proudly say that we tried to do something, as we read increasing stories of forced sex trafficking worldwide. We can say we didn't look away by passing this bill.

Everybody is not going to like everything in these bills. But these two lead issues are so critical and important, and time is so short for us to get these through. Let's not wait until next session as increasingly more and more girls are being tricked into this practice of forced sex trafficking.

The United States can step up awareness and advocacy, and as we do, governments around the world will do the same. The U.S. has to speak first, however, and this is the bill to do the speaking. Let's do it now.

As we vote on this tomorrow morning, I ask my colleagues to vote yes on these very important pieces of legislation to help children, to help women. These are vital pieces of legislation of which we can all be proud.

Mr. President, I understand there may be some more items, so I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MAKING TECHNICAL CORRECTIONS TO TITLE X OF THE ENERGY POLICY ACT OF 1992

Mr. BROWNBACK. Mr. President, I ask unanimous consent the Senate now proceed to the consideration of H.R. 2641, which is at the desk.

The PRESIDING OFFICER. The clerk will report the bill by title.

The assistant legislative clerk read as follows:

A bill (H.R. 2641) to make technical corrections to title X of the Energy Policy Act of 1992.

Without objection, the Senate proceeded to consider the bill.

Mr. BROWNBACK. I ask unanimous consent the bill be read the third time and passed, the motion to reconsider be laid upon the table, and any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 2641) was read the third time and passed.

RYAN WHITE CARE ACT AMENDMENTS OF 2000

Mr. BROWNBACK. Mr. President, I ask unanimous consent the Chair lay before the Senate a message from the House of Representatives to accompany S. 2311.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

Resolved, That the bill from the Senate (S. 2311) entitled ''An Act to revise and extend the Ryan White CARE Act programs under title XXVI of the Public Health Service Act, to improve access to health care and the quality of care under such programs, and to provide for the development of increased capacity to provide health care and related support services to individuals and families with HIV disease, and for other purposes'', do pass with amendments.

Mr. BROWNBACK. I ask unanimous consent the Senate agree to the amendments of the House of Representatives.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. JEFFORDS. Mr. President, it gives me great pleasure that the Senate is moving to pass the Ryan White Comprehensive AIDS Resources and Emergency Act Amendments of 2000, a measure that will reauthorize a national program providing primary health care services to people living with HIV and AIDS. I especially want to commend Senators HATCH and KENNEDY for the leadership they have provided since the inauguration of the legislation establishing the Ryan White programs over a decade ago. I also want to commend Senator FRIST whose medical expertise played a critical role in key provisions of the bill and continues to be an invaluable resource to our efforts on the range of health issues that come before the Senate. I want to recognize Senator DODD for his unwavering support for this legislation and people living with HIV and AIDS. Finally, I want to acknowledge Senator ENZI's recognition of the growing burden that AIDS and HIV have placed on rural communities throughout the country and the need to address those gaps in services.

It is also important that we recognize the dedicated efforts of our colleagues in the House of Representatives. Chairman BLILEY supported this bill through its passage and provided critical guidance through the negotiations. Representatives BILIRAKIS, COBURN, and WAXMAN have demonstrated time and time again their commitment to people living with AIDS and each has worked diligently to find a compromise to ensure the continued services for people with HIV/AIDS. Representatives BROWN and DINGELL have also played important roles in shepherding this bill through the legislative process.

Since its inception in 1990, the Ryan White program has enjoyed broad bipartisan support. During the last reauthorization of the Ryan White CARE Act in 1996, the measure garnered a vote of 97 to 3 on its final passage. As evidence that strong bipartisan support continues, I am happy to report that this reauthorization bill was passed unanimously by this Chamber in June of this year. The bipartisan support for this important legislation underlines the critical need for the assistance this Act provides across the Nation.

With this reauthorization, we mark the ten years through which the Ryan White CARE Act has provided needed health care and support services to HIV positive people around the country. Titles I and II have provided much needed relief to cities and states hardest hit by this disease, while Titles III and IV have had a direct role in providing healthcare services to underserved communities. Ryan White program dollars provide the foundation of care so necessary in fighting this epidemic and have allowed States and communities around the country to successfully address the needs of people affected by HIV disease.

In recent months a number General Accounting Office studies have shown that the CARE Act is providing services and support to people with HIV who are most in need and most deserving of our help. The GAO found that CARE Act funds are reaching the infected groups that have typically been underserved, including the poor, the uninsured, women, and ethnic minorities. These groups form a majority of CARE Act clients and are being served by the CARE Act in higher proportions than their representation in the AIDS population. The GAO also found that CARE Act funds support a wide array of primary care and support services, including the provision of powerful therapeutic regimens for people with HIV/AIDS that have dramatically reduced AIDS diagnoses and deaths.

Previous efforts to improve this legislation have led to incredible reductions in the number of HIV infected babies being born each year and, equally important, to increased outreach, counseling, voluntary testing, and treatment services being provided to women with HIV infection. Between 1993 and 1998, perinatal-acquired AIDS cases declined 74 percent in the U.S. In this bill, I have continued to support efforts to reach women in need of care for their HIV disease and have included provisions to ensure that women, infants and children receive resources in accordance with the prevalence of the infection among them.

The AIDS Drug Assistance Program has been another critical success. This program has provided people with HIV and AIDS access to newly developed, highly effective therapeutics. Because of these drugs, people are maintaining their health and living longer. The AIDS death rate and the number of new AIDS cases have been dramatically reduced. From 1996 to 1998, deaths from AIDS dropped 54 percent while new AIDS cases have been reduced by 27 percent. In this reauthorization bill we have improved access for underserved and poor communities and increased support for services that help maximize the impact of these therapies.

Despite our great success, the Ryan White program remains as vital to the public health of this Nation as it was in 1990 and in 1996. While the rate of decline in new AIDS cases and deaths is leveling off, HIV infection rates continue to rise in many areas; becoming increasingly prevalent in rural and underserved urban areas; and also among

women, youth, and minority communities. Local and state healthcare systems face an increasing burden of disease, despite our success in treating and caring for people living with HIV and AIDS. Rural and underserved urban areas are often unable to address the complex medical and support services needs of people with HIV infection. As the AIDS epidemic continues to expand into these areas across the country, this legislation will allow us to adapt our care systems to meet the most urgent needs in the communities hardest hit by the epidemic.

The bill being considered today was developed on a bipartisan basis, working with other Committee Members, community stakeholders and elected officials at the state and local levels from whom we sought input to ensure that we addressed the most important problems facing communities of people with HIV infection. Finally we have worked closely with our colleagues in the House of Representatives to produce this agreement. This morning, our colleagues in the House of Representatives unanimously passed this legislation that we have before us. The agreements we have reached with our House colleagues have been fully explained in an Statement of Explanation and I would like unanimous consent that this document be printed as part of the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

This bill will double the minimum base funding available to states through the CARE Act to assist them in developing systems of care for people struggling with HIV and AIDS. The bill also includes a new supplemental state grant to target assistance to small and mid-sized metropolitan areas to help them address the increasing number of people with HIV/AIDS living outside of urban areas that receive assistance under Title I of the Act. Rural and underserved areas receive a preference for planning, early intervention, and capacity development grants under title III. In order to assist states in expanding access to appropriate HIV/AIDS therapeutics to low-income people with HIV/AIDS, a supplemental grant has been added to the AIDS Drug Assistance Program.

The bill remains primarily a system of grants to State and local jurisdictions, thereby ensuring that grantees can respond to local needs. States, EMAs, and the affected communities will still decide how to best prioritize and address the healthcare needs of their HIV-positive citizens. This bill reinforces the ability of States and EMAs to identify and meet local needs.

Finally, in recognition of the changing nature of the epidemic, I have asked the Institute of Medicine to complete a study of the financing and delivery of primary care and support services for low income, uninsured, and under-insured individuals with HIV disease, within 21 months after the enactment of this Act. Changes in HIV surveillance and case reporting, and the effects of these changes on program funding, will be included in this study. The recommendations from this study will help Congress and the Secretary of Health and Human Services to ensure the most effective and efficient use of Federal funds for HIV and AIDS care and support.

I am proud that this bill has progressed through the Congress and that we will see this bill become law this year. The people struggling to overcome the challenges of HIV and AIDS must continue to benefit from high quality medical care and access to life-saving drugs. We have made incredible progress in the fight against HIV/AIDS and I want to ensure that every person in America in need of assistance benefits from our tremendous advances.

Many groups and individuals have contributed significantly to crafting this bill, but I want to acknowledge those at the Health Resources and Services Administration. All of the groups united under the umbrella of the National Organizations Responding to AIDS (NORA) deserve recognition. Representing a diverse community of people with AIDS, CARE Act service providers, and administrative agencies, NORA clearly and effectively communicated to Congress the needs and priorities of their constituents.

I also want to thank several staff members who have worked long and hard to craft this bill and to address the concerns and needs of the affected communities. Stephanie Robinson and Idalia Sanchez, for Senator KENNEDY, were key to reaching agreement on this bill and have provided invaluable assistance and support throughout the development of this legislation. Dave Larson and Mary Sumpter Johnson, of Senator FRIST's office, for their support for the needs of rural and underserved communities throughout the nation. Similarly, Jeannie Ireland with Senator DODD's office, Helen Rhee, working for Senator DEWINE, Libby Rolfe, for Mr. SESSIONS, and Raissa Geary and Mary Jordan in Senator ENZI's office, provided valuable input. Without the efforts of these staff members, we would not have such a strong, well-balanced, and targeted reauthorization bill before us today. I want to also express my gratitude and thanks to Bill Baird, Legislative Counsel, who worked tirelessly to craft legislative language. Finally, I want to acknowledge the contributions of Sean Donohue and William Oscar Fleming of my staff who guidance of this effort from the beginning has resulted in a bill that enjoys broad bipartisan support and which most importantly meets the pressing needs of people with HIV and AIDS.

EXHIBIT 1

RYAN WHITE CARE ACT AMENDMENTS OF 2000—MANAGERS' STATEMENT OF EXPLANATION

The Ryan White CARE Act Amendments of 2000 reauthorize Title XXVI of the Public Health Service Act to ensure that individuals living with HIV and AIDS receive health care and related support services. The legislation contains authorization for appropriations and programmatic changes to ensure the CARE Act programs respond to evolving demographic trends in the HIV/AIDS epidemic and advances in treatment and care.

In March, 1990, Congress enacted the Ryan White CARE Act, honoring Ryan White, a young man who taught the Nation to respond to the HIV/AIDS epidemic with hope and action rather than fear. By the spring of 1990, over 128,000 people had been diagnosed with AIDS in the United States and 78,000 had died of the disease. The CARE Act was reauthorized in 1996, as the epidemic spread to more than 600,000 Americans diagnosed with AIDS and amidst the nationwide recognition that CARE Act programs were indispensable to the care and treatment of Americans with HIV/AIDS.

The CARE Act Amendments of 2000 marks the second reauthorization of the CARE Act. In the last twenty years, the HIV/AIDS epidemic has claimed over 420,000 American men, women, and children. Today, the Centers for Disease Control and Prevention estimates that there are currently between 800,000 and 900,000 persons living with HIV in the United States, with 40,000 new infections annually.

While there is still no cure, the CARE Act has been instrumental in responding to the public health, social and economic burdens of the HIV/AIDS epidemic. However, the steady expansion and changed demographics of the epidemic, as well as the improved survival time for people living with AIDS, are placing increasing stress on State and local health care systems, community based organizations and families providing care. Most importantly, the epidemic is expanding beyond major cities to smaller cities and rural regions, and disproportionately affecting women, communities of color, children and youth.

The Ryan White CARE Act Amendments of 2000 preserves the best and proven features of existing CARE Act programs. But the CARE Act Amendments of 2000 also makes important and substantial reforms to respond to the significant changes in the HIV/AIDS epidemic of the last 5 years.

The Organization of Services Under the CARE Act Amendments of 2000 is as follows:

Title I. Emergency Relief for Areas with Substantial Need for Services: Provides emergency relief grants to 51 eligible metropolitan areas (EMAs) disproportionately affected by the HIV epidemic to provide primary care and HIV-related support services to people with HIV and AIDS. Half of the Title I funding is distributed by formula; the remaining half is distributed competitively, based on the demonstration of severity of need and other criteria.

Planning Council membership has been revised to include HIV prevention providers, homeless and housing service providers, and representatives of prisoners. A third of Planning Council members must be individuals with HIV/AIDS receiving care who are not officers, employees or consultants to Title I grantees.

Title II. CARE Grant Program: Provides formula grants to States, District of Columbia, Puerto Rico and U.S. Territories to improve the quality of health care and support services for individuals with HIV disease and their families. The funds are used: to provide medical support services, to continue health insurance payments, to provide home care services, and, through the AIDS Drug Assistance Programs (ADAP), to provide medications necessary for the care of these individuals. Supplemental formula grants are awarded to States with ''emerging communities'' which are ineligible for grants under Title I.

Subtitle B provides discretionary grants to States for the reduction of perinatal transmission of HIV, and for HIV counseling, testing, and outreach to pregnant women. Subtitle C provides discretionary grants to States for partner notification, counseling and referral services.

Title III. Early Intervention Services: Funds nonprofit entitles providing primary care and outpatient early intervention services, including case management, counseling, testing, referrals, and clinical and diagnostic services to individuals diagnosed with HIV. The unfunded program of State formula grants in current law is repealed.

Title IV. Other Programs and Activities: Provides grants for comprehensive services to children, youth, and women living with HIV and their families. Such services include primary, specialty and psychosocial care, as well as HIV outreach and prevention activities. Grantees must demonstrate linkages to, and provide clients with access and education on, HIV/AIDS clinical research.

Title IV newly authorizes the AIDS Education and Training Centers (AETC), a network of 14 regional centers conducting clinical HIV education and training of health providers, to provide prenatal and gynecological care. The HIV/AIDS Dental Reimbursement program, covering uncompensated oral health care for patients with HIV/AIDS, is expanded to provide community-based care in underserved areas.

Under Subtitle B, general provisions authorize CDC data collection of CARE Act planning and evaluation, enhanced interagency coordination of HIV services and prevention, development of a plan for the case management of prisoners with HIV, and administrative provisions related to audits, and a plan for simplification of CARE Act grant disbursements.

Title V. General Provisions: Authorizes Institute of Medicine (IOM) studies and expansion of Federal support for the development of rapid HIV tests. Makes necessary and technical corrections in Title XXVI of the Public Health Service Act.

A summary of selected provisions is as follows:

Use of HIV Case Data in Formula Grants: In order to target funding more accurately to reflect the HIV/AIDS epidemic, the Managers have revised and updated the Title I and Title II formulas to make use of data on cases of HIV infection as well as of AIDS. In Fiscal Year (FY) 2005, HIV and AIDS case data is intended to be used in the Title I and Title II formulas.

However, no later than July 1, 2004, the Secretary shall determine whether HIV case data, as reported to and confirmed by the Director of CDC, is sufficiently accurate and reliable from all eligible areas and States for such use in the formula. The Secretary shall also consider the findings of the Institute of Medicine (IOM) study undertaken under section 501(b).

If the Secretary makes an adverse determination regarding HIV case data, the Managers intend that only AIDS case data will be used in FY2005 formula allocations. The Secretary shall also provide grants and technical assistance to States and eligible areas to ensure that accurate and reliable HIV case data is available no later than FY2007.

Planning and priority setting: The Managers have strengthened the capacity of EMAs and States to plan, prioritize, and allocate funds, based on the size and demographic characteristics of the populations with HIV disease in the eligible area. Planning, priority setting, and funding allocation processes must take into account the demographics of the local HIV/AIDS epidemic, existing disparities in access HIV-related health care, and resulting adverse health outcomes. It is the intent of the Managers that CARE Act dollars more closely follow the shifting trends in the local epidemic and address disparities in health care access and health outcomes as well as the need for capacity development within the local and State HIV health care infrastructures.

The Managers intend both EMAs and States to develop strategies to bring into and retain in care those individuals who are aware of their HIV status but are not receiving services. As part of this process, the Managers place the highest priority on EMAs and States focusing on eliminating disparities in access and services among affected subpopulations and historically underserved communities. The Managers recognize, however, that the relative availability or lack of HIV prevalence data will be reflected in the scope, goals, timetable and allocation of funds for implementation of the strategy.

The Managers also expect the Secretary to collaborate with Titles I and II grant recipients and providers to develop epidemiologic measures and tools for use in identifying persons with HIV infection who know their HIV status but are not in care. The Managers recognize the difficulty the EMAs and States may experience in identifying persons with HIV infection who are not in care and who may be unknown to any health or social support system. The efforts on the part of EMAs and States to accomplish these important tasks, however, should not be delayed until this process is complete. Instead, the Managers expect Titles I and II grant recipients to establish and implement strategies responsive to these urgent needs before the development of nationally uniform measures, to the extent that is practicable and to which necessary prevalence data is reasonably available.

The Managers have also authorized outreach activities in Titles I and II intended to identify individuals with HIV disease know their HIV status but are not receiving services. The intent is to ensure that EMAs and States understand that outreach activities which are consistent with early intervention services and necessary to implement the aforementioned strategies, are appropriate uses of Titles I and II funds. It is not the Managers' intent that such activities supplant or otherwise duplicate activities such as case finding, surveillance and social marketing campaigns currently funded and administered by the Centers for Disease Control and Prevention (CDC). Instead, this authorization reflects the urgency of increasing the coordination between HIV prevention and HIV care and treatment services in all CARE Act programs.

Hold harmless provisions: The hold-harmless provisions are intended to minimize loss and stabilize systems of care in EMAs and States, while assuring that funds are allocated in Titles I and II to reflect the current distribution and epidemiology of the epidemic.

The Managers have revised the Title I hold harmless to limit a potential loss in an EMA's formula allocation to a small percentage of the amount allocated to the eligible area in the previous (or base) year. An EMA may lose no more than 15 percent of its base formula allocation over five years, beginning with 2 percent in the first year and increasing in subsequent years. If the Secretary determines that data on HIV prevalence are accurate and reliable for use in determining Title I formula grants for Fiscal Year 2005, all EMAs may lose no more than 2 percent of their Fiscal Year 2004 formula allocation in that year.

Should an EMA experience a decline in its Title I formula allocation followed by an intervening year in which there is no decline, its losses in any subsequent, nonconsecutive year of decline would once again be limited to 2 percent (i.e., the intervening year ''resets the clock'').

The Managers intend to ensure that essential primary care and support services are not compromised by short-term fluctuations in AIDS case counts. Because no new EMA is expected by HRSA's Bureau of HIV/AIDS to require the hold harmless in the first three or four years of this reauthorization period, the Managers expect this policy will shield all eligible areas, save those currently requiring the hold harmless, from any meaningful loss in Title I formula funding.

Under the Title II holds harmless, a State or territory may lose no more than 1 percent from the previous fiscal year amounts, or 5 percent over the 5-year reauthorization period. This protection extends to base Title II funding (which excludes funds for AIDS Drug Assistance Programs (ADAP)), as well as to overall Title II funding.

Women, child, infants, and youth set-aside: The Managers are aware of the rising incidence of HIV among youth and women, particularly women of color, and recognize the challenges in assuring them access to primary care and support services for HIV and AIDS. The Managers intend to increase the availability of primary care and health-related supportive services under Title I and Title II for each of the four groups described in the set-aside. Youth are added as a new category within this set-aside. The Managers intend the term ''youth'' to include persons between the ages of 13 and 24, and ''children'' to include those under the age of 13, including infants.

The Managers clarify that the set-asides for women, infants, children, and youth with HIV disease be allocated proportionally, based on the percentage of the local HIV-infected population that each group represents. The Managers intend that the States and EMAs continue to make every effort to reach and serve women, infants, children, and youth living with HIV/AIDS by allocating sufficient resources under Titles I and II to serve each of these populations. The Managers also recognize that these priority populations often comprise a greater proportion of HIV cases rather than AIDS cases in a local area. This distinction should be taken into account where necessary prevalence data is reasonably available.

The Managers are aware that these populations may also have access to HIV care through other parts of Title XXVI, Medicaid, State Children's Health Insurance Program (SCHIP), and other Federal and State programs. Therefore, the requirement to proportionally allocate funds provided under Title II to each of these populations may be waived for States which reasonably demonstrate that these populations are receiving adequate care.

Capacity development: Titles I, II and III of this legislation provide a new focus on strengthening the capacity of minority communities and underserved areas where HIV/AIDS is having a disproportionate impact. Currently, many underserved urban and rural areas are not able to compete successfully for planning grants and early intervention service grants due to the lack of infrastructure and experience with the Ryan White CARE Act programs. This gap in services available is increasingly important, as the HIV and AIDS epidemic extends into rural communities. In addition to authorizing capacity development under Titles I and II, the Managers establish a preference for rural areas under Title III that will allow program administrators to target capacity development grants, planning grants, and the delivery of primary care services to rural communities with a growing need for HIV

services. However, urban areas are not excluded from consideration for future grants nor is funding reduced to current grants in urban areas.

Quality management: The Managers recognize the importance of having CARE Act grantees ensure that quality services are provided to people with HIV and that quality management activities are conducted on an ongoing basis. Quality management programs are intended to serve grantees in evaluating and improving the quality of primary care and health-related supportive services provided under this act. The quality management program should accomplish a threeford purpose: (1) assist direct service medical providers funded through the CARE Act in assuring that funded services adhere to established HIV clinical practices and Public Health Service (PHS) guidelines to the extent possible; (2) ensure that strategies for improvements to quality medical care include vital health-related supportive services in achieving appropriate access to and adherence with HIV medical care; and (3) ensure that available demographic, clinical, and health care utilization information is used to monitor the spectrum of HIV-related illnesses and trends in the local epidemic.

The Managers expect the Secretary to provide States with guidance and technical assistance for establishing quality management programs, including disseminating such models as have been developed by States and are already being utilized by Title II programs and in clinical practice environments. Furthermore, the Managers intend that the Secretary provide clarification and guidance regarding the distinction between use of CARE Act funds for such program expenditures that are covered as either planning and evaluation and funds for program support costs. It is not the Managers' intent to divert current program resources or to reassign current program support costs or clinical quality programs to new cost areas, if they are an integral part of a State's current quality management efforts.

Program support costs are described as any expenditure related to the provision of delivering or receiving health services supported by CARE Act funds. As applied to the clinical quality programs, these costs include, but are not limited to, activities such as chart review, peer-to-peer review activities, data collection to measure health indicators or outcomes, or other types of activities related to the development or implementation of a clinical quality improvement program. Planning and evaluation costs are related to the collection and analysis of system and process indicators for purposes of determining the impact and effectiveness of funded health-related support services in providing access to and support of individuals and communities within the health delivery system.

Early intervention services: The Managers authorize early intervention services as eligible services under Titles I and II under certain circumstances. The Managers intend to allow grantees to provide certain early intervention services, such as HIV counseling, testing, and referral services, to individuals at high risk for HIV infection, in accordance with State or EMA planning activities. The Managers recognize the range of organizations that may be eligible to provide early intervention services, including other grantees under titles I, II and III such as community based organizations (CBOs) that act as points of entry into the health care system for traditionally underserved and minority populations.

The Managers believe that referral relationships maintained by providers of early intervention services are essential to increasing the numbers of people with HIV/AIDS who are identified and to bringing them into care earlier in the progression of their disease.

Health-care related support services: The Managers wish to stress the importance of CARE Act funds in meeting the health care needs of persons and families with HIV disease. The Act requires support services provided through CARE Act funds to be health care related. States and EMAs should ensure that support services meet the objective of increasing access to health care and ongoing adherence with primary care needs. The Managers reaffirm the critical relationship between support service provision and positive health outcomes.

Title I planning council duties and membership: The Managers have amended numerous aspects of CARE Act programs to enhance the coordination between HIV prevention and HIV/AIDS care and treatment services. In this case, Planning Council membership of the providers of HIV prevention services will help assure this coordination. To improve representation of underserved communities, providers of services to homeless populations and representatives of formerly incarcerated individuals with HIV disease are included in planning council membership. It is the intent of the Managers that the needs of all communities affected by HIV/AIDS and all providers working within the service areas be represented. The Managers also intend the Planning Councils more adequately reflect the gender and racial demographics of the HIV/AIDS population within their respective EMAs.

The Managers also intend that patients and consumers of Title I services constitute a substantial proportion of Planning Council memberships. The prohibited of officers, employees and consultants is not intended to impede the participation of qualified, motivated volunteers with Title I grantees from serving on Planning Councils where they do not maintain significant financial relationships with such grantees. In contrast to such significant financial relationships, volunteers may be reimbursed reasonable incidental costs, including for training and transportation, which help to facilitate their important contribution to the Planning Councils.

To ensure that new Planning Council members are adequately prepared for full participation in meetings, the Managers direct the Secretary to ensure that proper training and guidance is provided to members of the Councils. The Managers also expect Planning Councils to provide assistance, such as transportation and childcare, to facilitate the participation of consumers, particularly those from affected subpopulations and historically underserved communities.

Consistent with the ''sunshine'' policies of the Federal Advisory Committee Act (FACA), all meetings of the Planning Councils shall be open to the public and be held after adequate notice to the public. Detailed minutes, records, reports, agenda, and other relevant documents should also be available to the public. The Managers intend for such documents to be available for inspection and copying at a single location, including posting on the Internet.

Title I supplemental: In order to target funding to areas in greatest need of assistance, severity of need is given a greater weight of 33 percent in the award of Title I supplemental grants. The Managers intend that Title I supplemental awards are not intended to be allocated on the basis of formula grant allocations. Instead, such supplemental awards are to be directed principally to those eligible areas with 'severe need,'' or the greatest or expanding public health challenges in confronting the epidemic. The Managers have included additional factors to be considered in the assessment of severe need, including the current prevalence of HIV/AIDS, and the degree of increasing and unmet needs for services. Additionally, the Managers believe that syphilis, hepatitis B and hepatitis C should be regarded as important co-morbidities to HIV/AIDS.

It is the Managers' strong view that HRSA's Bureau of HIV/AIDS should employ standard, quantitative measures to the maximum extent possible in lieu of narrative self-reporting when awarding supplemental awards. The Managers therefore renew the Bureau's obligation to develop in a timely manner a mechanism for determining severe need upon the basis of national, quantitative incidence data. In this regard, the Managers recognize that adequate and reliable data on HIV prevalence may not be uniformly available in all eligible areas on the date of enactment. It is noted, however, that ''HIV disease'' under the CARE Act encompasses both persons living with AIDS as well as persons diagnosed as HIV positive who have not developed AIDS.

Title II base minimum funding: The minimum Title II base award is increased in order to increase the funding available to States for the capacity development of health system programs and infrastructure. The Federated States of Micronesia and the Republic of Palau are included as entities eligible to receive Title II funds, in recognition of the need to establish a minimum level of funding to assist in building HIV infrastructure.

Title II public participation: The Managers urge States to strengthen public participation in the Ryan White Title II planning process. While the Managers do not intend that States be mandated to consult with all entities participating in the Title I planning process, reference to such entities is intended to provide guidance to the States that such entities are important constituencies which the States should endeavor to include in their planning processes. Moreover, States may demonstrate compliance with the new requirement of an enhanced process of public participation by providing evidence that existing mechanisms for consumer and community input provide for the participation of such entities. The intent is to allow States to utilize the optimal public advisory planning process, such as special planning bodies or standing advisory groups on HIV/AIDS, for their particular population and circumstances.

The Managers are also aware of the difficulties that some States with limited resources may encounter in convening public hearings over large geographic or rural areas and encourage the Secretary to work with these States to develop appropriate processes for public input, and to consider such limitations when enforcing these requirements.

Title II HIV care consortia: The Manager intend that the States continue to work with local consortia to ensure that they identify potential disparities in access to HIV care services at the local level, with a special emphasis on those experiencing disparities in access to care, historically underserved populations, and HIV infected persons not in care. However, the Managers do not intend that States and/or consortia be mandated to consult with all entities participating in the Title I planning process. Rather, reference to such entities is intended to provide guidance to the States that such entities are important constituencies which the States should endeavor to include in their planning processes.

Title II ''emerging communities'' supplement: There continues to be a growing need to address the geographic expansion of this epidemic, and this Act continues the efforts made during the last reauthorization to direct resources and services to areas that are

particularly underserved, including rural areas and metropolitan areas with significant AIDS cases that are not eligible for Title I funding. A supplemental formula grant program is created within Title II to meet HIV care and support needs in non-EMA areas. There are a large number of areas within States that do not meet the definition of a Title I EMA but that, nevertheless, experience significant numbers of people living with AIDS. This provision stipulates that these ''emerging communities,'' defined as cities with between 500 and 1,999 reported AIDS cases in the most recent 5-year period, be allocated 50 percent of new appropriations to address the growing need in these areas. Funding for this provision is triggered when the allocations to carry out Part B, excluding amounts allocated under section 2618(a)(2)(I), are $20,000,000 in excess of funds available for this part in fiscal year 2000, excluding amounts allocated under section 2618(a)(2)(I). States can apply for these supplemental awards by describing the severity of need and the manner in which funds are to be used.

The Managers intend to acknowledge the challenges faced by many areas with a significant burden of HIV and AIDS and a lack of health care infrastructure or resources to provide HIV care services. This supplemental program allows the Secretary to make grants to States to address HIV service needs in these underserved areas. The Managers understand the necessity to continue to support existing and expanding critical Title II base services.

AIDS Drug Assistance Program supplemental grant and expanded services: Under this Act, the AIDS Drug Assistance Program (ADAP) has been strengthened to assist States in a number of areas. The Secretary is authorized to reserve 3 percent of ADAP appropriations for discretionary supplemental ADAP grants which shall be awarded in accordance with severity of need criteria established by the Secretary. Such criteria shall account for existing eligibility standards, formulary composition and the number of patients with incomes at or below 200 percent of poverty. The Managers also encourage the Secretary to consider such factors as the State's ability to remove restrictions on eligibility based on current medical conditions or income restrictions and to provide HIV therapeutics consistent with PHS guidelines.

States are also required to match the Federal supplement at a rate of 1:4. The Managers expect the State to continue to maintain current levels of effort in its ADAP funding. The Managers intend that the 25 percent State match required to receive funds under this section be implemented in a flexible manner that recognizes the variations between Federal, State, and programmatic fiscal years.

In addition, up to 5 percent of ADAP funds will be allowed to support services that directly encourage, support, and enhance adherence with treatment regimens, including medical monitoring, as well as purchase health insurance plans where those plans provided fuller and more cost-effective coverage of AIDS therapies and other needed health care coverage. However, up to 10 percent of ADAP funds may be expended for such purposes if the State demonstrates that such services are essential and do not diminish access to therapeutics. Finally, the Managers recognize that existing Federal policy provides adequate guidelines to states for carrying out provisions under this section.

Partner notification, perinatal transmission, and counseling services: Discretionary grants are authorized under this Act for partner notification, counseling and referral services. The Managers have also expanded the existing grant program to States for the reduction of perinatal transmission of HIV, and for HIV counseling, testing, and outreach to pregnant woman. Funding for perinatal HIV transmission reduction activities is expanded, with additional grants available to States with newborn testing laws or States with significant reductions in perinatal HIV transmission. In addition, this Act further specifies information to be conveyed to individuals receiving HIV positive test results in order to reduce risk of HIV transmission through sex or needle-sharing practices.

Coordination of coverage and services: This Act also strengthens the requirements made on the States and EMAs in a number of areas aimed at improving the coordination of coverage and services. Grantees must access the availability of other funding sources, such as Medicaid and the State Children's Health Insurance Program (SCHIP) and improve efforts to ensure that CARE Act funds are coordinated with other available payers.

Titles II and IV administrative expenses: The administrative cap for the directly funded Title III programs is increased. The administrative cap for Title III grants is raised from 7.5 percent to 10 percent to correspond with the 10 percent cap on individual contractors in Title I. The Secretary is directed to review administrative and program support expenses for Title IV, in consultation with grantees. In order to assure that children, youth, women, and families have access to quality HIV-related health and support services and research opportunities, the Secretary is directed to work with Title IV grantees to review expenses related to administrative, program support, and direct service-related activities.

Title IV access to research: This Act removes the requirement that Title IV grantees enroll a ''significant number'' of patients in research projects. Title IV provides an important link between women, children, and families affected by HIV/AIDS and HIV-related clinical research programs. The ''significant number'' requirement is removed here to eliminate the incentive for providers to inappropriately encourage or pressure patients to enroll in research programs.

To maintain appropriate access to research opportunities, providers are required to develop better documentation of the linkages between care and research. The Secretary of Health and Human Services (HHS), through the National Institutes of Health (NIH), is also directed to examine the distribution and availability of HIV-related clinical programs for purposes of enhancing and expanding access to clinical trials, including trials funded by NIH, CDC and private sponsors. The Managers encourage the Secretary to assure that NIH-sponsored HIV-related trials are responsive to the need to coordinate the health services received by participants with the achievement of research objectives. Nor do the Managers intend this requirement to require the redistribution of funds for such research projects.

Part F Dental Reimbursement Program: The Managers have established new grants for community-based health care to support collaborative efforts between dental education programs and community-based providers directed at providing oral health care to patients with HIV disease in currently unserved areas and communities without dental education programs. Although the Dental Program has been tremendously successful, there is still a large HIV/AIDS population that has not benefitted because there is not a dental education institution participating in their area. These patients are also in need of dental services that could be provided at community sites if more community-based providers would partner with a dental school or residency program. In these partnerships, dental students or residents could provide treatment for HIV/AIDs patients in underserved communities under the direction of a community-based dentist who would serve as adjunct faculty. By encouraging dental educational institutions to partner with community-based providers, the Managers intend to address the unmet need in these areas by ensuring that dental treatment for the HIV/AIDS population is available in all areas of the country, not just where dental schools are located.

Technical assistance and guidance: The Managers reaffirm the Secretary's responsibility in providing needed guidance and tools to grantees in assisting them in carrying out new requirements under this Act. The Secretary is required to work with States and EMAs to establish epidemiologic measures and tools for use in identifying the number of individuals with HIV infection, especially those who are not in care. The legislation requests an IOM study to assist the Secretary in providing this advice to grantees.

The Managers understand that the Secretary has convened a Public Health Service Working Group on HIV Treatment Information Dissemination, which has produced recommendations and a strategy for the dissemination of HIV treatment information to health care providers and patients. Recognizing the importance of such a strategy, the Managers intend that the Secretary issue and begin implementation of the strategy to improve the quality of care received by people living with HIV/AIDS.

Data Collection through CDC: The Managers believe that an additional authorization for HIV surveillance activities under the CDC will serve to advance the purposes of the CARE Act. To better identify and bring individuals with HIV/AIDS into care, States and cities may use such funding to enhance their HIV/AIDS reporting systems and expand case finding, surveillance, social marketing campaigns, and other prevention service programs. Notwithstanding its strong interest in improving the coordination between HIV prevention and HIV care and treatment services, the Managers intend that this enhanced funding for CDC and its grantees ensure that CARE Act programs and funds not duplicate or be diverted to activities currently funded and administered by the CDC.

Coordination: This Act requires the Secretary to submit a plan to Congress concerning the coordination of Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), and Health Care Financing Administration (HCFA), to enhance the continuity of care and prevention services for individuals with HIV disease or those at risk of such disease. The Managers believe that much greater effort is required to ensure that the provision of HIV prevention and care services becomes as seamless as possible, and that coordination be pursued at the Federal level, in the States and local communities to eliminate any administrative barriers to the efficient provision of high quality services to individuals with HIV disease.

A second plan for submission to Congress focuses on the medical case management and provision of support services to persons with HIV released from Federal or State prisons.

Administrative simplification: The Managers intend for the Secretary of HHS to explore opportunities to reduce the administrative requirements of Ryan CARE Act grantees through simplifying and streamlining the administrative processes required of grantees and providers under Titles I and II. In consultation with grantees and service providers of both parts, the Secretary is directed to (1) develop a plan for coordinating the disbursement of appropriations for grants under

Title I with the disbursement of appropriations for grants under Title II, (2) explore the impact of biennial application for Titles I and II on the efficiency of administration and the administrative burden imposed on grantees and providers under Titles I and II, and (3) develop a plan for simplifying the application process for grants under Titles I and II. It is the intent of the Managers to improve the ability to grantees to comply with administrative requirements while decreasing the amount of staff time and resources spent on administrative requirements.

Program and service studies: The Managers request that the Secretary, through the IOM, examine changing trends in the HIV/AIDS epidemic and the financing and delivery of primary care and support services for low-income, uninsured individuals with HIV disease. The Secretary is directed to make recommendation regarding the most effective use of scarce Federal resources. The purpose of the study is to examine key factors associated with the effective and efficient financing and delivery of HIV services (including the quality of services, health outcomes, and cost-effectiveness). The Managers expect that the study would include examination of CARE Act financing of services in relation to existing public sector financing and private health coverage; general demographics and comorbidities of individuals with HIV disease; regional variations in the financing and costs of HIV service delivery; the availability and utility of health outcomes measures and data for measuring quality of Ryan White funded service; and available epidemiologic tools and data sets necessary for local and national resource planning and allocation decisions, including an assessment of implementation of HIV infection reporting, as it impacts these factors.

The Managers also require an IOM study focuses on determining the number of newborns with HIV, where the HIV status of the mother is unknown; perinatal HIV transmission reduction efforts in States; and barriers to routine HIV testing of pregnant women and newborns when the mothers' HIV status is unknown. The study is intended to provide States with recommendations on improving perintal prevention services and reducing the number of pediatric HIV/AIDS cases resulting from perinatal transmission.

Development of Rapid HIV Test: The Managers encourage the Secretary to expedite the availability of rapid HIV tests which are safe, effective, reliable and affordable. The Managers intend that the National Institutes of Health expand research which may lead to such tests. The Managers also intend that the Director of CDC should take primary responsibility, in conjunction with the Commissioner of Food and Drugs, for a report to Congress on the public health need and recommendations for the expedited review of rapid HIV tests. The Managers believe that the Food and Drug Administration should account for the particular applications and urgent need for rapid HIV tests, as articulated by public health experts and the CDC, when determining the specific requirements to which such tests will be held prior to marketing.

Department of Veterans Affairs: The Managers note that the U.S. Department of Veterans Affairs is the largest single direct provider of HIV care and services in the country. Over 18,000 veterans received HIV care at VA facilities in 1999. Veterans with HIV infection are eligible to participate in Ryan White Title I and Title II programs when they meet eligibility requirements set by EMAs and States, whose plans for the delivery of services must account for the availability of VA services. VA facilities are eligible providers of HIV health and support services where appropriate. The Managers expect that HRSA's Bureau of HIV/AIDS shall encourage Ryan White grantees to develop collaborations between providers and VA facilities to optimize coordination and access to care to all persons with HIV/AIDS.

International HIV/AIDS Initiatives: The Managers note that the CARE Act provides a model of service delivery and Federal partnership with States, cities and community-based organizations which should prove valuable in global efforts to combat the HIV/AIDS epidemic. The Managers strongly encourage the Secretary, the Bureau of HIV/AIDS at HRSA, and the CDC to provide technical assistance available to other countries which has already proven invaluable in helping to limit the suffering caused by HIV/AIDS. It is the Managers' hope that the hard-earned knowledge and experience gained in this country can benefit people with HIV/AIDS overseas.

Mr. KENNEDY. Mr. President, it is a privilege to support the CARE Act Amendments of 2000. I commend the many Senators who worked hard and well on the issue of HIV and AIDS. Senator JEFFORDS and Senator HATCH have championed this issue since 1990 when the CARE Act was first proposed, and Senator FRIST has been an impressive leader in recent years. Their leadership has and the leadership of many others has raised our collective conscience about the HIV/AIDS crisis. Our goal in this legislation is to ensure that citizens with HIV disease continue to receive the benefits of advances in therapies and a system of support that has achieved remarkable success in recent years.

For 20 years, America has struggled with the devastation caused by HIV/AIDS. It is a virus that knows no color, religion, political affiliation, or income status. AIDS continues to kill brothers and sisters, children and parents, friends and loved ones—all in the prime of their lives. This epidemic knows no geographic boundaries and has no mercy on those it strikes. HIV/AIDS has become one of the greatest public health challenges of our times. The CARE Act has directed needed resources to accelerate research, develop effective therapies, and support the 900,000 persons and families living with HIV/AIDS in America, and it clearly deserves to be extended and expanded.

AIDS has claimed over 420,000 lives so far in the United States and it continues to claim the most vulnerable among us, especially women, youth, and minorities. We have good reason to be encouraged by medical advances over the past ten years, but we still face an epidemic that kills over 47,000 people each year. Like other epidemics before it, AIDS is now hitting hardest in areas where knowledge about the disease is scarce and poverty is high. The epidemic has dealt a particularly severe blow on communities of color, which account for 73 percent of all new infections. Women account for 30 percent of new infections. Over half of new infections occur in persons under 25.

An estimated 34 percent of AIDS cases in the U.S. occur in rural areas, and this percentage is growing. As the crisis continues year after year, it becomes increasingly difficult for anyone to claim that AIDS is someone else's problem. We all share in a very real way in being touched by the epidemic.

Fortunately, we have been able to slow the progression of this devastating disease. Many people living with HIV and AIDS are alive today and leading longer and healthier lives. AIDS deaths declined by 20 percent between 1997 and 1998, thanks to advances in care and effective new treatments. The smallest increase in new AIDS cases—11 percent—took place in 1999, compared with an 18 percent increase in new cases just a year before. We are helping people earlier in their disease progression and keeping them healthier longer.

Nevertheless, an estimated 30 percent of persons living with AIDS do not have insurance coverage to pay for costly treatments. As a result, heavy demands are placed on community-based organizations and state and local governments. For these Americans, the CARE Act Amendments of 2000 will continue to provide the only means to obtain the care and treatment they need.

In Massachusetts, there has been a 77 percent decline in AIDS and HIV-related deaths since 1995. But the number of cases increased in women by 11 percent from 1997 to 1998. Fifty-five percent of persons living with AIDS in the state are persons of color. Massachusetts is fortunate to have a state budget that provides funding for primary care, prevention, and surveillance efforts. But no state is economically sufficient enough to provide the significant financial resources needed to enable all persons living with HIV disease to obtain the medical and supportive services they need without the Ryan White CARE Act.

The CARE Act will continue to bring hope to the over 600,000 individuals it serves each year in dealing with this devastating disease. This reauthorization builds on past accomplishments, while recognizing the challenge of ensuring access drug treatment for all who need it, reducing health disparities in vulnerable populations, and improve the distribution and quality of services.

Funds totaling $3.4 billion over the next five years will target the hardest hit 51 metropolitan areas in the country under Title I of the Act. Local planning and priority-setting under Title I assures that each of the eligible metropolitan areas responds to local HIV/AIDS needs. Safeguards are put in place to ensure that Title I areas are protected from drastic shifts in funding that can destabilize their HIV care infrastructure by limiting these losses to a maximum of 15 percent over its FY 2000 levels without compounded the effects of the loss from year to year. We also have assured EMAs the opportunity to reset the clock each time they find they do not need hold harmless protection in order to allow them

the needed time and resources to plan prioritize, and redirect resources in response to major shifts that may occur in funding and in the local epidemic.

Under Title II, $4.4 billion over the next five years will provide emergency relief to assist states in developing their HIV health care infrastructure. These funds will also provide life-sustaining drugs to over 61,000 persons each month. In addition, these funds will provide assistance for emerging communities that are increasingly affected by HIV/AIDS, but do not currently qualify for additional assistance, while assuring that base Title II funding losses do not occur in any fiscal year for any state or territory.

Title III programs will receive $730 million during the five year period to assist over 200 local health centers and other primary health care providers in communities with a significant and disproportionate need for HIV care. Many of these communities are located in the hardest hit areas, serving low income communities. An additional $30 million in funds under Title III will provide planning and capacity development grants for hard-to-reach urban and rural communities.

In Title IV, $2700 million over the next five years will be used to meet the specific needs of women, infants, youth, and families. An additional $42 million will assure that oral health care is available to persons with HIV/AIDS who are uninsured. One hundred and forty-one million dollars in funding over the five-year period will assure that we continue our investment in improving the skills of the healthcare workforce.

In total, the CARE Act will authorize over $8.5 billion in funding to fight HIVS/AIDS over the next five years.

I commend the dedication of the AIDS community and the Administration in working with Congress over the past year to bring forward the best possible legislation. I also commend Sean Donohue and William Fleming of Senator JEFFORDS' staff, Dave Larsen of Senator FRIST's staff, and Stephanie Robinson and Idalia Sanchez of my staff for their effective work on this landmark legislation.

The Senate's action today reaffirms our long-standing commitment to provide greater help to those with HIV/AIDS and to families touched by this devastating disease. America has the resources to win the battle against AIDS. We must face this disease with the same courage demonstrated by Ryan White, the young man with hemophilia who contracted AIDS through blood transfusions, and for whom the original act was named. Ryan White touched the world's heart through his valiant effort to speak out against the ignorance and discrimination faced by persons living with AIDS. This legislation carries on his brave work and I urge the Senate to approve it.

Mr. FRIST. Mr. President, I am pleased to acknowledge the final Senate passage of the Ryan White CARE Act Amendments of 2000 today, which follows the actions of House of Representatives earlier this morning. This important bill forms a unique partnership between federal, local, and state governments; non-profit community organizations, health care and supportive service providers. For the last decade, this Act has successfully provided much needed assistance in health care costs and support services for low-income, uninsured and underinsured individuals with HIV/AIDS.

Through programs such as the AIDS Drug Assistance Program, ADAP, which provides access to pharmaceuticals, the CARE Act has helped extend and even save lives. Last year alone, nearly 100,000 people living with HIV and AIDS received access to drug therapy because of the CARE Act. Half the people served by the CARE Act have family incomes of less than $10,000 annually, which is less than the $12,000 annual average cost of new drug ''cocktails'' for treatment. The CARE Act is critical in ensuring that the number of people living with AIDS continues to increase, as effective new drug therapies are keeping HIV-infected persons healthy longer and dramatically reducing the death rate. Investments in enabling patients with HIV to live healthier and more productive lives have helped to reduce overall health costs. For example, the National Center for Health Statistics reported that the nation has seen a 30 percent decline in HIV related hospitalizations, producing nearly one million fewer HIV related hospital days and a savings of more than $1 billion.

During the 104th Congress, I had the pleasure of working with Senator Kassebaum on the Ryan White CARE Act Amendments of 1996 to ensure that this needed law was extended. Senator JEFFORDS, who has done a terrific job in crafting this bill, has already outlined some specifics of this legislation, however, I would like to conclude by discussing a specific provision which I am grateful Senator JEFFORDS included in this reauthorization.

This bill contains a provision, under Title II of this Act, addressing the fact that the face of this disease is changing as AIDS moves into communities which have not been impacted as great as several Title I grantees. One important aspect of this provision is the creation of supplemental grants for emerging metropolitan communities, which do not qualify for Title I funding but have reported between 500 and 2,000 AIDS cases in the last five years. For cities that have between 1,000 and 2,000 AIDS cases this provision would provide cities, including Memphis and Nashville, at least $5 million in new funding to divide each year, or 25 percent of new monies under Title II, whichever is greater. For cities with 500 to 999 AIDS cases in the last five years, at least $5 million in new funding each year will be divided, or 25 percent of new monies under Title II, whichever is greater. This provision will be implemented as soon as the appropriation level for Title II, excluding the ADAP program, is increased by $20 million above the FY2000 funding level. Once implemented, this program would remain in place every year after the initial trigger level is met with at least $10 million coming from the Title II funding to support this needed effort.

Mr. President, I would like to thank Senator JEFFORDS for his leadership on this issue, and Sean Donohue and William Fleming of his staff for all their expertise in drafting this bill. I would also like to thank Senator KENNEDY and Stephanie Robinson of his staff for their work and dedication to this issue. And finally I would like to think Dave Larson and Mary Sumpter Johnson of my health staff for their work on passage of this bill.