"(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, subject to subparagraph (H); and

"(ii) the percentage constituted by the sum of—

"(I) the product of .80 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 .20 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 an amount equal to the estimated number of living cases of acquired immune deficiency syndrome in the eligible area involved, as determined under subparagraph (D).

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

"(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) 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.".

"(F) 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.

"(G) 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, 100 percent;

"(II) with respect to fiscal year 1997, 99 percent;

"(III) with respect to fiscal year 1998, 98 percent;

"(IV) with respect to fiscal year 1999, 96.5 percent; and

"(V) with respect to fiscal year 2000, 95 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.

"(H) APPROPRIATIONS FOR TREATMENT DRUG PROGRAM.—With respect to the fiscal year involved, if under section 2677 an appropriations Act provides an amount exclusively for carrying out section 2616, the portion of such amount allocated to a State shall be the product of—

"(i) 100 percent of such amount; and

"(ii) the percentage constituted by the ratio of the State distribution factor for the State (as determined under subparagraph (B)) to the sum of the State distribution factors for all States.".

SEC. 6. CONSOLIDATION OF AUTHORIZATIONS OF APPROPRIATIONS.

(a) IN GENERAL.—Part D of title XXVI (42 U.S.C. 300ff-71) is amended by adding at the end thereof the following new section:

"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.

"(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 allocated to part A and part B to account for grants to new eligible areas under part A and other relevant factors. Not later than July 1, 1996, 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 determines that such a methodology under paragraph (1) cannot be developed, 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.".

(b) REPEALS.—Sections 2608 and 2620 (42 U.S.C. 300ff-18 and 300ff-30) are repealed.

(c) CONFORMING AMENDMENTS.—Title XXVI is amended—

(1) in section 2603 (42 U.S.C. 300ff-13)—

(A) in subsection (a)(2), by striking "2608" and inserting "2677"; and

(B) in subsection (b)(1), by striking "2608" and inserting "2677";

(2) in section 2605(c)(1) (42 U.S.C. 300ff-15(c)(1)) is amended by striking "2608" and inserting "2677"; and

(3) in section 2618 (42 U.S.C. 300ff-28)—

(A) in subsection (a)(1), is amended by striking "2620" and inserting "2677"; and

(B) in subsection (b)(1), is amended by striking "2620" and inserting "2677".

SEC. 7. PERINATAL TRANSMISSION OF HIV DISEASE.

(a) FINDINGS.—The Congress finds as follows:

(1) Research studies and Statewide clinical experiences have demonstrated that administration of anti-retroviral medication during pregnancy can significantly reduce the transmission of the human immunodeficiency virus (commonly known as HIV) from an infected mother to her baby.

(2) The Centers for Disease Control and Prevention have recommended that all pregnant women receive HIV counseling; voluntary, confidential HIV testing; and appropriate medical treatment (including anti-retroviral therapy) and support services.

(3) The provision of such testing without access to such counseling, treatment, and services will not improve the health of the woman or the child.

(4) The provision of such counseling, testing, treatment, and services can reduce the number of pediatric cases of acquired immune deficiency syndrome, can improve access to and provision of medical care for the woman, and can provide opportunities for counseling to reduce transmission among adults, and from mother to child.

(5) The provision of such counseling, testing, treatment, and services can reduce the overall cost of pediatric cases of acquired immune deficiency syndrome.

(6) The cancellation or limitation of health insurance or other health coverage on the basis of HIV status should be impermissible under applicable law. Such cancellation or limitation could result in disincentives for appropriate counseling, testing, treatment, and services.

(7) For the reasons specified in paragraphs (1) through (6)—

(A) routine HIV counseling and voluntary testing of pregnant women should become the standard of care; and

(B) the relevant medical organizations as well as public health officials should issue guidelines making such counseling and testing the standard of care.

(b) ADDITIONAL REQUIREMENTS FOR GRANTS.—Part B of title XXVI (42 U.S.C. 300ff-21 et seq.) is amended—

(1) by inserting after the part heading the following:

"Subpart I—General Grant Provisions";

(2) in section 2611(a), by adding at the end the following sentence: "The authority of the Secretary to provide grants under part B is subject to section 2626(e)(2) (relating to the decrease in perinatal transmission of HIV disease)."; and

(3) by adding at the end thereof the following new subpart:

"Subpart II—Provisions Concerning Pregnancy and Perinatal Transmission of HIV

"SEC. 2625. CDC GUIDELINES FOR PREGNANT WOMEN.

"(a) REQUIREMENT.—Notwithstanding any other provision of law, a State shall, not later than 120 days after the date of enactment of this subpart, certify to the Secretary that such State has in effect regulations or measures to adopt the guidelines issued by the Centers for Disease Control and Prevention concerning recommendations for human immunodeficiency virus counseling and voluntary testing for pregnant women.

"(b) NONCOMPLIANCE.—If a State does not provide the certification required under subsection (a) within the 120-day period described in such subsection, such State shall not be eligible to receive assistance for HIV counseling and testing under this section until such certification is provided.

"(c) ADDITIONAL FUNDS REGARDING WOMEN AND INFANTS.—

"(1) IN GENERAL.—If a State provides the certification required in subsection (a) and is receiving funds under part B for a fiscal year, the Secretary may (from the amounts available pursuant to paragraph (2)) make a

grant to the State for the fiscal year for the following purposes:

"(A) Making available to pregnant women appropriate counseling on HIV disease.

"(B) Making available outreach efforts to pregnant women at high risk of HIV who are not currently receiving prenatal care.

"(C) Making available to such women voluntary HIV testing for such disease.

"(D) Offsetting other State costs associated with the implementation of this section and subsections (a) and (b) of section 2626.

"(E) Offsetting State costs associated with the implementation of mandatory newborn testing in accordance with this title or at an earlier date than is required by this title.

"(2) FUNDING.—For purposes of carrying out this subsection, there are authorized to be appropriated $10,000,000 for each of the fiscal years 1996 through 2000. Amounts made available under section 2677 for carrying out this part are not available for carrying out this section unless otherwise authorized.

"(3) PRIORITY.—In awarding grants under this subsection the Secretary shall give priority to States that have the greatest proportion of HIV seroprevalance among child bearing women using the most recent data available as determined by the Centers for Disease Control and Prevention.

"SEC. 2626. PERINATAL TRANSMISSION OF HIV DISEASE; CONTINGENT REQUIREMENT REGARDING STATE GRANTS UNDER THIS PART.

"(a) ANNUAL DETERMINATION OF REPORTED CASES.—A State shall annually determine the rate of reported cases of AIDS as a result of perinatal transmission among residents of the State.

"(b) CAUSES OF PERINATAL TRANSMISSION.—In determining the rate under subsection (a), a State shall also determine the possible causes of perinatal transmission. Such causes may include—

"(1) the inadequate provision within the State of prenatal counseling and testing in accordance with the guidelines issued by the Centers for Disease Control and Prevention;

"(2) the inadequate provision or utilization within the State of appropriate therapy or failure of such therapy to reduce perinatal transmission of HIV, including—

"(A) that therapy is not available, accessible or offered to mothers; or

"(B) that available therapy is offered but not accepted by mothers; or

"(3) other factors (which may include the lack of prenatal care) determined relevant by the State.

"(c) CDC REPORTING SYSTEM.—Not later than 4 months after the date of enactment of the this subpart, the Director of the Centers for Disease Control and Prevention shall develop and implement a system to be used by States to comply with the requirements of subsections (a) and (b). The Director shall issue guidelines to ensure that the data collected is statistically valid.

"(d) DETERMINATION BY SECRETARY.—Not later than 180 days after the expiration of the 18-month period beginning on the date on which the system is implemented under subsection (c), the Secretary shall publish in the Federal Register a determination of whether it has become a routine practice in the provision of health care in the United States to carry out each of the activities described in paragraphs (1) through (5) of section 2627. In making the determination, the Secretary shall consult with the States and with other public or private entities that have knowledge or expertise relevant to the determination.

"(e) CONTINGENT APPLICABILITY.—

"(1) IN GENERAL.—If the determination published in the Federal Register under subsection (d) is that (for purposes of such subsection) the activities involved have become routine practices, paragraph (2) shall apply on and after the expiration of the 18-month period beginning on the date on which the determination is so published.

"(2) REQUIREMENT.—Subject to subsection (f), the Secretary shall not make a grant under part B to a State unless the State meets not less than one of the following requirements:

"(A) A 50 percent reduction (or a comparable measure for States with less than 10 cases) in the rate of new cases of AIDS (recognizing that AIDS is a suboptimal proxy for tracking HIV in infants and was selected because such data is universally available) as a result of perinatal transmission as compared to the rate of such cases reported in 1993 (a State may use HIV data if such data is available).

"(B) At least 95 percent of women in the State who have received at least two prenatal visits (consultations) prior to 34 weeks gestation with a health care provider or provider group have been tested for the human immunodeficiency virus.

"(C) The State has in effect, in statute or through regulations, the requirements specified in paragraphs (1) through (5) of section 2627.

"(f) LIMITATION REGARDING AVAILABILITY OF FUNDS.—With respect to an activity described in any of paragraphs (1) through (5) of section 2627, the requirements established by a State under this section apply for purposes of this section only to the extent that the following sources of funds are available for carrying out the activity:

"(1) Federal funds provided to the State in grants under part B or under section 2625, or through other Federal sources under which payments for routine HIV testing, counseling or treatment are an eligible use.

"(2) Funds that the State or private entities have elected to provide, including through entering into contracts under which health benefits are provided. This section does not require any entity to expend non-Federal funds.

"SEC. 2627. TESTING OF PREGNANT WOMEN AND NEWBORN INFANTS.

"An activity or requirement described in this section is any of the following:

"(1) In the case of newborn infants who are born in the State and whose biological mothers have not undergone prenatal testing for HIV disease, that each such infant undergo testing for such disease.

"(2) That the results of such testing of a newborn infant be promptly disclosed in accordance with the following, as applicable to the infant involved:

"(A) To the biological mother of the infant (without regard to whether she is the legal guardian of the infant).

"(B) If the State is the legal guardian of the infant:

"(i) To the appropriate official of the State agency with responsibility for the care of the infant.

"(ii) To the appropriate official of each authorized agency providing assistance in the placement of the infant.

"(iii) If the authorized agency is giving significant consideration to approving an individual as a foster parent of the infant, to the prospective foster parent.

"(iv) If the authorized agency is giving significant consideration to approving an individual as an adoptive parent of the infant, to the prospective adoptive parent.

"(C) If neither the biological mother nor the State is the legal guardian of the infant, to another legal guardian of the infant.

"(D) To the child's health care provider.

"(3) That, in the case of prenatal testing for HIV disease that is conducted in the State, the results of such testing be promptly disclosed to the pregnant woman involved.

"(4) That, in disclosing the test results to an individual under paragraph (2) or (3), appropriate counseling on the human immunodeficiency virus be made available to the individual (except in the case of a disclosure to an official of a State or an authorized agency).

"(5) With respect to State insurance laws, that such laws require—

"(A) that, if health insurance is in effect for an individual, the insurer involved may not (without the consent of the individual) discontinue the insurance, or alter the terms of the insurance (except as provided in subparagraph (C)), solely on the basis that the individual is infected with HIV disease or solely on the basis that the individual has been tested for the disease or its manifestation;

"(B) that subparagraph (A) does not apply to an individual who, in applying for the health insurance involved, knowingly misrepresented the HIV status of the individual; and

"(C) that subparagraph (A) does not apply to any reasonable alteration in the terms of health insurance for an individual with HIV disease that would have been made if the individual had a serious disease other than HIV disease.

For purposes of this subparagraph, a statute or regulation shall be deemed to regulate insurance for purposes of this paragraph only to the extent that such statute or regulation is treated as regulating insurance for purposes of section 514(b)(2) of the Employee Retirement Income Security Act of 1974.

"SEC. 2628. REPORT BY THE INSTITUTE OF MEDICINE.

"(a) IN GENERAL.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct an evaluation of the extent to which State efforts have been effective in reducing the perinatal transmission of the human immunodeficiency virus, and an analysis of the existing barriers to the further reduction in such transmission.

"(b) REPORT TO CONGRESS.—The Secretary shall ensure that, not later than 2 years after the date of enactment of this section, the evaluation and analysis described in subsection (a) is completed and a report summarizing the results of such evaluation and analysis is prepared by the Institute of Medicine and submitted to the appropriate committees of Congress together with the recommendations of the Institute.

"SEC. 2629. STATE HIV TESTING PROGRAMS ESTABLISHED PRIOR TO OR AFTER ENACTMENT.

"Nothing in this subpart shall be construed to disqualify a State from receiving grants under this title if such State has established at any time prior to or after the date of enactment of this subpart a program of mandatory HIV testing.".

SEC. 8. SPOUSAL NOTIFICATION.

(a) IN GENERAL.—The Secretary of Health and Human Services shall not make a grant under part B of title XXVI of the Public Health Service Act (42 U.S.C. 300ff–21 et seq.) to any State unless such State takes administrative or legislative action to require that a good faith effort be made to notify a spouse of a known HIV-infected patient that such spouse may have been exposed to the human immunodeficiency virus and should seek testing.

(b) DEFINITIONS.—For purposes of this section:

(1) SPOUSE.—The term "spouse" means any individual who is the marriage partner of an HIV-infected patient, or who has been the marriage partner of that patient at any time within the 10-year period prior to the diagnosis of HIV infection.

(2) HIV-INFECTED PATIENT.—The term "HIV-infected patient" means any individual who has been diagnosed to be infected with the human immunodeficiency virus.

(3) STATE.—The term "State" means any of the 50 States, the District of Columbia, or any territory of the United States.

SEC. 9. OPTIONAL PARTICIPATION OF FEDERAL EMPLOYEES IN AIDS TRAINING PROGRAMS.

(a) IN GENERAL.—Notwithstanding any other provision of law, a Federal employee may not be required to attend or participate in an AIDS or HIV training program if such employee refuses to consent to such attendance or participation, except for training necessary to protect the health and safety of the Federal employee and the individuals served by such employees. An employer may not retaliate in any manner against such an employee because of the refusal of such employee to consent to such attendance or participation.

(b) DEFINITION.—As used in subsection (a), the term "Federal employee" has the same meaning given the term "employee" in section 2105 of title 5, United States Code, and such term shall include members of the armed forces.

SEC. 10. PROHIBITION ON PROMOTION OF CERTAIN ACTIVITIES.

Part D of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-71) as amended by section 6, is further amended by adding at the end thereof the following new section:

"SEC. 2678. PROHIBITION ON PROMOTION OF CERTAIN ACTIVITIES.

"None of the funds authorized under this title shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual. Funds authorized under this title may be used to provide medical treatment and support services for individuals with HIV.".

SEC. 11. LIMITATION ON APPROPRIATIONS.

Notwithstanding any other provision of law, the total amounts of Federal funds expended in any fiscal year for AIDS and HIV activities may not exceed the total amounts expended in such fiscal year for activities related to cancer.

SEC. 12. ADDITIONAL PROVISIONS.

(a) DEFINITIONS.—Section 2676(4) (42 U.S.C. 300ff-76(4)) is amended by inserting "funeral-service practitioners," after "emergency medical technicians,".

(b) MISCELLANEOUS AMENDMENT.—Section 1201(a) (42 U.S.C. 300d(a)) is amended in the matter preceding paragraph (1) by striking "The Secretary," and all that follows through "shall," and inserting "The Secretary shall,".

(c) TECHNICAL CORRECTIONS.—Title XXVI (42 U.S.C. 300ff-11 et seq.) is amended—

(1) in section 2601(a), by inserting "section" before "2604";

(2) in section 2603(b)(4)(B), by striking "an expedited grants" and inserting "an expedited grant";

(3) in section 2617(b)(3)(B)(iv), by inserting "section" before "2615";

(4) in section 2647—

(A) in subsection (a)(1), by inserting "to" before "HIV";

(B) in subsection (c), by striking "section 2601" and inserting "section 2641"; and

(C) in subsection (d)—

(i) in the matter preceding paragraph (1), by striking "section 2601" and inserting "section 2641"; and

(ii) in paragraph (1), by striking "has in place" and inserting "will have in place";

(5) in section 2648—

(A) by converting the heading for the section to boldface type; and

(B) by redesignating the second subsection (g) as subsection (h);

(6) in section 2649—

(A) in subsection (b)(1), by striking "subsection (a) of"; and

(B) in subsection (c)(1), by striking "this subsection" and inserting "subsection";

(7) in section 2651—

(A) in subsection (b)(3)(B), by striking "facility" and inserting "facilities"; and

(B) in subsection (c), by striking "exist" and inserting "exists";

(8) in section 2676—

(A) in paragraph (2), by striking "section" and all that follows through "by the" and inserting "section 2686 by the"; and

(B) in paragraph (10), by striking "673(a)" and inserting "673(2)";

(9) in part E, by converting the headings for subparts I and II to Roman typeface; and

(10) in section 2684(b), in the matter preceding paragraph (1), by striking "section 2682(d)(2)" and inserting "section 2683(d)(2)".

SEC. 13. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b), this Act, and the amendments made by this Act, shall become effective on October 1, 1996.

(b) EXCEPTION.—The amendments made by sections 3(a), 5, 6, and 7 of this Act to sections 2601(c), 2601(d), 2603(a), 2618(b), 2626, 2677, and 2691 of the Public Health Service Act, shall become effective on the date of enactment of this Act.

And the House agree to the same.

That the Senate recede from its disagreement to the amendment of the House to the title of the bill, and agree to the same.

TOM BLILEY,
MICHAEL BILIRAKIS,
TOM COBURN,
HENRY A. WAXMAN,
GERRY STUDDS,
Managers on the Part of the House.

NANCY LANDON KASSEBAUM,
JIM JEFFORDS,
BILL FRIST,
EDWARD M. KENNEDY,
CHRISTOPHER J. DODD,
Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE ON CONFERENCE

1. SHORT TITLE

The Senate Bill titles the Act the Ryan White CARE Reauthorization Act of 1995. The House bill is titled the Ryan White CARE Act Amendments of 1995. The Senate recedes.

2. ELIGIBILITY AND EFFECTIVE DATES

The Conferees agreed to make October 1, 1996 the general effective date for the Act. However, the amendments limiting eligible areas to those with a population of 500,000 or higher, continuing the eligibility of current EMAs, and all formula changes (including the provisions on single appropriations and funding for Special Projects of National Significance) are effective immediately upon passage of the Act. The Secretary is required to make a report to Congress on the single appropriations provision by July 1, 1996.

It is the intent of the Conferees that, beginning in fiscal year 1996 and continuing through the reauthorization period, no new metropolitan area with fewer than 500,000 people be eligible for Part A funds. On October 1, 1996, the period for counting AIDS cases to determine eligibility is reduced to the most recent five calendar years. The Conferees wish to make clear, however, that metropolitan areas, once eligible to receive Part A funds, and all metropolitan areas currently receiving such funds, shall remain eligible regardless of fluctuations in the five year case count over time.

3. PLANNING COUNCIL ROLES AND RESPONSIBILITIES

The Senate bill prohibits the Planning Council from being chaired solely by an employee of the grantee. The House bill contains no such prohibition. The House recedes.

The House bill provides that the planning council may not be directly involved in the administration of a grant to a provider under Section 2601(a) nor designate particular entities as recipients of grants. Planning council members must also agree to comply with measures relating to conflicts of interest. The Senate bill does not contain such provisions. The Senate recedes with an amendment that the duties of the planning council, in addition to establishing funding priorities, include making recommendations concerning how best to meet established priorities.

It is the intent of the Conferees that the planning council provide guidance to the grantee regarding the types of organizations that may best meet each service priority established by the planning council. Types of organizations may, for example, include outpatient clinics, community-based organizations that historically have served affected communities and other types of organizations that meet criteria outlined in the legislation (i.e., cost effectiveness, priority of the affected community, etc.) While the conferees expect the grantee through the grant making process to satisfy the target population, service, and service delivery priorities established by the planning council, they do not intend that the planning council select which particular organizations receive funding, either by specific direction or by narrowly describing a type of organization. The legislation clearly states that such a planning council role is prohibited. The Conferees expect that the planning council will help to guide the grantee in how best to meet the established service priorities.

4. GRIEVANCE PROCEDURES

The Senate bill mandates that planning councils establish operating procedures which include specific policies for resolving disputes, responding to grievances, and minimizing and managing conflicts of interest. The House bill contains no such mandate. The House recedes with an amendment that the operating procedures relating to conflict of interest and grievance procedures be locally developed and included in the eligible area's application for Part A formula funds.

The Senate bill includes a requirement that the Secretary develop grievance procedures specific to each part of the Act, to resolve egregious violations of each part, and to establish appropriate enforcement mechanisms. The House bill contains no such provision. The Senate recedes with an amendment to require the Secretary to convene a process involving grantees and outside experts to develop models and prototypes for locally established grievance procedures, and lay out key elements that should be addressed in setting up grievance and arbitration processes at the local level.

The Committee wishes to emphasize that the grievance procedures should be locally established, with assistance from the Secretary. The procedures are to be reviewed by the Health Resources and Services Administration to ensure that they adequately address potential conflicts and grievances. While the bill does not require the Secretary to establish federal grievance procedures, the Committee emphasizes that the Secretary has the power, under this Act and existing law on federal contracts and grants, to withhold funds for violations of the Act.

5. SUPPLEMENTAL GRANTS

The Senate bill requires that the supplemental grant application demonstrate that

the planning council include representatives of the requisite population groups, service provides, and affected communities. The House bill does not include such a provision. The House recedes.

The House bill requires that the supplemental grant application demonstrate that both formula and supplemental grant funds from the previous year were distributed according to the priorities established by the planning council. The Senate bill does not contain such a provision. The Senate recedes.

6. SEVERE NEED

The Conferees agreed to clarify the meaning of "severe need" for the purposes of supplemental funding under Title I. The Secretary is directed to develop a quantitative measurement of that need and incorporate it into supplemental funding allocation decisions. The development of a quantitative measurement of severe need is not intended to replace existing factors the Secretary may use to determine supplemental awards, such as comprehensive planning, magnitude of the epidemic, planning council functioning and CEO responsibilities, program and fiscal performance, needs assessment and the match between needs and service priorities.

The Conferees believe that a comparison of severe need across EMAs should be part of the review of applications for supplemental grants and compare service delivery costs and complexity of delivering services due to comorbidity and other factors listed in the legislation. The Conferees emphasize that the list of factors is not all inclusive and recognizes that data needed to quantify these factors may not be available. The Secretary may consider other factors, to account appropriately for differences in the cost and complexity of service delivery across eligible areas. Those factors which are associated with nationwide quantitative data, however, should be given the highest importance. The Conferees intend that the Secretary have flexibility in developing this quantitative mechanism to carry out comparisons across eligible areas.

In the past, supplemental awards have been allocated on the basis of the formula grant. By including criteria for severe need, the conferees intend that those eligible areas with the greatest public health challenges be given appropriate consideration for larger supplemental awards.

7. WOMEN, INFANTS, AND CHILDREN

The House bill requires Part A and Part B grantees to utilize a portion of their funds to provide health and support services to women, infants, and children. The grantees are required to utilize at least 5 percent of such funds or a percentage of funds equal to the ratio of women, infants, and children with AIDS to the entire population with AIDS, whichever is less. The Senate bill does not contain such provisions. The Senate recedes with an amendment to strike the 15 percent comparison and, in the case of Part A grantees, to require that the grantee utilize the appropriate percentage of funds in accordance with the priorities established by the planning council.

The House bill requires that these funds be used primarily for the prevention of perinatal HIV transmission. The Senate bill does not contain such a provision. The House recedes with an amendment that language be included which indicates that services funded by the set-aside may include treatments to prevent the perinatal transmission of HIV.

It is the intent of the conferees that funding be allocated based on the demographics of the epidemic in a local area, and that spending for services for women, infants, and children be equal, on a percentage basis, to the percentage of women, infants, and children with AIDS.

8. ADMINISTRATIVE COSTS

Both the House and Senate bills maintain the administrative costs caps for Part A grantees and the Senate bill defines these costs. For Part B, the Senate bill defines administrative costs and modifies existing administrative cost caps for grantees. Part B grantees are limited to spending not more than than 10% of the award they receive in a fiscal year on administrative costs and 10% of that award on planning and evaluation activities. However, total spending on administration, planning, and evaluation cannot exceed 15% of the award a grantee receives in a fiscal year. The House recedes to the definition of administrative costs and to the 15% cap.

Regarding entities receiving funds from Part A or Part B grantees, the Senate limits expenditures for administrative activities to 12.5% for each such entity. The bill specifically defines administrative costs for these entities. The House bill limits such expenditures to 10% as measured across all entities receiving funding from Part A or Part B grantees, without regard to whether an individual entity is above or below that percentage. For example, if a state or eligible area awards $1 million to 10 service providers, regardless of the amount an individual provider spends on administration, the amount spent on administration added across all 10 providers cannot exceed $100,000 (10% of $1 million). For Part B grantees, entities subject to this cost cap include the lead agencies of consortia in carrying out their administrative duties associated with the operation of the consortium. The Senate recedes with an amendment to include the Senate bill's definition of administrative costs.

The Conferees wish to emphasize that grantees and subcontractors that can restrain administrative costs to less than 10% should do so. The set amount should be regarded as a ceiling, not a floor.

9. SINGLE APPLICATION

The Senate bill allows the Secretary to phase in the use of single application for formula and supplemental Part A funds and the awarding of a single grant. The House bill makes this allowance contingent upon the request of an individual grantee. The House recedes.

It is the intent of the conferees that the Secretary have the authority to implement mechanisms necessary to make a single grant based on a single application. It is the understanding of the conferees that the use of such a grant and application will reduce the administrative burdens on the Secretary, grantees, and individual providers. Under current methods, these entities often must track two separate funding streams that accrue to a single provider for the same services.

Use of a single grant or single application, however, must not result in a delay in allocating funding under the Act.

10. USE OF PART B FUNDS

The House bill adds a fifth eligible use of Part B funds, allowing states to fund services directly. The Senate bill does not include such a provision. The Senate recedes with an amendment that, in order to fund these services outside an existing consortia system, the state must demonstrate to the Secretary that utilizing other service delivery mechanisms is more effective. In making that determination, the State must consult with service provider representatives and recipients of services.

The House bill eliminates the requirement that states with more than 1% of all cases of AIDS expend at least 50% of their Part B funds on consortia. The Senate does not eliminate this provision. The Senate recedes.

The Conferees want to emphasize that the purpose of the Act is to provide health care services to individuals with HIV and AIDS. It is the expectation of the conferees that states will maximize the funds spent directly on health care services.

The Conferees wish to emphasize that the eligible funding areas under Part B are flexible enough to allow states to implement an appropriate array of services. With Part B funds, states can establish treatment programs, health insurance continuation programs, home health care programs and consortia. The Conferees expect states to use funds to provide or ensure the provision of services eligible for funding under Part A. Where consortia exist or are established under this part, in areas that would have been eligible for direct part A funding prior to enactment of this Act, they should function as planning bodies for local service delivery, much as planning councils function under Part A.

The Conferees also emphasize that the elimination of the requirement that states with more than 1% of national AIDS cases expend at least 50% of their Part B award on consortia is not to be interpreted to mean that Part A medical services should not be provided to beneficiaries who reside outside an eligible area. Eliminating the 50% expenditure requirement provides more flexibility to respond to local needs.

11. MINIMUM DRUG FORMULARY

The Senate bill requires the Secretary to develop a minimum drug formulary for suggested use by the states which must document their success in implementing the developed formulary. The House bill requires some portion of Part B funds to be used to fund drug assistance programs, including measures for the prevention and treatment of opportunistic infections. The Senate recedes with an amendment to strike references in Section 2612(a)(2) and Section 2616(a) to "treatments that have been determined to prolong life" and replace them with "therapeutics to treat HIV disease".

These amendments expand State flexibility to provide a broader range of treatments through State drug treatment programs funded by Ryan White Care Act funds, by allowing State drug treatment programs to provide any therapeutics that treat HIV and AIDS, rather than only those that "have been determined to prolong life." This is intended to increase access for persons with HIV and AIDS to treatments targeted toward various aspects of the disease, to prolong life. Such treatments may, for example, by addressing certain specific symptoms of HIV and AIDS, improve an individual's quality of life. With this flexibility, states will be able to improve access to the growing range of treatment options for HIV and AIDS, enabling patients to benefit from recent advances in the treatment of the disease.

The Senate bill requires the Secretary to review the current status of State drug reimbursement programs and assess barriers to the expanded availability of prophylactic treatments for opportunistic infections. The House bill does not contain such provisions. The House recedes with an amendment to replace "prophylactic treatment" with "treatments described in subsection (a)" and to require states to document their progress in making those treatments available.

In addition, the amendments require the Secretary to evaluate the effectiveness of State drug treatment programs in removing barriers to the availability of this wider range of therapeutics to treat HIV and AIDS, and also to evaluate the extent to which State drug treatment programs coordinate

with other recipients of Ryan White Care Act funds to remove barriers to the availability of treatments for HIV and AIDS. States also are required to document their progress in making treatments available to those eligible for assistance under the Ryan White Care Act, namely low-income individuals who have been medically diagnosed with HIV or AIDS. These requirements for evaluation and documentation are designed to assure that these funds are being used efficiently and effectively to achieve the goals of the Ryan White Care Act, specifically in the area of improving access for low income individuals to medical treatments for HIV and AIDS.

The Conferees emphasize that the Secretary is encouraged to advise states on classes of drugs that have been found effective in preventing and treating HIV disease as part of the assessment of barriers to expanded availability of therapeutics. For the purposes of this section, the Conferees include as therapeutics as pharmaceuticals (including the necessary equipment to utilize them) and other therapies which prevent the onset of opportunistic infections or deterioration of health.

12. STATEWIDE COORDINATED STATEMENT OF NEED

The Senate bill requires the state public health agency administering Part B funds to convene an annual meeting for the development of a coordinated statement of need. The House bill does not define the Statewide Coordinated Statement of Need. The House recedes with an amendment to require a periodic convening of such a meeting and to remove the parentheticals which describe required attendees.

The Conferees intend for this activity to result in a joint written statement developed in partnership with all CARE Act grantees within the State which identifies unmet need, epidemiological trends, barriers to care and other appropriate issues which impact on service availability.

The Conferees wish to emphasize that the Statewide Coordinated Statement of Need and the process to create it should not supplant existing planning processes utilized by grantees under this Act. It is meant to augment such planning and should be used as a tool to maximize coordination, integration, and effective linkages among the individual entities funded by the Act. For existing grantees, local plans and programs shall be considered consistent with the Coordinated Statement of Need if the grantees can show a good faith effort to participate in crafting the statement and a good faith consideration of the statement in their planning and decision making processes. New grantees must demonstrate their good faith consideration of the statement in making their applications for funding.

13. COORDINATION

The Senate bill requires the Public Health Service to coordinate the activities of the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the Substance Abuse and Mental Health Services Administration regarding the local development of a complete continuum of HIV-related services for individuals with HIV disease or at risk for HIV disease. The House bill requires the Secretary to submit a report to Congress on coordination of agency activities. The Senate recedes with an amendment that the report be submitted biennially beginning October 1, 1996.

14. EARLY INTERVENTION PROGRAMS

The Senate bill stipulates that early intervention funds are for primary care services for people with HIV. The House bill lists four types of services that are eligible for early intervention funds. The Senate recedes with an amendment that the House listed services are for people with HIV.

The Senate requires that 50% of early intervention grants to primary health care facilities, including migrant health centers, centers that provide health services for the homeless, and other federally-qualified health centers, be expended on-site or at sites where other primary care services are rendered. The House bill does not contain such a provision. The House recedes.

The conferees recognize that some grantees operate as consortia to provide 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.

The Senate bill provides planning and development grants to public and nonprofit entities that are not direct providers of primary health care to provide HIV-specific care services. The House bill provides the grants to all eligible public and private nonprofit entities to provide early intervention services. The Senate recedes with an amendment to add "HIV" to "early intervention services".

The Senate bill requires the Secretary to give preference to entities that would provide HIV primary care services in rural or under-served communities. The House bill requires preference to entities that currently provide HIV primary care services in rural and under-served communities. The Senate recedes with an amendment to delete "HIV" from "HIV primary care services".

The Senate bill requires family planning and hemophilia center grantees to ensure the availability of early intervention services through a series of linkages to community-based primary care providers and to establish mechanisms for referrals and follow-up. The House bill does not contain such a provision. The House recedes.

The Senate bill increases the cap on administrative costs to 10% and expands those costs to include planning, evaluation, and technical assistance. The House bill contains no such provision. The House recedes with an amendment to lower the cap to 7.5% and eliminate inclusion of technical assistance.

15. TITLE IV

The House bill titles Section 2671, Coordinated Services and Access to Research for Women, Infants, and Children. The Senate bill titles this section, Grants for Coordinated Services and Access to Research for Children, Youth, and Families. The Senate recedes with an amendment to add "Grants for" at the beginning of the title, and "and Youth" at the end of the title.

The House bill makes grants available to primary health care providers to provide opportunities for women, infants, and children to participate as subjects in research of potential clinical benefit. The Senate bill makes available such grants to facilitate voluntary participation of those groups in research protocols at the facility or by direct referral. The Senate recedes with an amendment to include youth in the eligible population group.

The House bill requires entities to provide outpatient health care to women, infants, and children. The Senate bill requires that health care and support services be provided to children, youth, and women with HIV disease and the families of such individuals. The Senate recedes with an amendment to require applicants to provide to patients and their families case management, transportation, child care, and other incidental services as may be necessary to enable the patient and the family to participate in the applicant's program, and referrals to inpatient hospital services, treatment for substance abuse, mental health services, and other support services as appropriate.

The House bill requires the grant applicant to make reasonable efforts to identify prospective patients who would be appropriate participants in research projects and to offer patients the opportunity to participate in projects. The Senate bill requires a broader list of assurances from the applicant, including that the grant will be used primarily to serve children, youth, and women; and that the applicant will arrange with research entities to collaborate in the conduct of facilitation of voluntary patient participation in qualified research protocols. The Senate recedes with an amendment to require entities to identify appropriate patients through the use of criteria provided by the entity for that purpose.

The House bill requires that applicant and the project of research comply with accepted standards of protection for human subjects including the provision of written informed consent. The Senate bill requires the Secretary to establish procedures which ensure those requirements. The Senate recedes.

The Conferees wish to emphasize that receipt of services by a patient shall not be conditioned upon consent to participate in research.

The House bill requires that for the third or subsequent fiscal year for which an applicant seeks a grant, the applicant must assure that a significant number, as determined by the Secretary, of women, infants, and children who are patients of the applicant are participating in research projects. The Senate bill does not contain such a provision. The Senate recedes.

Under the House bill, if the grantee is temporarily unable to comply with the "significant number" requirement, the Secretary may grant a reasonable amount of time for the grantee to reestablish compliance, under certain circumstances. The Senate bill does not contain such a provision. The Senate recedes.

In the House bill, the Secretary may waive the "significant numbers" requirement for an applicant who received a grant in fiscal year 1995 if the applicant is making a reasonable effort toward meeting this goal. The authority for the Secretary to issue this waiver expires on October 1, 1998, and waivers issued before October 1, 1998, expire on or before that date. The Senate bill does not contain such a provision. The Senate recedes with an amendment to provide that applicants must, not later than the end of the second fiscal year, meet the requirement that a significant number of women, infants, children, and youth participate in research projects.

The Conferees intend that the Secretary interpret the term "significant number" in a relative way. For grantees located in areas where there is access to many research activities, the "significant number" will be higher than for grantees located in more remote areas where research for women, infants, and children is less accessible. The Conferees intend that the Secretary take into account a variety of factors in determining "significant numbers", including: the number and type of clients serviced by the grantee, and the nature and availability of research programs accessible to patients of the grantee, and other factors the Secretary considers to be relevant.

The Senate bill includes a provision requiring submission of an application in such form as the Secretary determines is necessary. The House bill does not contain such a provision. The House recedes.

The House bill includes a section on Provisions Regarding Conduct of Research, allowing for the project of research to be conducted by the applicant or by an entity with

which the applicant has made arrangements. The Senate bill does not contain such a provision. The Senate recedes.

The House bill requires that the grant may not be expended for the conduct of any research project, that the research entity must be appropriately qualified to conduct the project, and that the research project must be in accordance with the priorities determined and listed by the Secretary in consultation with public and private research entities, providers and recipients of services under Part B. An entity shall be considered qualified if any research protocol of the entity has been recommended for funding under this Act pursuant to technical and scientific peer review through the National Institutes of Health. Under certain circumstances, the Secretary may give priority to a research protocol not on the list of high priority research. The Senate bill requires the Secretary to establish mechanisms, including an independent research review panel, to ensure that the research projects are of potential clinical benefit and meet accepted standards of research design. The Senate recedes with an amendment to allow grantees to fund services that facilitate and coordinate client access to comprehensive care services and research projects.

The Senate bill allows the Secretary to waive the requirements regarding coordination, statewide coordinated statement of need, and appropriate research opportunities if the applicant provides assurances that the requirements will be met by the end of the second grant year, or, in the case of existing grantees, within one year. The House bill does not contain such a provision. The Senate recedes.

The Senate bill contains a provision on Evaluations and Data Collection, requiring the Secretary to review the programs carried out under the section at the end of each fiscal year. The review may include recommendations on improving access to and participation in research protocols. The House bill does not contain such a provision. The House recedes with an amendment to title this section "Review Regarding Access To And Participation in Programs;" to require the review to be completed not later than 180 days after the end of the fiscal year; to state that the purpose of the review shall be to develop recommendations on procedures to allocate services and opportunities among patients of the entity and other procedures and policies of the entity regarding the participation of women, infants, children, and youth in research programs; and to require the Secretary to provide for evaluations of programs carried out by the entity.

The Senate bill allows the Secretary to establish reporting requirements necessary to administer the program and carry out the reviews, measure outcomes, and document clients served, services provided and participation in research protocols. The House bill does not contain such provisions. The Senate recedes.

The Senate bill includes a definition of qualified research entities and qualified research protocols. The House bill does not contain such a provision. The Senate recedes.

The House bill requires the Secretary to develop a plan that provides for the coordination of the activities of the National Institutes of Health (NIH) with the activities of this section, including that the projects of research conducted or supported by NIH are made aware of applicants and grantees of this section and that those projects as appropriate enter into arrangements for purposes of this section. The Senate bill does not contain such a provision. The Senate recedes.

The Conferees emphasize that Part D was enacted to provide funds for coordinated health and social services in association with voluntary participation in research programs. Such research will lead to a greater understanding of HIV disease among women, infants and children and to the development of preventive and therapeutic measures appropriate for those populations. The Conferees recognize that participation of children, youth, and pregnant women in HIV research programs is more successful when projects are convenient to women and children with HIV disease, when they are sensitive to needs for nontraditional services such as child care and transportation services, and when the opportunities to participate in research are provided within an established, comprehensive and community based HIV care system. For this reason, it is the intent of the Conferees that entities receiving grants under this program provide or arrange for innovative comprehensive HIV care for children, youth, women, and families with or affected by HIV.

It is the intent of the Conferees 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 services to, facilitate access to care.

16. AIDS DENTAL SCHOOL TRAINING

The House bill reauthorizes the current program and transfers it from Title 7 of the Public health Service Act to Title 26. The Senate bill does not reauthorize the program. The Senate recedes.

17. EVALUATION OF RYAN WHITE PROGRAMS

The House bill authorizes funding for the evaluation of Ryan White programs to come from the 1% Public Health Service set aside. The Senate bill does not contain such a provision. The Senate recedes.

18. SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

The Senate bill includes service delivery grants as special projects and describes those grants, which include programs that support family-based care networks critical to the delivery of care in minority communities and programs that build organizational capacity in disenfranchised communities. The House bill does not specifically define such grants. The House recedes with an amendment to replace the term "disenfranchised communities" with "minority communities".

19. AIDS EDUCATION AND TRAINING CENTERS

The House bill includes as an eligible activity the training of health providers in the prevention of perinatal HIV transmission and prevention and treatment of opportunistic infections. The Senate bill does not include such language. The Senate recedes.

By including the AIDS Education and Training Centers in the CARE Act reauthorization, the conferees reaffirm that this is an important federal program and will serve an important role in the future.

20. FORMULAS

The Senate bill distributes Part A funds to eligible metropolitan areas with a formula based only on weighted AIDS case counts. The Senate formula caps funding losses such that no eligible area will receive less than 98% of its FY 95 award in FY 96, 97% of its FY 95 award in FY 97, 95.5% of its FY 95 award in FY 98, 94% of its FY 95 award in FY 99, and 92.5% of its FY 95 award in FY 2000. The House bill uses the same weighted AIDS case count, but includes in its formula the Medicare Hospital Wage Index for each metropolitan area as a measure of service delivery cost. The House formula caps funding losses such that no eligible area will receive less than 99% of its FY 95 award in FY 96, 98% of its FY 95 award in FY 97, 97% of its FY 95 award in FY 98, 96% of its FY 95 award in FY 99, and 95% of its FY 95 award in FY 2000. The House recedes with an amendment to replace the Senate funding loss caps with losses such that no eligible area will receive less than 100% of its FY 95 award in FY 96, 99% of its FY 95 award in FY 97, 98% of its FY 95 award in FY 98, 96.5% of its FY 95 award in FY 99, and 95% of its FY 95 award in FY 2000.

The conferees feel that the formula changes for Part A, including the hold harmless provisions, adequately respond to the geographic diversification of the epidemic while simultaneously protecting against major disruptions in service delivery. The Committee understands that the formula changes will reduce the amount of supplemental funds that have been traditionally available to all Part A grantees because supplemental funds will be used to fund the hold harmless provisions. The Committee further understands that this reduction in the availability of supplemental funds could result in resource shifts beyond those built into the revised formula depending on the quality of the supplemental application as determined by the review process.

The Senate bill distributes Part B funds to states based on a formula that calculates two distribution factors: the state factor, based on weighted AIDS case counts for each state and the non-EMA factor based on weighted AIDS case counts for areas within the state outside of Part A eligible areas. Each of these distribution factors is weighted equally. The Senate bill also includes a provisions to cap funding losses such that no state will receive less than 98% of its FY 95 award in FY 96, 97% of its FY 95 award in FY 97, 95.5% of its FY 95 award in FY 98, 94% of its FY 95 award in FY 99, and 92.5% of its FY 95 award in FY 2000. The House bill retains the Part B formula contained in current law and sets aside 7% of available funds for distribution to states without Part A eligible areas, based on the relative case counts within those states. The House recedes with an amendment to weight the state factor in the Senate formula by a constant of .8 and the non-EMA factor by a constant of .2, and to substitute the Senate loss caps with the same loss caps used in the House version of the Part A formula.

Neither the House bill nor the Senate bill contained a provision allowing for the adjustment of the weights used to determine the estimate of living AIDS cases over the required 120 month period, in either the Part A or Part B formulas. The Conferees feel that such an adjustment may be necessary over time as life expectancy and disease progression changes for people living with AIDS. Therefore the Conferees expect the Secretary, in consultation with the Centers for Disease Control, to evaluate the need to update those weights every two years beginning with the grant awards in FY 1998 and report to the appropriate congressional committees.

The Conferees intend that if funds are appropriated specifically for the Drug Assistance Program, such funds be allocated according to the states entire weighted case counts.

21. SINGLE APPROPRIATION

Under the Senate bill, after one year, if the Secretary is unable to devise a methodology to adjust the split in the single appropriation between Parts A and B, the single appropriation reverts to two separate appropriations, beginning in FY 1997. Under the House bill, the single appropriation and the 64%/36% split between the two Parts remains