

Philadelphia Prevention Community Planning Group (CPG)
Meeting Minutes
Wednesday, January 27th, 2010
2:30 – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 203, Philadelphia, PA 19107

Present: Dawn Acero, David Acosta (Co-Chair), Wesley Anderson, Wade Briscoe, Marné Castillo, Jennifer Chapman, Arti Chhabria, Terri Clark, Christopher Collins (Co-Chair Elect), Tony Daniel, Annet Davis-Vogel, Tricia Dressel, Rick Feely (Co-Chair), Jeffrey Jenne, Andrea Johnson, Denette Lienau, Alison Lin, David Powell, Val Sowell, Roberta Waite

Excused: Antonio Davis, Andrew De Los Reyes, Nicholas Deroose, Tyreef King, Ken McGarvey, Michelle Teti

Guests: Henry Bennett, Jonathan Keel, Ronald Lassiter, Ronald Montgomery, Judith Peters, Melvin White, Jacquelin Whitfield

Absent: Yexsy Alicia, Khadeja Barnes, Robin Brennan, Kai Chandler, Tyrone McQueen, Nicole Quinn, Dionna Samuel

Staff: Joseph Ellis, Nicole Johns, Debbie C. Law, Michael Milsop, Mari Ross-Russell

Call to Order/ Introductions

D. Acosta called the meeting to order at 2:35 pm. Afterwards, each member of the group took a moment to introduce his or herself.

Approval of Agenda

Motion: After taking a moment to review the meeting agenda, T. Daniel moved and T. Clark seconded to approve the document. **Motion Passed:** All in favor.

Approval of Minutes (*December 16th, 2009*)

The members of the CPG spent some time reviewing a draft of the minutes from their last meeting. J. Jenne pointed out that, in the first full paragraph on page two of the minutes, the document that had had some language changed was the HIV case reporting form and not a new counseling and testing form. Additionally, in response to a question by J. Jenne, J. Peters clarified that the YRBS, which was mentioned under new business, stood for Youth Risk Behavior Survey. **Motion:** With the noted correction and clarification, T. Dressel moved and V. Sowell seconded to approve the draft of the minutes that was included in handouts. **Motion Passed:** All in favor.

Report of Co-Chairs

D. Acosta informed the group that Dr. Kevin Fenton had recently given a presentation at Drexel University that focused on PCSI (Program Collaboration and Service Integration). He said that Dr. Fenton had also examined Philadelphia's own collaborative efforts and reported that the city was far ahead of many other jurisdictions in integration. He noted that Philadelphia's success in integration was an achievement because all of the various disease systems had separate offices in the Health Department. He told the group that PCSI would become increasingly important in the next few years as the language was already starting to

appear in federal grants and CDC proposals. T. Clark asked whether Dr. Fenton's presentation could be made available to the members of the CPG. D. Acosta replied that, although AACO had not yet received a copy of the presentation, they would share it with the members of the CPG when it became available.

D. Acosta also reported that AACO was working on completing the 2009 APR (Annual Progress Report), which was due on March 29th. Additionally, he informed the group that he, along with C. Collins and J. Jenne, would be attending the next meeting of UCHAPS (Urban Coalition of HIV/AIDS Prevention Services) in Houston at the end of February. Lastly, he reported that, according to recent data, there had been an 11% reduction in late presenters – individuals who were already in advanced stages of HIV/AIDS by the time they were tested – in Philadelphia. He said that the reduction was an exciting achievement for the city's prevention efforts because it showed that the focus on testing was working. He told the group that, at their request, Dr. Kathleen Brady would be able to give them a more formal presentation on the matter.

C. Collins reported that he had attended the State CPG meeting in the previous week. He told the CPG that he was now interested in working to reinstate the YRT (Youth Round Table) after seeing how well the group's meetings operated and were attended at the state level. He said that he had already mentioned the idea to some young adults and was told that Monday evenings from 3:00 – 5:00 pm would work well for a meeting time. He felt that, with a bit more outreach, more youth could be attracted to the process and he therefore asked the members of the CPG for their assistance.

R. Feely supported the idea of reinstating the YRT in Philadelphia but he felt that it was unfair to base attendance expectations on the number of members at state meetings. He explained that it was easier to attract youth to such functions in more rural areas because, as was not the case in larger cities, there was less competition from other activities. A. Davis-Vogel felt that it would be unrealistic to expect that youth from all over the city would come to a single meeting in a central location. As a result, she suggested holding a few meetings in different parts of the city to attract more youth. M. Castillo supported the idea but noted that the meetings might be more successful if the group took some time to directly ask youth groups what would draw them to YRT meetings. She then suggested putting the matter on the agenda for the next CPG meeting to allow for more discussion. R. Hayward noted that recent reports of increasing teen pregnancy rates indicated that unprotected sex among youth was still a problem. As a result, he supported C. Collins' efforts and suggested using churches across the city to hold YRT meetings. A. Johnson pointed out that Y-HEP ran a successful program for youth and suggested looking into their outreach model. C. Collins brought the discussion to a close by thanking the group for all of their suggestions and promising to put the discussion on the agenda at a future CPG meeting.

Presentation:

- **Introduction to the Ryan White HIV/AIDS Treatment Extension Act of 2009** – *Matthew McClain*

M. Ross-Russell introduced M. McClain, informing the group that he had been a resident of Philadelphia who worked in community planning and consulting with both the care and prevention systems. She said that he had been asked to give his presentation to the CPG

because the new updates in the last reauthorization of the Ryan White Care Act would impact prevention efforts.

M. McClain showed the group a video of President Obama signing the Ryan White legislation. Afterwards, M. McClain commented on the speech the president gave before the signing, noting that he had used the word “gay,” envisioned eliminating the epidemic, discussed the national HIV/AIDS strategy, and spoke about stigma, which had been unprecedented in presidential discussions on HIV/AIDS. He also said that, while the budget called for a three-year freeze on discretionary spending, the president’s ideas on the national strategy for the disease would require some money. As a result, he said it would be interesting to see what the plan would specifically include when it was announced on February 1st. He then took a moment to explain the accompanying handouts – *Introduction to the Ryan White HIV/AIDS Treatment Extension Act of 2009* and *Public Law 111-87* – before beginning his presentation (see handouts for more information).

D. Lienau asked whether there were any previous reports on MAI (the Minority AIDS Initiative). M. McClain replied negatively but said that the upcoming examination would be comprehensive because the GAO (Government Accountability Office) was required to report to congress on MAI activities across departmental agencies. He noted that their report was due by October 30th, 2010.

R. Hayward asked how major cities, such as Philadelphia, should respond to the fact that positive individuals in rural areas were likely to move to urban centers in order to receive better care services. M. McClain replied that organizing focus groups or other studies to better understand migration patterns would be an important part of cities’ responses. However, he stressed the need to start the discussions early. He also said that arguments could be made to HRSA concerning the needs of cities near TGAs (Transitional Grant Areas) for better resources. However, he noted that reports on budget cycles would be required to support such arguments. R. Hayward pointed out that, since the disease was now more of a chronic illness than a fatal disease, more funding was already required by EMAs (Eligible Metropolitan Areas). M. McClain agreed and told the group that they needed to be diligent in their efforts to request more funding.

M. White asked why developments in lifting the syringe-exchange ban had taken so long when, during the Clinton presidency, it had been demonstrated that syringe-exchange programs did not encourage drug use. M. McClain replied that politics were to blame for the delay in lifting the ban. D. Acero asked whether any of the laws that criminalized people with HIV/AIDS were going to be revised, such as those that allowed for the arrest of positive individuals who spit in public. M. McClain replied that many of the laws that criminalized a positive serostatus were locally derived and would not be affected by changes in the new federal strategy. However, he said that, in light of some of the other changes, such as the lifted travel ban and the fact the US was about to host the International AIDS Conference for the first time, local changes were possible in the near future as well. He then brought his presentation to a close by thanking the members of the CPG for all of their work and encouraged them to reinstate the YRT, as C. Collins had proposed in his report.

Review Committee and Workgroup Reports

C. Collins took a moment to read the *CPG Subcommittees Report* for the month of January (see handout for more information).

Report of Staff

None

Old Business

R. Feely reminded the group that the Monitoring Committee had decided that the two community seats at UCHAPS meetings should be filled by one of the CPG's Community Co-Chairs and one staff person from the OHP. As a result, he asked why two governmental Co-Chairs and only one community Co-Chair would be attending the next meeting, as D. Acosta had mentioned in his report. D. Acosta replied that his travel to UCHAPS meetings was paid for by the CDC, which would pay for an OHP staff person to attend if no governmental representatives were able. M. Ross-Russell noted that the OHP had paid for community and staff members to attend the meetings until the city froze all funding for travel. Afterwards, she continued, UCHAPS started paying for the travel but, as a result, it was up to the coalition to decide who would attend.

New Business

None

Research Update

None

Announcements

V. Sowell announced that planning for AIDS Education Month had begun at Philadelphia FIGHT. She said that anyone who was interested in participating should contact her.

Adjournment

The meeting was adjourned by general consensus at 4:01 pm.

Respectfully submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*December 16th, 2009*)
- Introduction to the Ryan White HIV/AIDS Treatment Extension Act of 2009
- Public Law 111-87
- CPG Subcommittees Report – January 2010
- OHP Meeting Calendar

Philadelphia Prevention Community Planning Group (CPG)

Wednesday, January 27th, 2010

2:30 – 4:30 p.m.

Call to Order

Welcome/Introductions

Approval of Agenda

Approval of Minutes (*December 16th, 2009*)

Report of Co-Chairs (5 minutes)

Presentation: (1 hour)

- **Introduction to the Ryan White HIV/AIDS Treatment Extension Act of 2009** – *Matthew McClain*

Review Committee and Workgroup Reports (5 minutes)

Report of Staff (5 minutes)

Old Business

New Business

Research Update

Announcements

Adjournment

Please contact the office at least 5 days in advance if you require special assistance

*The next meeting date of the CPG is scheduled for **Wednesday, February 24th**, from 2:30 – 4:30 p.m.*

Office of HIV Planning, 340 N. 12TH Street, Suite 203, Philadelphia, PA 19107

(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

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Guests: Henry Bennett, Jonathan Keel, Ronald Lassiter, Ronald Montgomery, Judith Peters, Melvin White, Jacquelin Whitfield

Absent: Yexsy Alicia, Robin Brennan, Kai Chandler, Tyrone McQueen, Nicole Quinn

Staff: Joseph Ellis, Monica Getahun, Nicole Johns, Debbie C. Law, Michael Milsop, Mari Ross-Russell

Call to Order/ Introductions

R. Feely called the meeting to order at 2:38 pm. Afterwards, each member of the group took a moment to introduce his or herself.

Approval of Agenda

Motion: After taking a moment to review the meeting agenda, T. Clark moved and T. Daniel seconded to approve the document. **Motion Passed:** All in favor.

Approval of Minutes (*November 18th, 2009*)

The members of the CPG spent some time reviewing a draft of the minutes from their last meeting. **Motion:** Afterwards, T. Clark moved and T. Daniel seconded to approve the draft of the minutes that was included in handouts. **Motion Passed:** All in favor.

Report of Co-Chairs

R. Feely reported that the federal ban on syringe exchanges had been lifted. As a result, he continued, the city of Philadelphia and many others were now gathering data on their local syringe exchange programs for UCHAPS, as well as for their own purposes, in order for the CDC to determine the best ways for such programs to operate.

C. Collins reported that he had attended the orientation meeting for the State CPG in November. He said that what had struck him most about the meeting was the size and dedication of the state's Youth Roundtable (YRT) group, noting that they had a waiting list for membership. Stressing the importance of youth for the future of HIV prevention, he told the CPG that, as their future Community Co-Chair, he was going to try to

reinstate the Philadelphia YRT. In closing, he reported that the State CPG orientation had also included a lengthy presentation on epidemiological data.

To start his report, D. Acosta noted that the federal government had also opted not to include a previously suggested clause for lifting the ban on syringe exchanges, which would have prevented sites from operating within a thousand feet of any location in which children could be found. He pointed out that the inclusion of the clause would have made it impossible for any syringe exchange sites to operate. Additionally, D. Acosta reported that some of the language had been changed in a new counseling and testing form to make the document more sensitive and relevant to Trans populations. He said that the changes were made after the form had been distributed at a recent meeting of executive directors in which a number of individuals cited their disapproval with the language. He said the updated form would be released soon.

Discussion Items:

- **Follow up on Draft of Prioritized Populations** – *Planning Priorities Committee*
T. Daniel informed the group that the PPC had reviewed the data supporting their draft list of prioritized populations following the issues that had arisen during their presentation on the list at the November CPG meeting. He explained that the current discussion would be used to clarify the data that had led to the committee's decisions on the items in question.

T. Daniel reminded the group that one individual had felt that the priorities for African American MSM should focus only on 20 – 29 year olds instead of all age groups because they had the highest incidence rate for the population. He then directed the group's attention to the handout entitled *Newly Diagnosed HIV among Men who Have Sex with Men (MSM)*, pointing out that the data in the handout was from 2006 – 2008 and was broken down by both age and race. He then noted that, while 20 – 29 year old African American MSM had the highest incidence rate, the population's other age groups also exhibited alarmingly high infection rates. He then stated that, because of the high infection rates across all African American MSM age groups and the fact that the infection tended to pass from older to younger populations in the MSM community, the committee had decided to maintain their original prioritization decision for MSM.

M. Castillo reported that another concern raised during the last CPG meeting had been that Southwest Philadelphia was not specifically mentioned in the committee's geographical indicators of risk for Heterosexual populations. However, she noted that Southwest Philadelphia was a part of West Philadelphia, which had been included in the geographical indicators. She then directed the group's attention to the map entitled *Newly Diagnosed HIV by Census Tract, 2008*.

M. Castillo informed the group that the PPC was also planning two presentations to provide the CPG with more information on two specific populations. Primarily, she said that, in either January or February, there would be a presentation on the current state of Partner Services. She explained that the presentation would inform the group about both the new partner services guidelines as well as the uninfected, high-risk sex partners or

syringe sharing partners of PLWH/A, who would be highly prioritized in the city's next prevention plan following CDC recommendations. Additionally, she told the group that the PPC was planning on holding a discussion on API populations. She said that, although the population had not been prioritized due to its seemingly low infection rates in Philadelphia, there was some concern that epidemiological data on APIs was incorrect because cultural issues kept them from accessing prevention services.

- **CPG Mass Emails**

M. Ross-Russell said that the staff of the OHP wanted to gather the CPG's thoughts concerning mass emails. She explained that, because the office received numerous requests for information to be distributed to the group on a variety of topics, she wanted to ensure that CPG members did not feel as though their contact information was being used improperly. T. Daniel suggested that all informative emails be sent together at the end of the week to reduce the amount of messages received by members. D. Lienau proposed posting links to additional information on a separate webpage so that CPG members would not have to receive emails that were unrelated to planning.

D. Acosta stated that, as a person who often requested emails be forwarded to the group, he tried to ensure that everything he sent was only related to planning and did not include information that members were likely to receive elsewhere. He said that it was necessary for the OHP to send out planning-related information that was relevant to the entire group and noted that, by mixing in less important information, it was more likely that something could be overlooked. C. Collins supported the statement and suggested that members develop a list serve if they wanted to distribute information that was unrelated to planning. He then requested that members not use the 'reply all' option when responding to emails from the OHP. T. Clark stated that she appreciated all of the information she received from the OHP and did not want any changes to be made.

T. Daniel stated that he believed the OHP should be able to decide which information should be forwarded to the members of the CPG. As no one contested the statement, M. Ross-Russell said that, moving forward, OHP staff would determine which requests would be forwarded to the planning body. As a result, she asked the group to be mindful of the information they requested to have forwarded.

R. Feely specifically asked the group whether they wanted information on community events to be sent to them. D. Acosta requested that only emails related to planning be sent to the group, noting that there were other methods for advertising events on the internet for those who were interested. M. Ross-Russell informed the group that the OHP's new website, which was currently being developed, would have a separate page for posting event information. C. Collins reminded the group that information on community events was also announced during meetings.

Review Committee and Workgroup Reports

C. Collins and R. Feely took a moment to read the CPG Subcommittee Report for December to the rest of the planning body (see handout for more information). J. Chapman noted that the next meeting date of the PPC was scheduled for a Monday, and

not a Wednesday, as it was listed. T. Dressel informed the group that the Nominations Committee would be reviewing applications in March for the next seating of new CPG members. She clarified that applications had to be in by mid-March in order to be included in the review.

Report of Staff

N. Johns reported that the OHP was planning a consumer empowerment training session for March 9th in order to get more PLWH/A involved in the planning process.

M. Ross-Russell reported that copies of the Executive Summary of the 2009 Epidemiological Profile were available for anyone who was interested in the document. She noted that the summary included a data CD that contained full pdf files of the 2009 Integrated Epidemiological Profile, the 2009 Comprehensive HIV/AIDS Prevention Plan, and the 2008 Integrated Resource Inventory. She said that the latest plan for the care system had just been completed and would soon be available on the OHP website.

Old Business

None

New Business

J. Peters informed the group that the new YRBS would be released in January and suggested that the Literature & Education Committee give a presentation on the document.

Research Update

A. Davis-Vogel reported that the HIV Prevention Research Division at the University of Pennsylvania was recruiting for enrollment in a number of vaccine trials. R. Feely noted that Penn was including Trans women in its study for the first time and that the university was doing a lot of work to make its process more inclusive. D. Acosta informed the group that the microbicides trial had been pulled because of poor results. A. Davis-Vogel requested that the words “poor” and “bad” not be used in reference to the results of vaccine trials because she felt that the terminology discouraged individuals from taking part in the trials. She noted that, even if the results were not what researchers had hoped for, they were not necessarily bad because they still provided information. A. Johnson asked what individuals could do to promote involvement in the trials. M. White responded that better descriptions of the trials’ processes were required to gain the interest of African Americans, who he said were still mistrusting of the medical establishment. A guest suggested better advertising of the trials’ financial incentives and benefits to the community.

D. Acosta informed the group that, following the CDC’s release of the white paper on PCSI (Program Collaboration and Service Integration), Dr. Kevin Fenton would be in Philadelphia to look at the city’s integration efforts and to give a lecture at Drexel University on January 7th.

T. Clark reported that she had recently taken part in a teleconference about the new female condom, called FC2. She said that, after being redesigned, the female condom was now 30% less expensive to produce, had no seam, and was made out of polyurethane. She told the group that a recent pilot project in New York City for the new condoms had been well received by the community. She then asked if anyone from the Health Department knew whether a similar pilot project, which would include the distribution of free condoms, was being planned for Philadelphia. J. Jenne responded that, during a recent conference call, he had learned that a similar pilot project was being planned for Philadelphia. However, he said that he had not yet learned of any developments. R. Feely asked whether the new female condom had been approved for anal sex between MSM. T. Clark responded negatively, noting that the new condoms were targeted for female heterosexuals. J. Jenne noted that a study to investigate the use of the female condom by MSM had been proposed but turned down by the CDC.

Announcements

- A. Davis announced that Health Gap was holding a holiday party and fundraiser on December 18th at Action AIDS
- T. Daniel informed the group that the University of the Arts was holding a Black men's health forum on January 9th at the Gersham YMCA.
- C. Collins announced that there would be a 3MV Christmas party on Friday, December 18th.

Adjournment

The meeting was adjourned by general consensus at 3:34 pm.

Respectfully submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*November 18th, 2009*)
- Newly Diagnosed HIV among MSM and MSM Concurrent HIV/AIDS Data
- Newly Diagnosed HIV by Census Tract 2008
- CPG Subcommittees Report – December 2009
- OHP Meeting Calendar

Introduction to the Ryan White HIV/AIDS Treatment Extension Act of 2009

Today's Presentation

- Special video presentation
- Highlights
- Topics of special interest to Philadelphia
- Questions and answers

Highlights

- Authorized for 4 years, through 2013
- Does not sunset
- 5% increases for each Part authorized
- Continues ‘hold harmless’
- Adds provisions regarding early identification of HIV+ persons
- Adds a national HIV testing goal
- Requires reports to Congress on testing

Authorizations & Appropriations

- “Authorizations” recommendations of the Committees of jurisdiction (House Commerce and Senate Health Education Labor and Pensions) when new legislation is created.
- “Appropriations” occur annually in the Appropriations Committees.
- See handout Table 1 and Table 2

- MAI year is aligned with Part A
- 5% increases applies to MAI, by Part
- GAO report to Congress in October 2010 on MAI activities across all HHS departments
- See handout Table 3

- Not an issue for Philadelphia EMA
- Risk of loss of TGA status for some, including:
 - Vineland-Millville-Bridgeton and / or
 - Middlesex-Somerset-Hunterdon
- If either or both lose TGA status, will those clients want to come to Philadelphia?

Hold Harmless

- Also known as “loss gap”
- New law continues provision that limits reductions in Part A to 95% of FY 2009, 100% of FY 2010, 2011, and 2012.
- For FY 2013, the hold harmless limit will be 92.5% of the previous fiscal year’s grant.

Early Identification

- Provision intended to increase and incentivize early identification of those infected with HIV.
- Requires Councils and grantees to develop a strategy to identify and diagnose individuals with HIV/AIDS who are unaware of their status and link them to care and treatment.
- States must also plan, and coordinate with Part A.

EIS Counts!

- Beginning with FY 2010 award, 33% of the criteria on which allocations are made will be based on demonstrated success in identifying undiagnosed individuals with HIV/AIDS, making them aware of their status, and linking them to appropriate care.

Keep Spending!

- Penalties increased from 2% to 5% of the total award for unobligated dollars remaining at the end of the year.

Test 5 Million

- Requires HHS to establish a national HIV/AIDS testing goal of 5 million annually.
- HHS must report to Congress each year on progress toward this goal.
- Includes review of all domestic HIV/AIDS programs to determine effectiveness toward the goal.

CDC Gets Tested Too

- HHS required to submit to Congress by October 2010 and each year following a report based on comprehensive review of each CDC domestic HIV/AIDS program.
- Must include funding amounts, purposes of programs, goals, effectiveness and recommendations to Congress on ways to allocate funding.

Effectiveness Measures

- Number of previously undiagnosed individuals with HIV/AIDS made aware of their status and referred into the appropriate treatment;
- Amount of funding provided for each program or activity compared to the number of undiagnosed individuals with HIV/AIDS made aware of their status;
- Each program's contribution to the national HIV/AIDS testing goal; and
- Progress made toward program or activity goals.

Emergency Responders

- Reinstates a provision dropped from the 2006 law regarding notification of possible exposure to infectious diseases, including but not limited to HIV/AIDS.
- Little to no effect on the Ryan White Program itself.

What We Didn't Get

- Medical nutrition therapy, food, and nutrition as advised by a primary care provider as a core medical service in Part A and Part B was not included.
- Medical transportation as a core medical service was not included.
- Recommendations on the Severity of Need Index implementation (from the 2006 law) were not included.

Questions

.... and thank you!



Introduction to the
**Ryan White HIV/AIDS
Treatment Extension
Act of 2009
Public Law 111-87**

Philadelphia Office of HIV Planning

Prepared by:
McClain and Associates, Inc.
413 Schuyler Road
Silver Spring, MD 20910
AIDSpolicy@aol.com
Tel 301.996.0700

January 2010

Table of Contents

1. Section-by-Section Description
2. Text of the 2009 Legislation



President Barack Obama and lawmakers applaud Jeanne White-Ginder, right, mother of Ryan White, during his remarks before signing the Ryan White HIV/AIDS Treatment Extension Act of 2009 in the Diplomatic Reception Room of the White House. October 30, 2009. (Official White House Photo by Pete Souza)

1. Summary of Ryan White HIV/AIDS Treatment Extension Act of 2009

Section 1: Short Title; References

This section establishes the “Ryan White HIV/AIDS Treatment Extension Act 2009” as the title in the Public Health Services Act (42 U.S.C. 201 at seq.).

Section 2: Reauthorization of HIV Health Care Services Program

The 2006 law included a sunset provision that would have repealed the Ryan White legislation on September 30, 2009. A Continuing Resolution extended the authorities for the program through the end of October 2009. The 2009 legislation re-establishes the provisions of the Act, retroactive to September 30, 2009. The new law was signed into law on October 30, 2009.

The new law authorizes funding for four years, beginning in FY 2010. (The community consensus had asked for three years.) While the community has asked that appropriations language for all Parts be “such sums as necessary,” Congress authorized a 5% increase for Parts A through D and Part F for all four years. Note that authorizations are recommendations not requirements to the President and Congressional appropriators. As an example, the table below compares fiscal year 2009 authorization and appropriations for FY 2009 and FY 2010.

Part	FY 2009		FY 2010		Difference in Appropriations
	Authorization	Appropriation	Authorization	Appropriations	
A	\$ 649.5	\$ 663.1	\$ 681.9	\$ 679.1	⬇️ \$ 16.0
B	\$ 1,285.2	\$ 1,223.8	\$ 1,349.4	\$ 1,253.8	⬇️ \$ 30.0
C	\$ 235.1	\$ 201.9	\$ 246.8	\$ 206.8	⬇️ \$ 4.9
D	\$ 71.8	\$ 76.8	\$ 75.4	\$ 77.7	⬇️ \$ 0.9
F: AETCs	\$ 34.7	\$ 34.4	\$ 36.5	\$ 34.8	⬇️ \$ 0.4
F: Dental	\$ 13.0	\$ 13.4	\$ 13.7	\$ 13.6	⬇️ \$ 0.2
Total	\$ 2,288.9	\$ 2,213.4	\$ 2,404	\$ 2,265.9	⬇️ \$52.5

Table 2 shows the authorization amounts for fiscal years 2010 through 2013.

Table 2. Ryan White Program Authorizations 2010 to 2013 (\$ in millions)				
Part	FY 2010	FY 2011	FY 2012	FY 2013
A	\$ 681.9	\$ 716.0	\$ 751.8	\$ 789.4
B	\$ 1,349.4	\$ 1,416.9	\$ 1,487.7	\$ 1,562.1
C	\$ 246.8	\$ 259.1	\$ 272.1	\$ 285.7
D	\$ 75.4	\$ 79.1	\$ 83.1	\$ 87.2
F: AETCs	\$ 36.5	\$ 38.2	\$ 40.1	\$ 42.1
F: Dental	\$ 13.6	\$ 14.3	\$ 15.0	\$ 15.8
F: MAI	\$ 146.0	\$ 153.3	\$ 161.0	\$ 169.0
Total	\$ 2,550.1	\$ 2,676.9	\$ 2,810.0	\$ 2,951.3

The 2009 legislation also increases authorizations for the Minority AIDS Initiative by 5% annually. MAI funding reverts from competitive funding in Part A and Part B to formula funding, and will require the Government Accountability Office (GAO) to report to Congress no later than October 30, 2010 on Minority AIDS Initiative activities across departmental agencies (CDC, HRSA, SAMHSA, etc.), including a description of best practices in community outreach and capacity-building of community based organizations serving communities that are disproportionately affected by HIV/AIDS. It also requires the U.S. Department of Health and Human Services to prepare a plan for the use of Minority AIDS Initiative funds for capacity-building, taking into consideration the GAO report. The new legislation's MAI authorizations are shown below, by Part.

Table 2. Minority AIDS Initiative Authorizations 2010 to 2013 (\$ in millions)				
Part	FY 2010	FY 2011	FY 2012	FY 2013
A	\$ 46.7	\$ 49.0	\$ 51.5	\$ 54.1
B	\$ 8.7	\$ 9.2	\$ 9.6	\$ 10.1
C	\$ 61.3	\$ 64.4	\$ 67.6	\$ 71.0
D	\$ 20.4	\$ 21.4	\$ 22.5	\$ 23.6
F: AETCs	\$ 8.7	\$ 9.2	\$ 9.6	\$ 10.1
Total	\$ 146.0	\$ 153.3	\$ 161.0	\$ 169.0

Beginning in 2010, the new law synchronizes the schedule of application submissions and funding availability for MAI awards. For example, the Part A formula, supplemental, and MAI applications and program years will be on the same schedule. Part A and MAI years will begin on March 1.

Section 3: Extended Exemption Period for Names-Based Reporting

Under the 2006 law, the amount of funding that metropolitan areas and states received was based on formulas that reflect the number of people infected with HIV, as well as those already diagnosed with AIDS. Most states initially collected surveillance data on HIV under a code-based system, which excluded any identifying information for individuals. In the late 1990s, CDC recommended that all states switch to a name-based system, which decreases duplication and creates a more accurate count. Some states have been collecting name-based data for longer periods, but others had to change state laws and regulations to change their systems.

Today, every state collects name-based HIV data to some degree, which is reported to CDC on an annual basis. However, because state systems evolved at different rates, there is substantial variation in the maturity of their name-based HIV reporting systems and the extent to which they fully reflect the current epidemic in each state. Seven states, including California, Hawaii, Illinois, Maryland, Massachusetts, Oregon, and Rhode Island, and the District of Columbia, do not yet have fully mature names-based HIV surveillance systems.

Under the 2006 reauthorization, states were allowed to continue to submit code-based HIV data directly to HRSA, but they receive a 5% penalty to account for potential duplication. States reporting code-based data were also subject to a 5% cap on increases in case count. Once the Secretary of Health and Human Services, after consulting with the state's chief official, certified that the state's name-based data was accurate and reliable, the state switched to exclusive name-based reporting.

The 2009 legislation maintains these same provisions for states and jurisdictions with maturing names-based HIV case data during the first two years of the reauthorization period. Jurisdictions that report code-based data to HRSA will continue to incur a 5% penalty against their count of living cases of HIV and will still be subject to a 5% cap on increases in the HIV case count. In 2012, the 5% penalty will be increased to 6%. Beginning in FY2013, code-based protections will be eliminated and all States will be required to report cases using a names-based system.

Section 4: Extension of Transitional Grant Area Status

The 2006 reauthorization divided Part A funding into two separate categories—Emerging Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). EMAs were defined as areas with at least 50,000 people and at least 2,000 AIDS cases reported in the prior five years. TGAs were jurisdictions with at least 1,000 but fewer than 2,000 cumulative AIDS cases during the prior five calendar years.

An EMA retained its status until it (a) fails for 3 years to have at least 2,000 cases of AIDS during the most recent 5 calendar years and (b) fails for 3 years to have 3,000 or more living cases of AIDS as of December 31 of the most recent calendar year.

A TGA retained its status until it (a) fails for 3 years to have at least 1,000 but fewer than 2,000 cases of AIDS during the most recent 5 calendar years and (b) fails for 3 years to have 1,500 or more living cases of AIDS as of December 31 of the most recent calendar year. HRSA identified 6 TGAs that potentially will lose their eligibility in fiscal year 2011 based on decreasing number of AIDS cases: Santa Rosa, California; Vineland-Millville-Bridgeton, New Jersey; Ponce, Puerto Rico; Caguas, Puerto Rico, Middlesex-Somerset-Hunterdon, New Jersey; and Dutchess County, New York.

When a TGA fails for three consecutive years to meet the criteria for eligibility, both its formula funding and an additional \$500,000 is reallocated to Part B and redistributed among states based on need. While EMA and TGA eligibility are based on AIDS cases alone, the actual award amounts they received were based on both HIV and AIDS cases.

The new legislation extends current rules for TGA status. It adds a provision that if a metropolitan area has between 1,400-1,500 cumulative living AIDS cases and does not have more than 5% of its total grants unobligated for the prior fiscal year, it will be treated as having met the criteria for continued eligibility as a TGA.

The legislation also modifies the transfer of amounts from TGAs that lose their eligibility during the reauthorization period. As was previously the case, when a TGA loses its status, \$500,000 will be transferred to the overall Part B pool for states. However, given the economic conditions of many states, and the desire to maintain stability for people living with HIV/AIDS, the state in which the TGA resides will retain 75% of the TGA formula funding in the first year after the TGA loses eligibility, 50% in the second, and 25% in the third. By the fourth year, all of the former TGAs funding will go to the overall Part B pool.

Section 5: Hold Harmless

In the 2006 legislation, Parts A and B received both formula funding and supplemental funding. Formula funding, as described above, was distributed based on HIV and AIDS cases in the area. Under Part A, two-thirds of funds were distributed based on a formula and one-third of funds were supplemental. Supplemental funding was awarded on a competitive basis.

Under Part B, the proportion of funds that were supplemental could vary annually. The Part B supplemental pool would come from one-third of money appropriated above the fiscal year 2006 amount; from cancelled and returned unobligated funding; and from grant funds taken out of awards for grantees as a penalty for unobligated balances.

Large shifts in funding from one year to the next can be destabilizing and lead to weakened systems of care for Ryan White patients. Under the 2006 law, a “hold harmless” provision protected both EMAs and states from larger decreases in formula funding. Formula awards for a jurisdiction’s grant in fiscal year 2007 could not be less than 95% of funding for fiscal year 2006, and funding for fiscal years 2008 and 2009 could be no less than 100% of fiscal year 2007.

The new legislation continues the hold harmless at a rate of 95% of fiscal year 2009 funding in 2010 and 100% of fiscal year 2010 funding for each of the fiscal years 2011 and 2012. For fiscal year 2013, the amount will be 92.5% of the previous fiscal year’s grant. This hold harmless will continue to apply to both Part A and Part B grants.

This section of the new law also makes four technical corrections, for example:

(3) in sections 2622(a) and 2623(b)(2)(A), by striking “2618(a)(2)(G)” and inserting “2618(a)(2)(F)”

Section 6: Amendments to the General Grant Provisions (new section)

In the new legislation provisions are included to increase and incentivize early identification of those infected with HIV. This section requires the planning councils for Part A grant recipients to develop a strategy, in coordination with other appropriate community strategies or activities, to identify and diagnose individuals with HIV/AIDS who are unaware of their status and link them with the appropriate care and treatment.

For the purposes of allocating competitive grants under Part A supplemental grant funding, one-third of the criteria on which allocations are made will be based on demonstrated success in identifying undiagnosed individuals with HIV/AIDS, making them aware of their status, and linking them to appropriate care.

Section 7: Increase in Adjustment for Names-Based Reporting (new section)

The legislation adds an adjustment for areas that switched to names-based reporting early in 2007 and received a decrease in total funding of at least 30% from year 2006 as a result of determinations based on the new reporting system. For those jurisdictions, the Secretary shall base awards on living HIV/AIDS cases (for the most recent year confirmed) plus an increase of 3%. This adjustment will apply to Part A and Part B grants.

Section 8: Treatment of Unobligated Funds

The 2006 Act contained several provisions related to the requirement that Part A and Part B grantees obligate funds by the end of the grant year. ¹

- Formula and ADAP Base funding: If a Part A or Part B grantee had any unobligated dollars remaining at the end of the grant year, it could request a waiver to carry over the funding. If the waiver was not granted or if the funds were not spent by the end of the carryover year, the funds returned to the Secretary and became available for supplemental grants.

If a Part A or Part B grantee reported an unobligated balance that was 2% or more of the total award, certain penalties applied, whether or not the jurisdiction received a carryover waiver. For formula funds, future formula funding was reduced by the amount of the unobligated balance, beginning in the year following the report. In addition, the jurisdiction would not be eligible for supplemental funding in the year following the report.

- Supplemental funding: If a Part A or Part B grantee had unobligated supplemental funding at the end of the grant year, the funds were cancelled and returned to the Secretary for redistribution.

Because of multiple factors including state and local budget problems and hiring freezes, some Part A and Part B grantees were unable to obligate 98% of their funds by the end of the year. Nine states experienced a reduction in their fiscal year 2009 grants due to unobligated balances in fiscal year 2007.

The new legislation increases the unobligated penalty threshold from 2% of the total award to 5%. For formula funds, if the unobligated amount is over the 5% threshold, the next year's formula funding will be reduced by the amount of unobligated balance, but the reduction

¹ HRSA Policy Notice 7-9, Policy Notice – Notice 07-09 – The Unobligated Balances Provision (online at <http://hab.hrsa.gov/law/0709.htm>).

amount will not include any unobligated balance that was approved for carryover by HRSA. In addition, a jurisdiction with over 5% of its funds unobligated will not be eligible for supplemental funding in the following year.

Section 9: Applications by States (new section to the law)

The provision requires states, as part of their planning process for Ryan White funding, to establish a comprehensive strategy to identify and diagnose individuals with HIV/AIDS who are unaware of their status and link them with the appropriate care and treatment. The states will be required to incorporate data compiled by Part A grantees.

Section 10: ADAP Rebate Funds

In the 2006 law, the unobligated balances requirement addressed in Section 8 intersects with the treatment of rebate dollars under the AIDS Drug Assistance Program (ADAP). Many states purchase ADAP drugs directly from the manufacturer and receive substantial rebates in return. These rebates must be put back into the program and, as a general requirement, states must spend rebate dollars before grant dollars. However, the amount and timing of rebate dollars is unpredictable. For example, a state may have received a significant rebate amount late in the award year. Because rebates must be spent before program funds, states were in the positing of ending the year with more than the permitted threshold of unobligated program funds.

Under the new Act, if an expenditure of ADAP rebate funds would trigger a penalty or a higher penalty than would otherwise have applied, the Secretary shall deem the state's unobligated balance to be reduced by the amount of rebate funds in the proposed expenditure. The provision also specifies that any unobligated ADAP grant amounts that are returned to the Secretary shall first go to the State ADAP program and then to Part B Supplemental fund.

Section 11: Application to Primary Care Services

Part D of Ryan White provides grants to entities serving women, infants, children, and youths living with HIV/AIDS. Programs provide for outpatient medical care and offer case management, referrals, and other services to enable participation in the program, including services designed to recruit and retain youth with HIV.

The new legislation clarifies that Part D should be the payer of last resort and specifies that Part D grantees can provide care directly, or through contracts or memoranda of understanding as vehicles for Part D providers to ensure access to primary care.

Section 12: National HIV/AIDS Testing Goal (new provision)

The provision requires the Secretary to establish a national HIV/AIDS testing goal of 5 million tests through federally-supported HIV/AIDS prevention, treatment, and care programs through the Centers for Disease Control and Prevention and other federal programs.

The Secretary is required to report to Congress by January 1 of each year on the progress made toward achieving the goal. The Secretary is required to review each domestic HIV/AIDS prevention program to determine its effectiveness based on the program's contributions toward the testing goal and the program's stated purposes.

In addition, the Secretary is required to submit to Congress no later than October 30, 2010 and each year thereafter, in consultation with the Director of CDC, a report based on a comprehensive review of each of the programs and activities conducted by CDC as part of its domestic HIV/AIDS activities. The report must include funding amounts for each program, the purpose of each program or activity, goals, effectiveness, and recommendations to Congress on ways to allocate funding for domestic HIV/AIDS prevention activities and programs in order to achieve the national HIV/AIDS testing goal.

Of note, CDC must base its report on effectiveness on:

- Number of previously undiagnosed individuals with HIV/AIDS made aware of their status and referred into the appropriate treatment;
- Amount of funding provided for each program or activity compared to the number of undiagnosed individuals with HIV/AIDS made aware of their status;
- Each program's contribution to the national HIV/AIDS testing goal; and
- Progress made toward program or activity goals.

Section 13: Notification of Possible Exposure to Infectious Disease

This provision was removed in the 2006 reauthorization. In the new law, the provision is reinstated to ensure that emergency responders are notified if the provider is in contact with a victim of an emergency that has a communicable infectious disease, while preserving confidentiality requirements. The legislation makes minor changes, including permitting the Secretary to suspend the requirements in a public health emergency.

Other

While much of what the community consensus requested from Congress was included in the legislation, certain issues were not:

- Medical nutrition therapy, food, and nutrition as advised by a primary care provider as a more medical service in Part A and Part B was not included.
- Medical transportation as a core medical service was not included.
- Recommendations on the Severity of Need Index implementation (from the 2006 law) were not included.

2. Ryan White HIV/AIDS Treatment Extension Act of 2009

Public Law 111–87
111th Congress

An Act

To amend title XXVI of the Public Health Service Act to revise and extend the program for providing life-saving care for those with HIV/AIDS.

Oct. 30, 2009
[S. 1793]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES.

(a) **SHORT TITLE.**—This Act may be cited as the “Ryan White HIV/AIDS Treatment Extension Act of 2009”.

(b) **REFERENCES.**—Except as otherwise specified, whenever in this Act an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act (42 U.S.C. 201 et seq.).

SEC. 2. REAUTHORIZATION OF HIV HEALTH CARE SERVICES PROGRAM.

(a) **ELIMINATION OF SUNSET PROVISION.**—

(1) **IN GENERAL.**—The Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Public Law 109–415; 120 Stat. 2767) is amended by striking section 703.

(2) **EFFECTIVE DATE.**—Paragraph (1) shall take effect as if enacted on September 30, 2009.

(3) **CONTINGENCY PROVISIONS.**—Notwithstanding section 703 of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Public Law 109–415; 120 Stat. 2767) and section 139 of the Continuing Appropriations Resolution, 2010—

(A) the provisions of title XXVI of the Public Health Service Act (42 U.S.C. 300ff et seq.), as in effect on September 30, 2009, are hereby revived; and

(B) the amendments made by this Act to title XXVI of the Public Health Service Act (42 U.S.C. 300ff et seq.) shall apply to such title as so revived and shall take effect as if enacted on September 30, 2009.

(b) **PART A GRANTS.**—Section 2610(a) (42 U.S.C. 300ff–20(a)) is amended by striking “and \$649,500,000 for fiscal year 2009” and inserting “\$649,500,000 for fiscal year 2009, \$681,975,000 for fiscal year 2010, \$716,074,000 for fiscal year 2011, \$751,877,000 for fiscal year 2012, and \$789,471,000 for fiscal year 2013”.

(c) **PART B GRANTS.**—Section 2623(a) (42 U.S.C. 300ff–32(a)) is amended by striking “and \$1,285,200,000 for fiscal year 2009” and inserting “\$1,285,200,000 for fiscal year 2009, \$1,349,460,000 for fiscal year 2010, \$1,416,933,000 for fiscal year 2011, \$1,487,780,000 for fiscal year 2012, and \$1,562,169,000 for fiscal year 2013”.

Ryan White HIV/
AIDS Treatment
Extension Act of
2009.
42 USC 201 note.

42 USC 300ff–11
et seq and note.
42 USC 300ff–11
note.
42 USC 300ff–11
note.

Applicability.

42 USC
300ff–31b.

(d) PART C GRANTS.—Section 2655 (42 U.S.C. 300ff-55) is amended by striking “and \$235,100,000 for fiscal year 2009” and inserting “\$235,100,000 for fiscal year 2009, \$246,855,000 for fiscal year 2010, \$259,198,000 for fiscal year 2011, \$272,158,000 for fiscal year 2012, and \$285,766,000 for fiscal year 2013”.

(e) PART D GRANTS.—Section 2671(i) (42 U.S.C. 300ff-71(i)) is amended by inserting before the period at the end “, \$75,390,000 for fiscal year 2010, \$79,160,000 for fiscal year 2011, \$83,117,000 for fiscal year 2012, and \$87,273,000 for fiscal year 2013”.

(f) DEMONSTRATION AND TRAINING GRANTS UNDER PART F.—
(1) HIV/AIDS COMMUNITIES, SCHOOLS, AND CENTERS.—Section 2692(c) (42 U.S.C. 300ff-111(c)) is amended—

(A) in paragraph (1)—

(i) by striking “is authorized” and inserting “are authorized”; and

(ii) by inserting before the period at the end “, \$36,535,000 for fiscal year 2010, \$38,257,000 for fiscal year 2011, \$40,170,000 for fiscal year 2012, and \$42,178,000 for fiscal year 2013”; and

(B) in paragraph (2)—

(i) by striking “is authorized” and inserting “are authorized”; and

(ii) by inserting before the period at the end “, \$13,650,000 for fiscal year 2010, \$14,333,000 for fiscal year 2011, \$15,049,000 for fiscal year 2012, and \$15,802,000 for fiscal year 2013”.

(2) MINORITY AIDS INITIATIVE.—Section 2693 (42 U.S.C. 300ff-121) is amended—

(A) in subsection (a), by striking “and \$139,100,000 for fiscal year 2009.” and inserting “\$139,100,000 for fiscal year 2009, \$146,055,000 for fiscal year 2010, \$153,358,000 for fiscal year 2011, \$161,026,000 for fiscal year 2012, and \$169,077,000 for fiscal year 2013. The Secretary shall develop a formula for the awarding of grants under subsections (b)(1)(A) and (b)(1)(B) that ensures that funding is provided based on the distribution of populations disproportionately impacted by HIV/AIDS.”;

(B) in subsection (b)(2)—

(i) in subparagraph (A)—

(I) in the matter preceding clause (i), by striking “competitive,”; and

(II) by adding at the end the following:

“(iv) For fiscal year 2010, \$46,738,000.

“(v) For fiscal year 2011, \$49,075,000.

“(vi) For fiscal year 2012, \$51,528,000.

“(vii) For fiscal year 2013, \$54,105,000.”;

(ii) in subparagraph (B)—

(I) in the matter preceding clause (i), by striking “competitive”; and

(II) by adding at the end the following:

“(iv) For fiscal year 2010, \$8,763,000.

“(v) For fiscal year 2011, \$9,202,000.

“(vi) For fiscal year 2012, \$9,662,000.

“(vii) For fiscal year 2013, \$10,145,000.”;

(iii) in subparagraph (C), by adding at the end the following:

“(iv) For fiscal year 2010, \$61,343,000.

Grants.

“(v) For fiscal year 2011, \$64,410,000.

“(vi) For fiscal year 2012, \$67,631,000.

“(vii) For fiscal year 2013, \$71,012,000.”;

(iv) in subparagraph (D), by striking “\$18,500,000” and all that follows through the period and inserting the following: “the following, as applicable:

“(i) For fiscal year 2010, \$20,448,000.

“(ii) For fiscal year 2011, \$21,470,000.

“(iii) For fiscal year 2012, \$22,543,000.

“(iv) For fiscal year 2013, \$23,671,000.”; and

(v) in subparagraph (E), by striking “\$8,500,000” and all that follows through the period and inserting the following: “the following, as applicable:

“(i) For fiscal year 2010, \$8,763,000.

“(ii) For fiscal year 2011, \$9,201,000.

“(iii) For fiscal year 2012, \$9,662,000.

“(iv) For fiscal year 2013, \$10,144,000.”; and

(C) by adding at the end the following:

“(d) **SYNCHRONIZATION OF MINORITY AIDS INITIATIVE.**—For fiscal year 2010 and each subsequent fiscal year, the Secretary shall incorporate and synchronize the schedule of application submissions and funding availability under this section with the schedule of application submissions and funding availability under the corresponding provisions of this title XXVI as follows:

“(1) The schedule for carrying out subsection (b)(1)(A) shall be the same as the schedule applicable to emergency assistance under part A.

“(2) The schedule for carrying out subsection (b)(1)(B) shall be the same as the schedule applicable to care grants under part B.

“(3) The schedule for carrying out subsection (b)(1)(C) shall be the same as the schedule applicable to grants for early intervention services under part C.

“(4) The schedule for carrying out subsection (b)(1)(D) shall be the same as the schedule applicable to grants for services through projects for HIV-related care under part D.

“(5) The schedule for carrying out subsection (b)(1)(E) shall be the same as the schedule applicable to grants and contracts for activities through education and training centers under section 2692.”.

(3) **HHS REPORT.**—Not later than 6 months after the publication of the Government Accountability Office Report on the Minority Aids Initiative described in section 2686, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a Departmental plan for using funding under section 2693 of the Public Health Service Act (42 U.S.C. 300ff–93) in all relevant agencies to build capacity, taking into consideration the best practices included in such Report.

(g) **GAO REPORT.**—Section 2686 (42 U.S.C. 300ff–86) is amended to read as follows:

“SEC. 2686. GAO REPORT.

“The Comptroller General of the Government Accountability Office shall, not less than 1 year after the date of enactment of the Ryan White HIV/AIDS Treatment Extension Act of 2009, submit to the appropriate committees of Congress a report

describing Minority AIDS Initiative activities across the Department of Health and Human Services, including programs under this title and programs at the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and other departmental agencies. Such report shall include a history of program activities within each relevant agency and a description of activities conducted, people served and types of grantees funded, and shall collect and describe best practices in community outreach and capacity-building of community based organizations serving the communities that are disproportionately affected by HIV/AIDS.”.

SEC. 3. EXTENDED EXEMPTION PERIOD FOR NAMES-BASED REPORTING.

(a) PART A GRANTS.—Section 2603(a)(3) (42 U.S.C. 300ff–13(a)(3)) is amended—

(1) in subparagraph (C)—

(A) in clause (ii)—

(i) in the matter preceding subclause (I), by striking “2009” and inserting “2012”; and

(ii) in subclause (II), by striking “or 2009” and inserting “or a subsequent fiscal year through fiscal year 2012”;

(B) in clause (iv), by striking “2010” and inserting “2012”;

(C) in clause (v), by inserting “or a subsequent fiscal year” after “2009”;

(D) in clause (vi)(II), by inserting after “5 percent” the following: “for fiscal years before fiscal year 2012 (and 6 percent for fiscal year 2012)”;

(E) in clause (ix)(II)—

(i) by striking “2010” and inserting “2013”; and

(ii) by striking “2009” and inserting “2012”; and

(F) by adding at the end the following:

“(xi) FUTURE FISCAL YEARS.—For fiscal years beginning with fiscal year 2013, determinations under this paragraph shall be based only on living names-based cases of HIV/AIDS with respect to the area involved.”; and

(2) in subparagraph (D)—

(A) in clause (i)—

(i) in the matter preceding subclause (I), by striking “2009” and inserting “2012”; and

(ii) in subclause (II), by striking “and 2009” and inserting “through 2012”; and

(B) in clause (ii), by striking “2009” and inserting “2012”.

(b) PART B GRANTS.—Section 2618(a)(2) (42 U.S.C. 300ff–28(a)(2)) is amended—

(1) in subparagraph (D)—

(A) in clause (ii)—

(i) in the matter preceding subclause (I), by striking “2009” and inserting “2012”; and

(ii) in subclause (II), by striking “or 2009” and inserting “or a subsequent fiscal year through fiscal year 2012”;

(B) in clause (iv), by striking “2010” and inserting “2012”;

(C) in clause (v), by inserting “or a subsequent fiscal year” after “2009”;

(D) in clause (vi)(II), by inserting after “5 percent” the following: “for fiscal years before fiscal year 2012 (and 6 percent for fiscal year 2012)”;

(E) in clause (viii)(II)—

(i) by striking “2010” and inserting “2013”; and

(ii) by striking “2009” and inserting “2012”; and

(F) by adding at the end the following:

“(x) FUTURE FISCAL YEARS.—For fiscal years beginning with fiscal year 2013, determinations under this paragraph shall be based only on living names-based cases of HIV/AIDS with respect to the State involved.”; and

(2) in subparagraph (E), by striking “2009” each place it appears and inserting “2012”.

SEC. 4. EXTENSION OF TRANSITIONAL GRANT AREA STATUS.

(a) ELIGIBILITY.—Section 2609 (42 U.S.C. 300ff–19) is amended—

(1) in subsection (c)(1)—

(A) in the heading, by striking “2007” and inserting “2011”; and

(B) by striking “2007” each place it appears and inserting “2011”; and

(C) by striking “2006” and inserting “2010”;

(2) in subsection (c)(2)—

(A) in subparagraph (A)(ii), by striking “to have a” and inserting “subject to subparagraphs (B) and (C), to have a”;

(B) by redesignating subparagraph (B) as subparagraph (C);

(C) by inserting after subparagraph (A) the following:

“(B) PERMITTING MARGIN OF ERROR APPLICABLE TO CERTAIN METROPOLITAN AREAS.—In applying subparagraph (A)(ii) for a fiscal year after fiscal year 2008, in the case of a metropolitan area that has a cumulative total of at least 1,400 (and fewer than 1,500) living cases of AIDS as of December 31 of the most recent calendar year for which such data is available, such area shall be treated as having met the criteria of such subparagraph if not more than 5 percent of the total from grants awarded to such area under this part is unobligated as of the end of the most recent fiscal year for which such data is available.”; and

(D) in subparagraph (C), as so redesignated, by striking “Subparagraph (A) does not apply” and inserting “Subparagraphs (A) and (B) do not apply”; and

(3) in subsection (d)(1)(B), strike “2009” and insert “2013”.

(b) TRANSFER OF AMOUNTS DUE TO CHANGE IN STATUS AS TRANSITIONAL AREA.—Subparagraph (B) of section 2610(c)(2) (42 U.S.C. 300ff–20(c)(2)) is amended—

(1) by striking “(B)” and inserting “(B)(i) subject to clause (ii),”;

(2) by striking the period at the end and inserting “; and”;
and

(3) by adding at the end the following:

“(ii) for each of fiscal years 2010 through 2013, notwithstanding subsection (a)—

“(I) there shall be transferred to the State containing the metropolitan area, for purposes described in section 2612(a), an amount (which shall not be taken into account in applying section 2618(a)(2)(H)) equal to—

“(aa) for the first fiscal year of the metropolitan area not being a transitional area, 75 percent of the amount described in subparagraph (A)(i) for such area;

“(bb) for the second fiscal year of the metropolitan area not being a transitional area, 50 percent of such amount; and

“(cc) for the third fiscal year of the metropolitan area not being a transitional area, 25 percent of such amount; and

“(II) there shall be transferred and made available for grants pursuant to section 2618(a)(1) for the fiscal year, in addition to amounts available for such grants under section 2623, an amount equal to the total amount of the reduction for such fiscal year under subparagraph (A), less the amount transferred for such fiscal year under subclause (I).”.

SEC. 5. HOLD HARMLESS.

(a) PART A GRANTS.—Section 2603(a)(4) (42 U.S.C. 300ff–13(a)(4)) is amended—

(1) in the matter preceding clause (i) in subparagraph (A)—

(A) by striking “2006” and inserting “2009”; and

(B) by striking “2007 through 2009” and inserting “2010 through 2013”;

(2) by striking clauses (i) and (ii) in subparagraph (A) and inserting the following:

“(i) For fiscal year 2010, an amount equal to 95 percent of the sum of the amount of the grant made pursuant to paragraph (3) and this paragraph for fiscal year 2009.

“(ii) For each of the fiscal years 2011 and 2012, an amount equal to 100 percent of the amount of the grant made pursuant to paragraph (3) and this paragraph for fiscal year 2010.

“(iii) For fiscal year 2013, an amount equal to 92.5 percent of the amount of the grant made pursuant to paragraph (3) and this paragraph for fiscal year 2012.”; and

(3) in subparagraph (C), by striking “2009” and inserting “2013”.

(b) PART B GRANTS.—Section 2618(a)(2)(H) (42 U.S.C. 300ff–28(a)(2)(H)) is amended—

(1) in clause (i)(I)—

(A) by striking “2007” and inserting “2010”; and

(B) by striking “2006” and inserting “2009”;

(2) by striking clause (ii) and redesignating clause (iii) as clause (ii);

(3) in clause (ii), as so redesignated—

(A) in the heading, by striking “2008 AND 2009” and inserting “2011 AND 2012”;

(B) by striking “2008 and 2009” and inserting “2011 and 2012”; and

(C) by striking “2007” and inserting “2010”;

(4) by inserting after clause (ii), as so redesignated, the following new clause:

“(iii) FISCAL YEAR 2013.—For fiscal year 2013, the Secretary shall ensure that the total for a State of the grant pursuant to paragraph (1) and the grant pursuant to subparagraph (F) is not less than 92.5 percent of such total for the State for fiscal year 2012.”; and

(5) in clause (v), by striking “2009” and inserting “2013”.

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

(1) in subparagraphs (A)(i) and (H) of section 2618(a)(2), by striking the term “subparagraph (G)” each place it appears and inserting “subparagraph (F)”; 42 USC 300ff–28.

(2) in sections 2620(a)(2), 2622(c)(1), and 2622(c)(4)(A), by striking “2618(a)(2)(G)(i)” and inserting “2618(a)(2)(F)(i)”; 42 USC 300ff–29a, 300ff–31a.

(3) in sections 2622(a) and 2623(b)(2)(A), by striking “2618(a)(2)(G)” and inserting “2618(a)(2)(F)”; and 42 USC 300ff–31b.

(4) in section 2622(b), by striking “2618(a)(2)(G)(ii)” and inserting “2618(a)(2)(F)(ii)”.

SEC. 6. AMENDMENTS TO THE GENERAL GRANT PROVISIONS.

(a) ADMINISTRATION AND PLANNING COUNCIL.—Section 2602(b)(4) (42 U.S.C. 300ff–12(b)(4)) is amended—

(1) in subparagraph (A), by inserting “, as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status” after “HIV/AIDS”;

(2) in subparagraph (B)—

(A) in clause (i), by striking “and” at the end after the semicolon;

(B) in clause (ii), by inserting “and” after the semicolon; and

(C) by adding at the end the following:

“(iii) individuals with HIV/AIDS who do not know their HIV status;” and

(3) in subparagraph (D)—

(A) in clause (ii), by striking “and” at the end after the semicolon;

(B) in clause (iii), by inserting “and” after the semicolon; and

(C) by adding at the end the following:

“(iv) includes a strategy, coordinated as appropriate with other community strategies and efforts, including discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of such status, and enabling such individuals to use the health and support services described in

section 2604, with particular attention to reducing barriers to routine testing and disparities in access and services among affected subpopulations and historically underserved communities;”.

(b) TYPE AND DISTRIBUTION OF GRANTS.—Section 2603(b) (42 U.S.C. 300ff–13(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (G), by striking “and” at the end after the semicolon;

(B) in subparagraph (H), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following:

“(I) demonstrates success in identifying individuals with HIV/AIDS as described in clauses (i) through (iii) of paragraph (2)(A).”; and

(2) in paragraph (2)(A), by striking the period and inserting: “, and demonstrated success in identifying individuals with HIV/AIDS who do not know their HIV status and making them aware of such status counting one-third. In making such determination, the Secretary shall consider—

“(i) the number of individuals who have been tested for HIV/AIDS;

“(ii) of those individuals described in clause (i), the number of individuals who tested for HIV/AIDS who are made aware of their status, including the number who test positive; and

“(iii) of those individuals described in clause (ii), the number who have been referred to appropriate treatment and care.”.

(c) APPLICATION.—Section 2605(b)(1) (42 U.S.C. 300ff–15(b)(1)) is amended by inserting “, including the identification of individuals with HIV/AIDS as described in clauses (i) through (iii) of section 2603(b)(2)(A)” before the semicolon at the end.

SEC. 7. INCREASE IN ADJUSTMENT FOR NAMES-BASED REPORTING.

(a) PART A GRANTS.—

(1) FORMULA GRANTS.—Section 2603(a)(3)(C)(vi) (42 U.S.C. 300ff–13(a)(3)(C)(vi)) is amended by adding at the end the following:

“(III) INCREASED ADJUSTMENT FOR CERTAIN AREAS PREVIOUSLY USING CODE-BASED REPORTING.—For purposes of this subparagraph for each of fiscal years 2010 through 2012, the Secretary shall deem the applicable number of living cases of HIV/AIDS in an area that were reported to and confirmed by the Centers for Disease Control and Prevention to be 3 percent higher than the actual number if—

“(aa) for fiscal year 2007, such area was a transitional area;

“(bb) fiscal year 2007 was the first year in which the count of living non-AIDS cases of HIV in such area, for purposes of this section, was based on a names-based reporting system; and

“(cc) the amount of funding that such area received under this part for fiscal year 2007

was less than 70 percent of the amount of funding (exclusive of funds that were identified as being for purposes of the Minority AIDS Initiative) that such area received under such part for fiscal year 2006.”.

(2) SUPPLEMENTAL GRANTS.—Section 2603(b)(2) (42 U.S.C. 300ff–13(b)(2)) is amended by adding at the end the following:

“(D) INCREASED ADJUSTMENT FOR CERTAIN AREAS PREVIOUSLY USING CODE-BASED REPORTING.—For purposes of this subsection for each of fiscal years 2010 through 2012, the Secretary shall deem the applicable number of living cases of HIV/AIDS in an area that were reported to and confirmed by the Centers for Disease Control and Prevention to be 3 percent higher than the actual number if the conditions described in items (aa) through (cc) of subsection (a)(3)(C)(vi)(III) are all satisfied.”.

(b) PART B GRANTS.—Section 2618(a)(2)(D)(vi) (42 U.S.C. 300ff–28(a)(2)(D)(vi)) is amended by adding at the end the following:

“(III) INCREASED ADJUSTMENT FOR CERTAIN STATES PREVIOUSLY USING CODE-BASED REPORTING.—For purposes of this subparagraph for each of fiscal years 2010 through 2012, the Secretary shall deem the applicable number of living cases of HIV/AIDS in a State that were reported to and confirmed by the Centers for Disease Control and Prevention to be 3 percent higher than the actual number if—

“(aa) there is an area in such State that satisfies all of the conditions described in items (aa) through (cc) of section 2603(a)(3)(C)(vi)(III); or

“(bb)(AA) fiscal year 2007 was the first year in which the count of living non-AIDS cases of HIV in such area, for purposes of this part, was based on a names-based reporting system; and

“(BB) the amount of funding that such State received under this part for fiscal year 2007 was less than 70 percent of the amount of funding that such State received under such part for fiscal year 2006.”.

SEC. 8. TREATMENT OF UNOBLIGATED FUNDS.

(a) ELIGIBILITY FOR SUPPLEMENTAL GRANTS.—Title XXVI (42 U.S.C. 300ff–11 et seq.) is amended—

(1) in section 2603(b)(1)(H) (42 U.S.C. 300ff–13(b)(1)(H)), by striking “2 percent” and inserting “5 percent”; and

(2) in section 2620(a)(2) (42 U.S.C. 300ff–29a(a)(2)), by striking “2 percent” and inserting “5 percent”.

(b) CORRESPONDING REDUCTION IN FUTURE GRANT.—

(1) IN GENERAL.—Title XXVI (42 U.S.C. 300ff–11 et seq.) is amended—

(A) in section 2603(c)(3)(D)(i) (42 U.S.C. 300ff–13(c)(3)(D)(i)), in the matter following subclause (II), by striking “2 percent” and inserting “5 percent”; and

(B) in section 2622(c)(4)(A) (42 U.S.C. 300ff–31a(c)(4)(A)), in the matter following clause (ii), by striking “2 percent” and inserting “5 percent”.

(2) AUTHORITY REGARDING ADMINISTRATION OF PROVISION.—Title XXVI (42 U.S.C. 300ff–11 et seq.) is amended—

(A) in section 2603(c) (42 U.S.C. 300ff–13(c)), by adding at the end the following:

“(4) AUTHORITY REGARDING ADMINISTRATION OF PROVISIONS.—In administering paragraphs (2) and (3) with respect to the unobligated balance of an eligible area, the Secretary may elect to reduce the amount of future grants to the area under subsection (a) or (b), as applicable, by the amount of any such unobligated balance in lieu of cancelling such amount as provided for in paragraph (2) or (3)(A). In such case, the Secretary may permit the area to use such unobligated balance for purposes of any such future grant. An amount equal to such reduction shall be available for use as additional amounts for grants pursuant to subsection (b), subject to subsection (a)(4) and section 2610(d)(2). Nothing in this paragraph shall be construed to affect the authority of the Secretary under paragraphs (2) and (3), including the authority to grant waivers under paragraph (3)(A). The reduction in future grants authorized under this paragraph shall be notwithstanding the penalty required under paragraph (3)(D) with respect to unobligated funds.”;

(B) in section 2622 (42 U.S.C. 300ff–31a), by adding at the end the following:

“(e) AUTHORITY REGARDING ADMINISTRATION OF PROVISIONS.—In administering subsections (b) and (c) with respect to the unobligated balance of a State, the Secretary may elect to reduce the amount of future grants to the State under section 2618, 2620, or 2621, as applicable, by the amount of any such unobligated balance in lieu of cancelling such amount as provided for in subsection (b) or (c)(1). In such case, the Secretary may permit the State to use such unobligated balance for purposes of any such future grant. An amount equal to such reduction shall be available for use as additional amounts for grants pursuant to section 2620, subject to section 2618(a)(2)(H). Nothing in this paragraph shall be construed to affect the authority of the Secretary under subsections (b) and (c), including the authority to grant waivers under subsection (c)(1). The reduction in future grants authorized under this subsection shall be notwithstanding the penalty required under subsection (c)(4) with respect to unobligated funds.”;

(C) in section 2603(b)(1)(H) (42 U.S.C. 300ff–13(b)(1)(H)), by striking “canceled” and inserting “canceled, offset under subsection (c)(4),”; and

(D) in section 2620(a)(2) (42 U.S.C. 300ff–29a(a)(2)), by striking “canceled” and inserting “canceled, offset under section 2622(e).”.

(c) CONSIDERATION OF WAIVER AMOUNTS IN DETERMINING UNOBLIGATED BALANCES.—

(1) PART A GRANTS.—Section 2603(c)(3)(D)(i)(I) (42 U.S.C. 300ff–14(c)(3)(D)(i)(I)) is amended by inserting after “unobligated balance” the following: “(less any amount of such balance that is the subject of a waiver of cancellation under subparagraph (A))”.

(2) PART B GRANTS.—Section 2622(c)(4)(A)(i) (42 U.S.C. 300ff–31a(c)(4)(A)(i)) is amended by inserting after “unobligated balance” the following: “(less any amount of such balance that is the subject of a waiver of cancellation under paragraph (1))”.

SEC. 9. APPLICATIONS BY STATES.

Section 2617(b) (42 U.S.C. Section 300ff–27(b)) is amended—

- (1) in paragraph (6), by striking “and” at the end;
- (2) in paragraph (7), by striking the period at the end and inserting “; and”; and
- (3) by adding at the end the following:
 - “(8) a comprehensive plan—
 - “(A) containing an identification of individuals with HIV/AIDS as described in clauses (i) through (iii) of section 2603(b)(2)(A) and the strategy required under section 2602(b)(4)(D)(iv);
 - “(B) describing the estimated number of individuals within the State with HIV/AIDS who do not know their status;
 - “(C) describing activities undertaken by the State to find the individuals described in subparagraph (A) and to make such individuals aware of their status;
 - “(D) describing the manner in which the State will provide undiagnosed individuals who are made aware of their status with access to medical treatment for their HIV/AIDS; and
 - “(E) describing efforts to remove legal barriers, including State laws and regulations, to routine testing.”.

SEC. 10. ADAP REBATE FUNDS.

(a) USE OF UNOBLIGATED FUNDS.—Section 2622(d) (42 U.S.C. 300ff–31a(d)) is amended by adding at the end the following: “If an expenditure of ADAP rebate funds would trigger a penalty under this section or a higher penalty than would otherwise have applied, the State may request that for purposes of this section, the Secretary deem the State’s unobligated balance to be reduced by the amount of rebate funds in the proposed expenditure. Notwithstanding 2618(a)(2)(F), any unobligated amount under section 2618(a)(2)(F)(ii)(V) that is returned to the Secretary for reallocation shall be used by the Secretary for—

- “(1) the ADAP supplemental program if the Secretary determines appropriate; or
- “(2) for additional amounts for grants pursuant to section 2620.”.

(b) TECHNICAL CORRECTION.—Subclause (V) of section 2618(a)(2)(F)(ii) (42 U.S.C. 300ff–28(a)(2)(F)(ii)) is amended by striking “, subject to subclause (VI)”.

SEC. 11. APPLICATION TO PRIMARY CARE SERVICES.

(a) IN GENERAL.—Section 2671 (42 U.S.C. 300ff–71), as amended, is amended—

- (1) by redesignating subsection (i) as subsection (j);
- (2) in subsection (g), by striking “subsection (i)” and inserting “subsection (j)”; and
- (3) by inserting after subsection (h) the following:

“(i) APPLICATION TO PRIMARY CARE SERVICES.—Nothing in this part shall be construed as requiring funds under this part to be

used for primary care services when payments are available for such services from other sources (including under titles XVIII, XIX, and XXI of the Social Security Act).”

(b) PROVISION OF CARE THROUGH MEMORANDUM OF UNDERSTANDING.—Section 2671(a) (42 U.S.C. 300ff-71(a)) is amended by striking “(directly or through contracts)” and inserting “(directly or through contracts or memoranda of understanding)”.

SEC. 12. NATIONAL HIV/AIDS TESTING GOAL.

Part E of title XXVI (42 U.S.C. 300ff-81 et seq.) is amended—

42 USC 300ff-88.

- (1) by redesignating section 2688 as section 2689; and
- (2) by inserting after section 2687 the following:

Deadlines.
42 USC
300ff-87a.

“SEC. 2688. NATIONAL HIV/AIDS TESTING GOAL.

“(a) IN GENERAL.—Not later than January 1, 2010, the Secretary shall establish a national HIV/AIDS testing goal of 5,000,000 tests for HIV/AIDS annually through federally-supported HIV/AIDS prevention, treatment, and care programs, including programs under this title and other programs administered by the Centers for Disease Control and Prevention.

“(b) ANNUAL REPORT.—Not later than January 1, 2011, and annually thereafter, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall submit to Congress a report describing, with regard to the preceding 12-month reporting period—

“(1) whether the testing goal described in subsection (a) has been met;

“(2) the total number of individuals tested through federally-supported and other HIV/AIDS prevention, treatment, and care programs in each State;

“(3) the number of individuals who—

“(A) prior to such 12-month period, were unaware of their HIV status; and

“(B) through federally-supported and other HIV/AIDS prevention, treatment, and care programs, were diagnosed and referred into treatment and care during such period;

“(4) any barriers, including State laws and regulations, that the Secretary determines to be a barrier to meeting the testing goal described in subsection (a);

“(5) the amount of funding the Secretary determines necessary to meet the annual testing goal in the following 12 months and the amount of Federal funding expended to meet the testing goal in the prior 12-month period; and

“(6) the most cost-effective strategies for identifying and diagnosing individuals who were unaware of their HIV status, including voluntary testing with pre-test counseling, routine screening including opt-out testing, partner counseling and referral services, and mass media campaigns.

Reports.

“(c) REVIEW OF PROGRAM EFFECTIVENESS.—Not later than 1 year after the date of enactment of this section, the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, shall submit a report to Congress based on a comprehensive review of each of the programs and activities conducted by the Centers for Disease Control and Prevention as part of the Domestic HIV/AIDS Prevention Activities, including the following:

“(1) The amount of funding provided for each program or activity.

“(2) The primary purpose of each program or activity.

“(3) The annual goals for each program or activity.

“(4) The relative effectiveness of each program or activity with relation to the other programs and activities conducted by the Centers for Disease Control and Prevention, based on the—

“(A) number of previously undiagnosed individuals with HIV/AIDS made aware of their status and referred into the appropriate treatment;

“(B) amount of funding provided for each program or activity compared to the number of undiagnosed individuals with HIV/AIDS made aware of their status;

“(C) program’s contribution to the National HIV/AIDS testing goal; and

“(D) progress made toward the goals described in paragraph (3).

“(5) Recommendations if any to Congress on ways to allocate funding for domestic HIV/AIDS prevention activities and programs in order to achieve the National HIV/AIDS testing goal.

“(d) COORDINATION WITH OTHER FEDERAL ACTIVITIES.—In pursuing the National HIV/AIDS testing goal, the Secretary, where appropriate, shall consider and coordinate with other national strategies conducted by the Federal Government to address HIV/AIDS.”.

SEC. 13. NOTIFICATION OF POSSIBLE EXPOSURE TO INFECTIOUS DISEASES.

Title XXVI (42 U.S.C. 300ff–11 et seq.) is amended by adding at the end the following:

“PART G—NOTIFICATION OF POSSIBLE EXPOSURE TO INFECTIOUS DISEASES

“SEC. 2695. INFECTIOUS DISEASES AND CIRCUMSTANCES RELEVANT TO NOTIFICATION REQUIREMENTS.

42 USC
300ff–131.

“(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this part, the Secretary shall complete the development of—

Deadline.

“(1) a list of potentially life-threatening infectious diseases, including emerging infectious diseases, to which emergency response employees may be exposed in responding to emergencies;

Records.

“(2) guidelines describing the circumstances in which such employees may be exposed to such diseases, taking into account the conditions under which emergency response is provided; and

Guidelines.

“(3) guidelines describing the manner in which medical facilities should make determinations for purposes of section 2695B(d).

Guidelines.

“(b) SPECIFICATION OF AIRBORNE INFECTIOUS DISEASES.—The list developed by the Secretary under subsection (a)(1) shall include a specification of those infectious diseases on the list that are routinely transmitted through airborne or aerosolized means.

“(c) DISSEMINATION.—The Secretary shall—

“(1) transmit to State public health officers copies of the list and guidelines developed by the Secretary under subsection

(a) with the request that the officers disseminate such copies as appropriate throughout the States; and

“(2) make such copies available to the public.

Public
information.
42 USC
300ff–132.

“SEC. 2695A. ROUTINE NOTIFICATIONS WITH RESPECT TO AIRBORNE INFECTIOUS DISEASES IN VICTIMS ASSISTED.

“(a) ROUTINE NOTIFICATION OF DESIGNATED OFFICER.—

“(1) DETERMINATION BY TREATING FACILITY.—If a victim of an emergency is transported by emergency response employees to a medical facility and the medical facility makes a determination that the victim has an airborne infectious disease, the medical facility shall notify the designated officer of the emergency response employees who transported the victim to the medical facility of the determination.

“(2) DETERMINATION BY FACILITY ASCERTAINING CAUSE OF DEATH.—If a victim of an emergency is transported by emergency response employees to a medical facility and the victim dies at or before reaching the medical facility, the medical facility ascertaining the cause of death shall notify the designated officer of the emergency response employees who transported the victim to the initial medical facility of any determination by the medical facility that the victim had an airborne infectious disease.

Deadline.

“(b) REQUIREMENT OF PROMPT NOTIFICATION.—With respect to a determination described in paragraph (1) or (2) of subsection (a), the notification required in each of such paragraphs shall be made as soon as is practicable, but not later than 48 hours after the determination is made.

42 USC
300ff–133.

“SEC. 2695B. REQUEST FOR NOTIFICATION WITH RESPECT TO VICTIMS ASSISTED.

“(a) INITIATION OF PROCESS BY EMPLOYEE.—If an emergency response employee believes that the employee may have been exposed to an infectious disease by a victim of an emergency who was transported to a medical facility as a result of the emergency, and if the employee attended, treated, assisted, or transported the victim pursuant to the emergency, then the designated officer of the employee shall, upon the request of the employee, carry out the duties described in subsection (b) regarding a determination of whether the employee may have been exposed to an infectious disease by the victim.

“(b) INITIAL DETERMINATION BY DESIGNATED OFFICER.—The duties referred to in subsection (a) are that—

“(1) the designated officer involved collect the facts relating to the circumstances under which, for purposes of subsection (a), the employee involved may have been exposed to an infectious disease; and

“(2) the designated officer evaluate such facts and make a determination of whether, if the victim involved had any infectious disease included on the list issued under paragraph (1) of section 2695(a), the employee would have been exposed to the disease under such facts, as indicated by the guidelines issued under paragraph (2) of such section.

“(c) SUBMISSION OF REQUEST TO MEDICAL FACILITY.—

“(1) IN GENERAL.—If a designated officer makes a determination under subsection (b)(2) that an emergency response employee may have been exposed to an infectious disease, the designated officer shall submit to the medical facility to which

the victim involved was transported a request for a response under subsection (d) regarding the victim of the emergency involved.

“(2) FORM OF REQUEST.—A request under paragraph (1) shall be in writing and be signed by the designated officer involved, and shall contain a statement of the facts collected pursuant to subsection (b)(1).

“(d) EVALUATION AND RESPONSE REGARDING REQUEST TO MEDICAL FACILITY.—

“(1) IN GENERAL.—If a medical facility receives a request under subsection (c), the medical facility shall evaluate the facts submitted in the request and make a determination of whether, on the basis of the medical information possessed by the facility regarding the victim involved, the emergency response employee was exposed to an infectious disease included on the list issued under paragraph (1) of section 2695(a), as indicated by the guidelines issued under paragraph (2) of such section.

“(2) NOTIFICATION OF EXPOSURE.—If a medical facility makes a determination under paragraph (1) that the emergency response employee involved has been exposed to an infectious disease, the medical facility shall, in writing, notify the designated officer who submitted the request under subsection (c) of the determination.

“(3) FINDING OF NO EXPOSURE.—If a medical facility makes a determination under paragraph (1) that the emergency response employee involved has not been exposed to an infectious disease, the medical facility shall, in writing, inform the designated officer who submitted the request under subsection (c) of the determination.

“(4) INSUFFICIENT INFORMATION.—

“(A) If a medical facility finds in evaluating facts for purposes of paragraph (1) that the facts are insufficient to make the determination described in such paragraph, the medical facility shall, in writing, inform the designated officer who submitted the request under subsection (c) of the insufficiency of the facts.

“(B)(i) If a medical facility finds in making a determination under paragraph (1) that the facility possesses no information on whether the victim involved has an infectious disease included on the list under section 2695(a), the medical facility shall, in writing, inform the designated officer who submitted the request under subsection (c) of the insufficiency of such medical information.

“(ii) If after making a response under clause (i) a medical facility determines that the victim involved has an infectious disease, the medical facility shall make the determination described in paragraph (1) and provide the applicable response specified in this subsection.

“(e) TIME FOR MAKING RESPONSE.—After receiving a request under subsection (c) (including any such request resubmitted under subsection (g)(2)), a medical facility shall make the applicable response specified in subsection (d) as soon as is practicable, but not later than 48 hours after receiving the request.

“(f) DEATH OF VICTIM OF EMERGENCY.—

“(1) FACILITY ASCERTAINING CAUSE OF DEATH.—If a victim described in subsection (a) dies at or before reaching the medical

facility involved, and the medical facility receives a request under subsection (c), the medical facility shall provide a copy of the request to the medical facility ascertaining the cause of death of the victim, if such facility is a different medical facility than the facility that received the original request.

Applicability.

“(2) RESPONSIBILITY OF FACILITY.—Upon the receipt of a copy of a request for purposes of paragraph (1), the duties otherwise established in this part regarding medical facilities shall apply to the medical facility ascertaining the cause of death of the victim in the same manner and to the same extent as such duties apply to the medical facility originally receiving the request.

“(g) ASSISTANCE OF PUBLIC HEALTH OFFICER.—

“(1) EVALUATION OF RESPONSE OF MEDICAL FACILITY REGARDING INSUFFICIENT FACTS.—

“(A) In the case of a request under subsection (c) to which a medical facility has made the response specified in subsection (d)(4)(A) regarding the insufficiency of facts, the public health officer for the community in which the medical facility is located shall evaluate the request and the response, if the designated officer involved submits such documents to the officer with the request that the officer make such an evaluation.

Deadline.

“(B) As soon as is practicable after a public health officer receives a request under subparagraph (A), but not later than 48 hours after receipt of the request, the public health officer shall complete the evaluation required in such paragraph and inform the designated officer of the results of the evaluation.

“(2) FINDINGS OF EVALUATION.—

“(A) If an evaluation under paragraph (1)(A) indicates that the facts provided to the medical facility pursuant to subsection (c) were sufficient for purposes of determinations under subsection (d)(1)—

“(i) the public health officer shall, on behalf of the designated officer involved, resubmit the request to the medical facility; and

“(ii) the medical facility shall provide to the designated officer the applicable response specified in subsection (d).

“(B) If an evaluation under paragraph (1)(A) indicates that the facts provided in the request to the medical facility were insufficient for purposes of determinations specified in subsection (c)—

“(i) the public health officer shall provide advice to the designated officer regarding the collection and description of appropriate facts; and

“(ii) if sufficient facts are obtained by the designated officer—

“(I) the public health officer shall, on behalf of the designated officer involved, resubmit the request to the medical facility; and

“(II) the medical facility shall provide to the designated officer the appropriate response under subsection (c).

“SEC. 2695C. PROCEDURES FOR NOTIFICATION OF EXPOSURE.42 USC
300ff–134.

“(a) CONTENTS OF NOTIFICATION TO OFFICER.—In making a notification required under section 2695A or section 2695B(d)(2), a medical facility shall provide—

“(1) the name of the infectious disease involved; and

“(2) the date on which the victim of the emergency involved was transported by emergency response employees to the medical facility involved.

“(b) MANNER OF NOTIFICATION.—If a notification under section 2695A or section 2695B(d)(2) is mailed or otherwise indirectly made—

“(1) the medical facility sending the notification shall, upon sending the notification, inform the designated officer to whom the notification is sent of the fact that the notification has been sent; and

“(2) such designated officer shall, not later than 10 days after being informed by the medical facility that the notification has been sent, inform such medical facility whether the designated officer has received the notification.

Deadline.

“SEC. 2695D. NOTIFICATION OF EMPLOYEE.42 USC
300ff–135.

“(a) IN GENERAL.—After receiving a notification for purposes of section 2695A or 2695B(d)(2), a designated officer of emergency response employees shall, to the extent practicable, immediately notify each of such employees who—

“(1) responded to the emergency involved; and

“(2) as indicated by guidelines developed by the Secretary, may have been exposed to an infectious disease.

“(b) CERTAIN CONTENTS OF NOTIFICATION TO EMPLOYEE.—A notification under this subsection to an emergency response employee shall inform the employee of—

“(1) the fact that the employee may have been exposed to an infectious disease and the name of the disease involved;

“(2) any action by the employee that, as indicated by guidelines developed by the Secretary, is medically appropriate; and

“(3) if medically appropriate under such criteria, the date of such emergency.

“(c) RESPONSES OTHER THAN NOTIFICATION OF EXPOSURE.—After receiving a response under paragraph (3) or (4) of subsection (d) of section 2695B, or a response under subsection (g)(1) of such section, the designated officer for the employee shall, to the extent practicable, immediately inform the employee of the response.

“SEC. 2695E. SELECTION OF DESIGNATED OFFICERS.42 USC
300ff–136.

“(a) IN GENERAL.—For the purposes of receiving notifications and responses and making requests under this part on behalf of emergency response employees, the public health officer of each State shall designate 1 official or officer of each employer of emergency response employees in the State.

“(b) PREFERENCE IN MAKING DESIGNATIONS.—In making the designations required in subsection (a), a public health officer shall give preference to individuals who are trained in the provision of health care or in the control of infectious diseases.

“SEC. 2695F. LIMITATION WITH RESPECT TO DUTIES OF MEDICAL FACILITIES.Applicability.
Time period.
42 USC
300ff–137.

“The duties established in this part for a medical facility—

“(1) shall apply only to medical information possessed by the facility during the period in which the facility is treating the victim for conditions arising from the emergency, or during the 60-day period beginning on the date on which the victim is transported by emergency response employees to the facility, whichever period expires first; and

“(2) shall not apply to any extent after the expiration of the 30-day period beginning on the expiration of the applicable period referred to in paragraph (1), except that such duties shall apply with respect to any request under section 2695B(c) received by a medical facility before the expiration of such 30-day period.

42 USC
300ff–138.

“SEC. 2695G. MISCELLANEOUS PROVISIONS.

“(a) **LIABILITY OF MEDICAL FACILITIES, DESIGNATED OFFICERS, PUBLIC HEALTH OFFICERS, AND GOVERNING ENTITIES.**—This part may not be construed to authorize any cause of action for damages or any civil penalty against any medical facility, any designated officer, any other public health officer, or any governing entity of such facility or officer for failure to comply with the duties established in this part.

“(b) **TESTING.**—This part may not, with respect to victims of emergencies, be construed to authorize or require a medical facility to test any such victim for any infectious disease.

“(c) **CONFIDENTIALITY.**—This part may not be construed to authorize or require any medical facility, any designated officer of emergency response employees, or any such employee, to disclose identifying information with respect to a victim of an emergency or with respect to an emergency response employee.

“(d) **FAILURE TO PROVIDE EMERGENCY SERVICES.**—This part may not be construed to authorize any emergency response employee to fail to respond, or to deny services, to any victim of an emergency.

“(e) **NOTIFICATION AND REPORTING DEADLINES.**—In any case in which the Secretary determines that, wholly or partially as a result of a public health emergency that has been determined pursuant to section 319(a), individuals or public or private entities are unable to comply with the requirements of this part, the Secretary may, notwithstanding any other provision of law, temporarily suspend, in whole or in part, the requirements of this part as the circumstances reasonably require. Before or promptly after such a suspension, the Secretary shall notify the Congress of such action and publish in the Federal Register a notice of the suspension.

Federal Register,
publication.
Notice.

“(f) **CONTINUED APPLICATION OF STATE AND LOCAL LAW.**—Nothing in this part shall be construed to limit the application of State or local laws that require the provision of data to public health authorities.

42 USC
300ff–139.

“SEC. 2695H. INJUNCTIONS REGARDING VIOLATION OF PROHIBITION.

“(a) **IN GENERAL.**—The Secretary may, in any court of competent jurisdiction, commence a civil action for the purpose of obtaining temporary or permanent injunctive relief with respect to any violation of this part.

Administrative
process.

“(b) **FACILITATION OF INFORMATION ON VIOLATIONS.**—The Secretary shall establish an administrative process for encouraging

emergency response employees to provide information to the Secretary regarding violations of this part. As appropriate, the Secretary shall investigate alleged such violations and seek appropriate injunctive relief.

“SEC. 2695I. APPLICABILITY OF PART.

“This part shall not apply in a State if the chief executive officer of the State certifies to the Secretary that the law of the State is substantially consistent with this part.”.

42 USC
300ff-140.

Approved October 30, 2009.

LEGISLATIVE HISTORY—S. 1793 (H.R. 3792):

HOUSE REPORTS: No. 111–305 (Comm. on Energy and Commerce) accompanying H.R. 3792.

CONGRESSIONAL RECORD, Vol. 155 (2009):

Oct. 19, considered and passed Senate.

Oct. 21, considered and passed House.

DAILY COMPILATION OF PRESIDENTIAL DOCUMENTS (2009):

Oct. 30, Presidential remarks.



CPG Subcommittees Report – January 2010

Monitoring Committee

- The Monitoring Committee did not meet in January; their next meeting date and time are TBD.

Planning Priorities Committee

- At the last PPC meeting, A. de los Reyes gave the group a preliminary version of his upcoming presentation on Partner Services so that the committee could discuss any potential revisions.
- The PPC also planned how they would undertake their upcoming process of weighting factors for prioritizing populations.
- The next meeting of the PPC is scheduled for Monday, February 22nd, from 1:00 – 3:00 pm.

The Literature & Education Committee

- At their January meeting, the Lit & Ed Committee continued with their review of interventions, making decisions on the following programs: Motivational Interviewing HIV & Partner Violence Risk Reduction, Health Improvement Project (HIP), VOICES/VOCES, and Doing Something Different.
- Their next meeting will be held on Wednesday, February 24th, from 12:00 – 2:00 pm.

CPG Nominations Committee

- The Nominations Committee did not meet in January; their next meeting is scheduled for Wednesday, February 17th, from 1:00 – 3:00 pm.

The Points of Integration Workgroup

- The Points of Integration Workgroup did not meet in January; their next meeting is scheduled for Wednesday, February 3rd, from 12:30 – 2:30 pm.

The Positive Committee

- In January, the Positive Committee discussed activities for the year and received a skills building training about how to understand and analyze local epidemiological data.
- In February, the committee will begin discussions about what works and doesn't work in prevention services. Each month the group will discuss the needs, challenges, and experiences of different high risk populations. These discussions will be forwarded to the CPG to be considered in the prioritization process.
- The next meeting of the Positive Committee is scheduled for Monday, February 8th, from 12:00 – 2:00 pm.