED FUNDS*.—The Secretary may, in determining the amount of a grant for a fiscal year under this paragraph, adjust the grant amount to reflect the amount of unexpended and uncanceled grant funds remaining at the end of the fiscal year preceding the year for which the grant determination is to be made. The amount of any such unexpended funds shall be determined using the financial status report of the grantee.

(F) *PUERTO RICO, VIRGIN ISLANDS, GUAM*.—For purposes of subparagraph (D), the cost index for an eligible area within Puerto Rico, the Virgin Islands, or Guam shall be 1.0.

(4) *INCREASE IN GRANT*.—With respect to an eligible area under section 2601(a), the Secretary shall increase the amount of a grant under paragraph (2) for a fiscal year to ensure that such eligible area receives not less than—

(A) with respect to fiscal year 1996, 98 percent;

(B) with respect to fiscal year 1997, 97 percent;

(C) with respect to fiscal year 1998, 95.5 percent;

(D) with respect to fiscal year 1999, 94 percent; and

(E) with respect to fiscal year 2000, 92.5 percent;

of the amount allocated for fiscal year 1995 to such entity under this subsection.

(b) *SUPPLEMENTAL GRANTS*.—

(1) *IN GENERAL*.—Not later than 150 days after the date on which appropriations are made under section [2608] 2677 for a fiscal year, the Secretary shall disburse the remainder of amounts not disbursed under section 2603(a)(2) for such fiscal year for the purpose of making grants under section 2601(a) to eligible areas whose application under section 2605(b)—

* * * * *

(D) demonstrates the ability of the area to utilize such supplemental financial resources in a manner that is immediately responsive and cost effective; [and]

(E) demonstrates that resources will be allocated in accordance with the local demographic incidence of AIDS including appropriate allocations for services for infants, children, women, and families with HIV disease[.];

(F) demonstrates the inclusiveness of the planning council membership, with particular emphasis on affected communities and individuals with HIV disease; and

(G) demonstrates the manner in which the proposed services are consistent with the local needs assessment and the Statewide coordinated statement of need.

(2) **PRIORITY.**—

(A) **SEVERE NEED.**—In determining severe need in accordance with paragraph (1)(B), the Secretary shall give priority consideration in awarding grants under this section to any qualified applicant that demonstrates an ability to spend funds efficiently and demonstrates a more severe need based on prevalence of—

(i) sexually transmitted diseases, substance abuse, tuberculosis, severe mental illness, or other diseases determined relevant by the Secretary, which significantly affect the impact of HIV disease in affected individuals and communities;

(ii) AIDS in individuals, and subpopulations, previously unknown in the eligible metropolitan area; or

(iii) homelessness.

(B) **PREVALENCE.**—In determining prevalence of diseases under subparagraph (A), the Secretary shall use data on the prevalence of the illnesses described in such subparagraph in HIV-infected individuals unless such data is not available nationally. Where such data is not nationally available, the Secretary may use the prevalence (with respect to such illnesses) in the general population.

[(2)] (3) **REMAINDER OF AMOUNTS.**—In determining the amount of funds to be obligated under paragraph (1), the Secretary shall include amounts that are not paid to the eligible areas under expedited procedures under section 2603(a)(2) as a result of—

* * * * *

[(3)] (4) **AMOUNT OF GRANT.**—The amount of each grant made for purposes of this subsection shall be determined by the Secretary based on the application submitted by the eligible area under section 2605(b).

[(4)] (5) **FAILURE TO SUBMIT.**—

* * * * *

SEC. 2604. USE OF AMOUNTS.

* * * * *

(b) **PRIMARY PURPOSES.**—

(1) **IN GENERAL.**— * * *

* * * * *

(A) outpatient and ambulatory health and support services, including case management *substance abuse treatment and mental health treatment*, and comprehensive treatment services which shall include *treatment education and prophylactic treatment for opportunistic infections*, for individuals and families with HIV disease; and

* * * * *

(2) **APPROPRIATE ENTITIES.**—

(A) *IN GENERAL.*—Subject to subparagraph (B), direct financial assistance may be provided under paragraph (1) to public or nonprofit private entities, or *private for-profit entities if such entities are the only available provider of quality HIV care in the area*, including hospitals (which may include Department of Veterans Affairs facilities), community-based organizations, hospices, ambulatory care facilities, community health centers, migrant health centers, **[and homeless health centers]**, *homeless health centers, substance abuse treatment programs, and mental health programs.*

* * * * *

(e) **ADMINISTRATION **[AND PLANNING]**.**—**[The chief]**

(1) *IN GENERAL.*—*The chief executive officer of an eligible area shall not use in excess of 5 percent of amounts received under a grant awarded under this part for administration***[, accounting, reporting, and program oversight functions]**. *An entity (including subcontractors) receiving an allocation from the grant awarded to the chief executive officer under this part shall not use in excess of 12.5 percent of amounts received under such allocation for administration.*

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

(A) *routine grant administration and monitoring activities, including the development of applications for part A funds, the receipt and disbursement of program funds, the development and establishment of reimbursement and accounting systems, the preparation of routine programmatic and financial reports, and compliance with grant conditions and audit requirements; and*

(B) *all activities associated with the grantee's contract award procedures, including the development of requests for proposals, contract proposal review activities, negotiation and awarding of contracts, monitoring of contracts through telephone consultation, written documentation or onsite visits, reporting on contracts, and funding reallocation activities.*

(3) *SUBCONTRACTOR ADMINISTRATIVE COSTS.*—*For the purposes of this subsection, subcontractor administrative activities include—*

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

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

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

* * * * *

SEC. 2605. APPLICATION.

(a) *IN GENERAL.*—To be eligible to receive a grant under section 2601, an eligible area shall prepare and submit to the Secretary an application, *in accordance with subsection (c) regarding a single application and grant award*, at such time, in such form, and contain-

ing such information as the Secretary shall require, including assurances adequate to ensure—

* * * * *

(1) * * *

* * * * *

(B) that the political subdivisions within the eligible area will maintain the level of expenditures by such political subdivisions for HIV-related services for individuals with HIV disease at a level that is equal to the level of such expenditures by such political subdivisions for the [1-year period preceding the first fiscal year for which a grant is received by the eligible area] *preceding fiscal year*; and

* * * * *

(4) * * *

* * * * *

(B) by an entity that provides health services on a pre-paid basis; [and]

(5) to the maximum extent practicable, that—

* * * * *

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

(6) *that the applicant has participated, or will agree to participate, in the Statewide coordinated statement of need process where it has been initiated by the State, and ensure that the services provided under the comprehensive plan are consistent with the Statewide coordinated statement of need.*

(b) [ADDITIONAL] APPLICATION.—An eligible area that desires to receive a grant under section 2603(b) shall prepare and submit to the Secretary an [additional application] *application, in accordance with subsection (c) regarding a single application and grant award*, at such time, in such form, and containing such information as the Secretary shall require, including the information required under such subsection and information concerning—

* * * * *

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

(4) the aggregate amounts expended for each such category of services[.]; and

(c) SINGLE APPLICATION AND GRANT AWARD.—

(1) APPLICATION.—*The Secretary may phase in the use of a single application that meets the requirements of subsections (a) and (b) of section 2603 with respect to an eligible area that desires to receive grants under section 2603 for a fiscal year.*

(2) GRANT AWARD.—*The Secretary may phase in the awarding of a single grant to an eligible area that submits an approved application under paragraph (1) for a fiscal year.*

[(c)](d) DATE CERTAIN FOR SUBMISSION.—

(1) REQUIREMENT.—Except as provided in paragraph (2), to be eligible to receive a grant under section 2601(a) for a fiscal

year, an application under subsection (a) shall be submitted not later than 45 days after the date on which appropriations are made under section ~~2608~~ 2677 for the fiscal year.

* * * * *

~~[(d)]~~(e) REQUIREMENTS REGARDING IMPOSITION OF CHARGES FOR SERVICES.—

* * * * *

SEC. 2606. TECHNICAL ASSISTANCE.

The Administrator of the Health Resources and Services Administration ~~may~~ *shall*, beginning on the date of enactment of this title, provide technical assistance, *including peer based assistance to assist newly eligible metropolitan areas in the establishment of HIV health services planning councils and*, to assist entities in complying with the requirements of this part in order to make such entities eligible to receive a grant under this part. *The Administrator may make planning grants available to metropolitan areas, in an amount not to exceed \$75,000 for any metropolitan area, projected to be eligible for funding under section 2601 in the following fiscal year. Such grant amounts shall be deducted from the first year formula award to eligible areas accepting such grants. Not to exceed 1 percent of the amount appropriated for a fiscal year under section 2677 for grants under part A may be used to carry out this section.*

* * * * *

~~[SEC. 2608. AUTHORIZATION OF APPROPRIATIONS]~~

~~[There are authorized to be appropriated to make grants under this part, \$275,000,000 in each of the fiscal years 1991 and 1992, and such sums as may be necessary in each of the fiscal years 1993 through 1995] such sums as may be necessary in each of the fiscal years 1996, 1997, 1998, 1999, and 2000.]~~

* * * * *

PART B—CARE GRANT PROGRAM

SEC. 2613. GRANTS TO ESTABLISH HIV CARE CONSORTIA.

(a) * * *

(1) is an association of one or more public, and one or more nonprofit private *(or private for-profit providers or organizations if such entities are the only available providers of quality HIV care in the area)*, health care and support service providers and community based organizations operating within areas determined by the State to be most affected by HIV disease; and

* * * * *

(2) * * *

* * * * *

(A) essential health services such as case management services, medical, nursing, *substance abuse treatment, mental health treatment*, and dental care, diagnostics, monitoring, *prophylactic treatment for opportunistic infections, treatment education to take place in the context of health care delivery*, and medical follow-up services, mental

health, developmental, and rehabilitation services, home health and hospice care; and

* * * * *

(c) APPLICATION.—

(1) * * *

* * * * *

(C) demonstrates that adequate planning has occurred to meet the special needs of families with HIV disease, including family centered *and youth centered* care;

* * * * *

(2) CONSULTATION.—* * *

* * * * *

(A)(i) * * *

* * * * *

(ii) in the case of a public health agency that does not directly provide such HIV-related health care services such agency shall consult with an entity or entities that directly provide ambulatory and outpatient HIV-related health care services within the geographic area to be **【served; and】**served;

(B) not less than one community-based organization that is organized solely for the purpose of providing HIV-related support services to individuals with HIV disease**【.】**;

(C) *grantees under section 2671 and representatives of organizations with a history of serving children, youth, women, and families with HIV and operating in the community to be served; and*

(D) *representatives of community-based providers that are necessary to provide the full continuum of HIV-related health care services, which are available within the geographic area or be served.*

【(d) DEFINITION.—As used in this part, the term “family centered care” means the system of services described in this section that is targeted specifically to the special needs of infants, children, women, and families. Family centered care shall be based on a partnership between parents, professionals, and the community designed to ensure an integrated, coordinated, culturally sensitive, and community-based continuum of care for children, women and families with HIV disease.**】**

(d) DEFINITION.—As used in this part, the terms “family centered care” and “youth centered care” mean the system of services described in this section that is targeted specifically to the special needs of infants, children (including those orphaned by the AIDS epidemic), youth, women, and families. Family centered and youth centered care shall be based on a partnership among parents, extended family members, children and youth, professionals, and the community designed to ensure an integrated, coordinated, culturally sensitive, and community-based continuum of care.

* * * * *

SEC. 2616. PROVISION OF TREATMENTS.

* * * * *

[(c) STATE DUTIES.—In carrying out this section the State shall—

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

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

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

[(4) facilitate access to treatments for such individuals.]

(c) *STANDARDS FOR TREATMENT PROGRAM.*—In carrying out this section, the Secretary shall—

(1) *review the current status of State drug reimbursement programs and assess barriers to the expended availability of prophylactic treatments for opportunistic infections (including active tuberculosis; and*

(2) *establish, in consultation with States, providers, and affected communities, a recommended minimum formulary of pharmaceutical drug therapies approved by the Food and Drug Administration.*

In carrying out paragraph (2), the Secretary shall identify those treatments in the recommended minimum formulary that are for the prevention of opportunistic infections (including the prevention of active tuberculosis).

(d) *STATE DUTIES.*—

(1) *IN GENERAL.*—In implementing subsection (a), States shall document the progress made in making treatments described in subsection (c)(2) available to individuals eligible for assistance under this section, and to develop plans to implement fully the recommended minimum formulary of pharmaceutical drug therapies approved by the Food and Drug Administration.

(2) *OTHER MECHANISMS FOR PROVIDING TREATMENTS.*—In meeting the standards of the recommended minimum formulary developed under subsection (c), a State may identify other mechanisms such as consortia and public programs for providing such treatments to individuals with HIV.

SEC. 2617. STATE APPLICATION.

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(B) DESCRIPTION OF INTENDED USES AND AGREEMENTS.—* * *

* * * * *

(2) * * *

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(A) the services and activities to be provided and an explanation of the manner in which the elements of the program to be implemented by the State with such assistance will maximize the quality of health and support services

available to individuals with HIV disease throughout the State; **[and]**

* * * * *

(C) a description of how the allocation and utilization of resources are consistent with the State coordinated statement of need including traditionally underserved populations and subpopulations) developed in partnership with other grantees in the State that receive funding under this title;

(3) the public health agency administering the grant for the State shall convene a meeting at least annually of individuals with HIV who utilize services under this part (including those individuals from traditionally underserved populations and subpopulations) and representatives of grantees funded under this title (including HIV health services planning councils, early intervention programs, children, youth and family service projects, special projects of national significance, and HIV care consortia) and other providers (including federally qualified health centers) and public agency representatives with the State currently delivering HIV services to affected communities for the purpose of developing a Statewide coordinated statement of need; and The State shall not be required to finance attendance at the meetings described in paragraph (3). A State may pay the travel-related expenses of individuals attending such meetings where appropriate and necessary to ensure adequate participation.

[(3)] (4) an assurance by the State that—

* * * * *

SEC 2618. DISTRIBUTION OF FUNDS.

(a) SPECIAL PROJECTS OF A NATIONAL SIGNIFICANCE.—

(1) IN GENERAL.—Of the amount appropriate under section **[2620]** 2677 for each fiscal year, the Secretary shall use not to exceed 10 percent of such amount to establish and administer a special projects of national significance program to award direct grants to public and nonprofit private entities including community-based organizations to fund special programs for the care and treatment of individuals with HIV disease.

(b) AMOUNT OF GRANT TO STATE.—

(1) MINIMUM ALLOTMENT.—Subject to the extent of amounts made available under section 2620, the amount of a grant to be made under this part for—

[(A)] each of the several States and the District of Columbia for a fiscal year shall be the greater of—

[(i)] \$100,00, and

[(ii)] an amount determined under paragraph (2);
and

[(B)] each territory of the United States, as defined in paragraph 31, shall be an amount determined under paragraph (2).

[(2)] Determination.—

[(A) FORMULA.—The amount referred to in paragraph (1)(A)(ii) for a State and paragraph (1)(B) for a territory of the United States shall be the product of—

[(i) an amount equal to the amount appropriate under section 2620 for the fiscal year involved; and

[(ii) the ratio of the distribution factor for the State or territory to the sum of the distribution factors for all the States or territories.

[(B) DISTRIBUTION FACTOR.—As used in subparagraph (A)(ii), the term “distribution factor” means—

[(i) in the case of a State, the product of—

[(I) the number of cases of acquired immune deficiency syndrome in the State, as indicated by the number of cases reported to and confirmed by the Secretary for the 2 most recent fiscal years for which such data are available; and

[(II) the cube root of the ratio (based on the most recent available data) of—

[(aa) the average per capita income of individuals in the United States (including the territories); to

[(bb) the average per capita income of individuals in the State; and

[(ii) in the case of a territory of the United States the number of additional cases of such syndrome in the specific territory, as indicated by the number of cases reported to and confirmed by the Secretary for the 2 most recent fiscal years for which such data is available.

[(3) DEFINITIONS.—As used in this subsection—

[(A) the term “State” means each of the 50 States, the District of Columbia and the Commonwealth of Puerto Rico; and

[(B) the term “territory of the United States” means the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the Republic of the Marshall Islands.]

(1) *MINIMUM ALLOTMENT.*—Subject to the extent of amounts made available under section 2677, the amount of a grant to be made under this part for—

(A) each of the several States and the District of Columbia for a fiscal year shall be the greater of—

(i)(I) with respect to a State or District that has less than 90 living cases of acquired immune deficiency syndrome, as determined under paragraph (2)(D), \$100,000; or

(i)(II) with respect to a State or District that has 90 or more living cases of acquired immune deficiency syndrome, as determined under paragraph (2)(D), \$250,000;

(ii) an amount determined under paragraph (2); and

(B) each territory of the United States, as defined in paragraph (3), shall be an amount determined under paragraph (2).

(2) *DETERMINATION.*—

(A) *FORMULA.*—The amount referred to in paragraph (1)(A)(ii) for a State and paragraph (1)(B) for a territory of the United States shall be the product of—

(i) an amount equal to the amount appropriated under section 2677 for the fiscal year involved for grants under part B; and

(ii) the percentage constitute by the sum of—

(I) the product of .50 and the ratio of the State distribution factor for the State or territory (as determined under subsection (B)) to the sum of the respective State distribution factors for all States or territories; and

(II) the product of .50 and the ratio of the non-EMA distribution factor for the State or territory (as determined under subparagraph (C)) to the sum of the respective distribution factors for all States or territories.

(B) *STATE DISTRIBUTION FACTOR.*—For purposes of subparagraph (A)(ii)(I), the term “State distribution factor” means the product of—

(i) an amount equal to the estimated number of living cases of acquired immune deficiency syndrome in the State or territory involved, as determined under subparagraph (D); and

(ii) the cost index for the State or territory involved, as determined under subparagraph (E).

(C) *NON-EMA DISTRIBUTION FACTOR.*—For purposes of subparagraph (A)(ii)(II), the term “non-ema distribution factor” means the products of—

(i) an amount equal to the sum of—

(I) the estimated number of living cases of acquired immune deficiency syndrome in the State or territory involved, as determined under subparagraph (D); less

(II) the estimated number of living cases of acquired immune deficiency syndrome in such State or territory that are within an eligible area (as determined under part A); and

(ii) the cost index for the State or territory involved, as determined under subparagraph (E).

(D) *ESTIMATE OF LIVING CASES.*—The amount determined in this subparagraph is an amount equal to the product of—

(i) the number of cases of acquired immune deficiency syndrome in the State or territory during each year in the most recent 120-month period for which data are available with respect to all States and territories, as indicated by the number of such cases reported to and confirmed by the Director of the Centers for Disease Control and Prevention for each year during such period; and

(ii) with respect to each of the first through the tenth year during such period, the amount referred to in 2603(a)(3)(C)(ii).

(E) *COST INDEX.*—

(i) *The amount determined in this subparagraph is an amount equal to the sum of—*

(I) *the amount determined under clause (ii) for a fiscal year;*

(II) *the product of—*

(aa) *the average hospital wage index reported by hospitals in the State or territory involved under section 1886(d)(3)(E) of the Social Security Act for the 3-year period immediately preceding the year for which the grant is being awarded; and*

(bb) *.70; and*

(III) *.30.*

(ii) *The amount determined in this clause for a fiscal year is an amount equal to the percentage constituted by the ratio of—*

(I) *the total amount—*

(aa) *of salaries reported by each hospital within the State or territory under the medicare prospective payment system under title XVIII of the Social Security Act for the fiscal year involved; divided by*

(bb) *the total number of hours worked by those included in the reported salaries under subclause (II) for the fiscal year involved, as determined under regulations promulgated by the Secretary; and*

(ii) *the sum of the amount determined under subclause (I) with respect to all States and territories.*

(F) *PUERTO RICO, VIRGIN ISLANDS, GUAM.—For purposes of subparagraph (D), the cost index for Puerto Rico, the Virgin Islands, and Guam shall be 1.0.*

(G) *UNEXPENDED FUNDS.—The Secretary may, in determining the amount of a grant for a fiscal year under this subsection, adjust the grant amount to reflect the amount of unexpended and uncanceled grant funds remaining at the end of the fiscal year preceding the year for which the grant determination is to be made. The amount of any such unexpended funds shall be determined using the financial status report of the grantee.*

(H) *LIMITATION.—*

(i) *IN GENERAL.—The Secretary shall ensure that the amount of a grant awarded to a State or territory for a fiscal year under this part is equal to not less than—*

(I) *with respect to fiscal year 1996, 98 percent;*

(II) *with respect to fiscal year 1997, 97 percent;*

(III) *with respect to fiscal year 1998, 95.5 percent;*

(IV) *with respect to fiscal year 1999, 94 percent;*

and

(V) *with respect to fiscal year 2000, 92.5 percent; of the amount such State or territory received for fiscal year 1995 under this part. In administering this subparagraph, the Secretary shall, with respect to States*

that will receive grants in amounts that exceed the amounts that such States received under this part in fiscal year 1995, proportionally reduce such amounts to ensure compliance with this subparagraph. In making such reductions, the Secretary shall ensure that no such State receives less than that State received for fiscal year 1995.

(ii) *RATABLE REDUCTION.*—If the amount appropriated under section 2677 and available for allocation under this part is less than the amount appropriated and available under this part for fiscal year 1995, the limitation contained in clause (i) shall be reduced by a percentage equal to the percentage of the reduction in such amounts appropriated and available.”.

(c) *ALLOCATION OF ASSISTANCE BY STATES.*—

* * * * *

[(3) *PLANNING AND EVALUATIONS.*—A State may not use in excess of 5 percent of amounts received under a grant awarded under this part for planning and evaluation activities.

[(4) *ADMINISTRATION.*—A State may not use in excess of 5 percent of amounts received under a grant awarded under this part for administration, accounting, reporting, and program oversight functions.]

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

(4) *ADMINISTRATION.*—

(A) *IN GENERAL.*—Subject to paragraph (5) and except as provided in paragraph (6), a State may not use more than 10 percent of amounts received under a grant awarded under this part for administration. An entity (including subcontractors) receiving an allocation from the grant awarded to the State under this part shall not use in excess of 12.5 percent of amounts received under such allocation for administration.

(B) *ADMINISTRATIVE ACTIVITIES.*—For the purposes of subparagraph (A), amounts may be used for administrative activities that include routine grant administration and monitoring activities.

(C) *SUBCONTRACTOR ADMINISTRATIVE COSTS.*—For the purposes of this paragraph, subcontractor administrative activities include—

(i) usual and recognized overhead, including established indirect rates for agencies;

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

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

(5) *LIMITATION ON USE OF FUNDS.*—Except as provided in paragraph (6), a State may not use more than a total of 15 percent of amounts received under a grant awarded under this part for the purposes described in paragraphs (3) and (4).

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

[(5)] (7) *CONSTRUCTION.*—A State may not use amounts received under a grant awarded under this part to purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or to make cash payments to intended recipients of services.

* * * * *

SEC. 2619. TECHNICAL ASSISTANCE

The Secretary [may] *shall* provide technical assistance in administering and coordinating the activities authorized under section 2612, including technical assistance for the development and implementation of Statewide coordinated statements of need.

[SEC. 2620. AUTHORIZATION OF APPROPRIATIONS]

[There are authorized to be appropriated to make grants under this part, [\$275,000,000 in each of the fiscal years 1991 and 1992, and such sums as may be necessary in each of the fiscal years 1993 through 1995] *such sums as may be necessary in each of the fiscal years 1996, 1997, 1998, 1999, and 2000.*]

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PART B—CARE GRANT PROGRAM

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SEC. 2621. GRIEVANCE PROCEDURES.

Not later than 90 days after the date of enactment of this section, the Administration, in consultation with affected parties, shall establish grievance procedures, specific to each part of this title, to address allegations of egregious violations of each such part. Such procedures shall include an appropriate enforcement mechanism.

SEC. 2622. COORDINATION.

The Secretary shall ensure that the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the Substance Abuse and Mental Health Services Administration coordinate the planning and implementation of Federal HIV programs in order to facilitate the local development of a complete continuum of HIV-related services for individuals with HIV disease and those at risk of such disease. The Secretary shall periodically prepare and submit to the relevant committees of Congress a report concerning such coordination efforts at the Federal, State, and local levels as well as the existence of Federal barriers to HIV program integration.

* * * * *

SEC. 2651. ESTABLISHMENT OF PROGRAM.

* * * * *

(b) PURPOSES OF GRANTS.—

(1) IN GENERAL.—The Secretary may not make a grant under subsection (a) unless the applicant for the [grant agrees to expend the grant for the purposes of providing, on an out-patient basis, each of the early intervention services specified in paragraph (2) with respect to HIV disease.] *grant agrees to—*

(A) expend the grant for the purposes of providing, on an out-patient basis, each of the early intervention services specified in paragraph (2) with respect to HIV disease; and

(B) expend not less than 50 percent of the amount received under the grant to provide a continuum of primary care services, including, as appropriate, dental care services, to individuals confirmed to be living with HIV.

* * * * *

(4) REQUIREMENT OF AVAILABILITY OF ALL EARLY INTERVENTION SERVICES THROUGH EACH GRANTEE.—[The Secretary]

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

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

(i) paragraphs (1), (2), (5), and (6) of section 2652(a) shall use not less than 50 percent of the amount of such a grant to provide the services described in subparagraphs (A), (B), (D), and (E) of section 2651(b)(2) directly and on-site or at sites where other primary care services are rendered; and

(ii) paragraphs (3) and (4) of section 2652(a) shall ensure the availability of early intervention services through a system of linkages to community-based primary care providers, and to establish mechanisms for the referrals described in section 2651(b)(2)(C), and for follow-up concerning such referrals.

* * * * *

SEC. 2652. MINIMUM QUALIFICATIONS OF GRANTEES.

* * * * *

(b) STATUS AS MEDICAID PROVIDER—

(1) IN GENERAL.— * * *

* * * * *

(B) the applicant for the grant will enter into an agreement with a public or nonprofit private entity, or a private for-profit entity if such entity is the only available provider of quality HIV care in the area, under which the entity will provide the service, and the entity has entered into such

a participation agreement and is qualified to receive such payments.

* * * * *

SEC. 2654. MISCELLANEOUS PROVISIONS.

* * * * *

(c) *PLANNING AND DEVELOPMENT GRANTS.*—

(1) *IN GENERAL.*—The Secretary may provide planning grants, in an amount not to exceed \$50,000 for each such grant, to public and nonprofit private entities that are not direct providers of primary care services for the purpose of enabling such providers to provide HIV primary care services.

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

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

(4) *LIMITATION.*—Not to exceed 1 percent of the amount appropriated for a fiscal year under section 2655 may be used to carry out this section.

SEC. 2655. AUTHORIZATION OF APPROPRIATIONS.

For the purpose of making grants under section 2651, there are authorized to be appropriated [\$75,000,000 for fiscal years 1991, and such sums as may be necessary for each of the fiscal years 1992 through 1995.] such sums as may be necessary in each of the fiscal years 1996, 1997, 1998, 1999, and 2000.

* * * * *

SEC. 2664. ADDITIONAL REQUIRED AGREEMENTS.

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(g) *ADMINISTRATION OF GRANT.*— * * *

* * * * *

(2) the applicant will establish such procedures for fiscal control and fund accounting as may be necessary to ensure proper disbursement and accounting with respect to the grant; [and]

(3) the applicant will not expend more than [5 percent] 10 percent including planning, evaluation and technical assistance of the grant for administrative expenses with respect to the grant[.]; and

(4) the applicant will submit evidence that the proposed program is consistent with the Statewide coordinated statement of need and agree to participate in the ongoing revision of such statement of need.

* * * * *

[PART D—GENERAL PROVISIONS]

[SEC. 2671. DEMONSTRATION GRANTS FOR RESEARCH AND SERVICES FOR PEDIATRIC PATIENTS REGARDING ACQUIRED IMMUNE DEFICIENCY SYNDROME.]

[(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and the Director of the National Institutes of Health, shall make demonstration grants to community health centers, and other appropriate public or nonprofit private entities that provide primary health care to the public, for the purpose of—

[(1) conducting, at the health facilities of such entities, clinical research on therapies for pediatric patients with HIV disease as well as pregnant women with HIV disease; and

[(2) with respect to the pediatric patients who participate in such research, providing health care on an outpatient basis to such patients and the families of such patients.]

[(b) MINIMUM QUALIFICATIONS OF GRANTEES.—The Secretary may not make a grant under subsection (a) unless the health facility operated by the applicant for the grant serves a significant number of pediatric patients and pregnant women with HIV disease.

[(c) COOPERATION WITH BIOMEDICAL INSTITUTIONS.—

[(1) DESIGN OF RESEARCH PROTOCOL.—The Secretary may not make a grant under subsection (a) unless the applicant for the grant—

[(A) has entered into a cooperative agreement or contract with an appropriately qualified entity with expertise in biomedical research under which the entity will assist the applicant in designing and conducting a protocol for the research to be conducted pursuant to the grant; and

[(B) agrees to provide the clinical data developed in the research to the Director of the National Institutes of Health.

[(2) ANALYSIS AND EVALUATION.—The Secretary, acting through the Director of the National Institutes of Health—

[(A) may assist grantees under subsection (a) in designing and conducting protocols described in subparagraph (A) of paragraph (1); and

[(B) shall analyze and evaluate the data submitted to the Director pursuant to subparagraph (B) of such paragraph.

[(d) CASE MANAGEMENT.—The Secretary may not make a grant under subsection (a) unless the applicant for the grant agrees to provide for the case management of the pediatric patient involved and the family of the patient.

[(e) REFERRALS FOR ADDITIONAL SERVICES.—The Secretary may not make a grant under subsection (a) unless the applicant for the grant agrees to provide for the pediatric patient involved and the family of the patient—

[(1) referrals for inpatient hospital services, treatment for substance abuse, and mental health services; and

[(2) referrals for other social and support services, as appropriate.]

[(f) INCIDENTAL SERVICES.—The Secretary may not make a grant under subsection (a) unless the applicant for the grant agrees to provide the family of the pediatric patient involved with such transportation, child care, and other incidental services as may be necessary to enable the pediatric patient and the family of the patient to participate in the program established by the applicant pursuant to such subsection.]

[(g) APPLICATION.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.]

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

[(i) DEFINITION.—For purposes of this section, the term “community health center” has the meaning given such term in section 330(a).]

[(j) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated \$20,000,000 for fiscal year 1991, and such sums as may be necessary for each of the fiscal years 1992 through 1995.]

PART D—GRANTS FOR COORDINATED SERVICES AND ACCESS TO
RESEARCH FOR CHILDREN, YOUTH, AND FAMILIES

SEC. 2671. GRANTS FOR COORDINATED SERVICES AND ACCESS TO RESEARCH FOR CHILDREN, YOUTH, AND FAMILIES.

(a) *IN GENERAL.*—The Secretary, acting through the Administrator of the Health Resources and Services Administration, and in consultation with the Director of the National Institutes of Health, shall award grants to appropriate public or nonprofit private entities that, directly or through contractual arrangements, provide primary care to the public for the purpose of—

(1) *providing outpatient health care and support services (which may include family-centered and youth-centered care, as defined in this title, family and youth support services, and services for orphans) to children, youth, women with HIV disease, and the families of such individuals, and supporting the provision of such care with programs of HIV prevention and HIV research; and*

(2) *facilitating the voluntary participation of children, youth, and women with HIV disease in qualified research protocols at the facilities of such entities or by direct referral.*

(b) *ELIGIBLE ENTITIES.*—The Secretary may not make a grant to an entity under subsection (a) unless the entity involved provides assurances that—

(1) *the grant will be used primarily to serve children, youth, and women with HIV disease;*

(2) *the entity will enter into arrangements with one or more qualified research entities to collaborate in the conduct or facilitation of voluntary patient participation in qualified research protocols;*

(3) the entity will coordinate activities under the grant with other providers of health care services under this title, and under title V of the Social Security Act;

(4) the entity will participate in the Statewide coordinated statement of need under section 2619 and in the revision of such statement; and

(5) the entity will offer appropriate research opportunities to each patient, with informed consent.

(c) APPLICATION.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

(d) PATIENT PARTICIPATION IN RESEARCH PROTOCOLS.—

(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and the Director of the Office of AIDS Research, shall establish procedures to ensure that accepted standards of protection of human subjects (including the provision of written informed consent) are implemented in projects supported under this section. Receipt of services by a patient shall not be conditioned upon the consent of the patient to participate in research.

(2) RESEARCH PROTOCOLS.—

(A) IN GENERAL.—The Secretary shall establish mechanisms to ensure that research protocols proposed to be carried out to meet the requirements of this section, are of potential clinical benefit to the study participants, and meet accepted standards of research design.

(B) REVIEW PANEL.—Mechanisms established under subparagraph (A) shall include an independent research review panel that shall review all protocols proposed to be carried out to meet the requirements of this section to ensure that such protocols meet the requirements of this section. Such panel shall make recommendations to the Secretary as to the protocols that should be approved. The panel shall include representatives of public and private researchers, providers of services, and recipients of services.

[(e) TRAINING AND TECHNICAL ASSISTANCE.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may use not to exceed five percent of the amounts appropriated under subsection (h) in each fiscal year to conduct training and technical assistance (including peer-based models of technical assistance) to assist applicants and grantees under this section in complying with the requirements of this section.

(f) EVALUATIONS AND DATA COLLECTION.—

(1) EVALUATIONS.—The Secretary shall provide for the review of programs carried out under this section at the end of each grant year. Such evaluations may include recommendations as to the improvement of access to and participation in services and access to and participation in qualified research protocols supported under this section.

(2) REPORTING REQUIREMENTS.—The Secretary may establish data reporting requirements and schedules as necessary to ad-

minister the program established under this section and conduct evaluations, measure outcomes, and document the clients served, services provided, and participation in qualified research protocols.

(3) **WAIVERS.**—Notwithstanding the requirements of subsection (b), the Secretary may award new grants under this section to an entity if the entity provide assurances, satisfactory to the Secretary, that the entity will implement the assurances required under paragraph (2), (3), (4), or (5) of subsection (b) by the end of the second grant year. If the Secretary determines through the evaluation process that a recipient of funds under this section is in material noncompliance with the assurances provided under paragraph (2), (3), (4), or (5) of subsection (b), the Secretary may provide for continued funding of up to one year if the recipient provides assurances, satisfactory to the Secretary, that such noncompliance will be remedied within such period.

(g) **DEFINITIONS.**—For purposes of this section:

(1) **QUALIFIED RESEARCH ENTITY.**—The term “qualified research entity” means a public or private entity with expertise in the conduct of research that has demonstrated clinical benefit to patients.

(2) **QUALIFIED RESEARCH PROTOCOL.**—The term “qualified research protocol” means a research study design of a public or private clinical program that meets the requirements of subsection (d).

(h) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of the fiscal years 1996 through 2000.

* * * * *

SEC. 2677. AUTHORIZATION OF APPROPRIATIONS.

(a) **IN GENERAL.**—Subject to subsection (b), there are authorized to be appropriated to make grants under parts A and B, such sums as may be necessary for each of the fiscal years 1996 through 2000. Of the amount appropriated under this section for a fiscal year, the Secretary shall make available 64 percent of such amount to carry out part A and 36 percent of such amount to carry out part B.

(b) **DEVELOPMENT OF METHODOLOGY.**—

(1) **IN GENERAL.**—With respect to each of the fiscal years 1997 through 2000, the Secretary shall develop and implement a methodology for adjusting the percentages referred to in subsection (a) to account for grants to new eligible areas under part a and other relevant factors. Not later than 1 year after the date of enactment of this section, the Secretary shall prepare and submit to the appropriate committees of Congress a report regarding the findings with respect to the methodology developed under this paragraph.

(2) **FAILURE TO IMPLEMENT.**—If the Secretary fails to implement a methodology under paragraph (1) by October 1, 1996, there are authorized to be appropriated—

(A) such sums as may be necessary to carry out part A for each of the fiscal years 1997 through 2000; and

(B) such sums as may be necessary to carry out part B for each of the fiscal years 1997 through 2000.

* * * * *

PART F—DEMONSTRATION AND TRAINING

Subpart I—Special Projects of National Significance

SEC. 2691. SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE.

(a) *IN GENERAL.*—Of the amount appropriated under each of parts A, B, C, and D of this title for each fiscal year, the Secretary shall use the greater of \$20,000,000 or 3 percent of such amount appropriated under each such part, but not to exceed \$25,000,000, to administer a special projects of national significance program to award direct grants to public and nonprofit private entities including community-based organizations to fund special programs for the care and treatment of individuals with HIV disease.

(b) *GRANTS.*—The Secretary shall award grants under subsection (a) based on—

- (1) the need to assess the effectiveness of a particular model for the care and treatment of individuals with HIV disease;
- (2) the innovative nature of the proposed activity; and
- (3) the potential replicability of the proposed activity in other similar localities or nationally.

(c) *SPECIAL PROJECTS.*—Special projects of national significance shall include the development and assessment of innovative service delivery models that are designed to—

- (1) address the needs of special populations;
- (2) assist in the development of essential community-based service delivery infrastructure; and
- (3) ensure the ongoing availability of services for Native American communities to enable such communities to care for Native Americans with HIV disease.

(d) *SPECIAL POPULATIONS.*—Special projects of national significance may include the delivery of HIV health care and support services to traditionally underserved populations including—

- (1) individuals with families with HIV disease living in rural communities;
- (2) adolescents with HIV disease;
- (3) Indian individuals and families with HIV disease;
- (4) homeless individuals and families with HIV disease;
- (5) hemophiliacs with HIV disease; and
- (6) incarcerated individuals with HIV disease.

(e) *SERVICE DEVELOPMENT GRANTS.*—Special projects of national significance may include the development of model approaches to delivering HIV care and support services including—

- (1) programs that support family-based care networks critical to the delivery of care in minority communities;
- (2) programs that build organizational capacity in disenfranchised communities;
- (3) programs designed to prepare AIDS service organizations and grantees under this title for operation within the changing health care environment; and

(4) programs designed to integrate the delivery of mental health and substance abuse treatment with HIV services.

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

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

Subpart II—AIDS Education and Training Centers

SEC. 2692. HIV/AIDS COMMUNITIES, SCHOOLS, AND CENTER.

(a) Schools; centers

(1) In general * * *

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(A) training health personnel, including practitioners in title XXVI programs and other community providers, in the diagnosis, treatment, and prevention of HIV infection and disease;

[(A)] (B) to train the faculty of schools of, and graduate department or programs of, medicine, nursing, osteopathic medicine, dentistry, public health, allied health, and mental health practice to teach health professions students to provide for the health care needs of individuals with HIV disease; and

[(B)] to train practitioners to provide for the health care needs of such individuals;]

[(C)] with respect to improving clinical skills in the diagnosis, treatment, and prevention of such disease, to educate and train the health professionals and clinical staff of schools of medicine, osteopathic medicine, and dentistry; and]

[(D)] (C) to develop and disseminate curricula and resource materials relating to the care and treatment of individuals with such disease and the prevention of the disease among individuals who are at risk of contracting the disease.

(b) *AUTHORIZATION OF APPROPRIATIONS.*—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of the fiscal years 1996 through 2000.

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