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112TH CONGRESS
2D SESSION

H. R. 6138

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

IN THE HOUSE OF REPRESENTATIVES

JULY 18, 2012

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

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A BILL

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

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Ending the HIV/AIDS Epidemic Act of 2012''.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

SEC. 3. STATEMENT OF POLICY.

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

(1) expand access to lifesaving antiretroviral therapy for people living with HIV/AIDS and immediately link people to continuous and coordinated high-quality care when they learn they are infected with HIV;

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

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

(4) accelerate research for more efficacious HIV prevention and treatments tools, a cure, and a vaccine; and

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

SEC. 4. FINDINGS.

The Congress makes the following findings:

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

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

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

(4) One in five individuals living with HIV/AIDS in the United States is unaware of being infected, and significant disparities persist across different communities and populations with regard to incidence of infection, access to treatment, and health outcomes.

(5) Each year, 50,000 people become newly infected with HIV in the United States.

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

(7) In 1998, Congress created the National Minority AIDS Initiative to provide technical assistance, build capacity, and strengthen outreach efforts among local institutions and community-based organizations that serve racial and ethnic minorities living with or vulnerable to HIV/AIDS.

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

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

(9) In 2009, the Ryan White HIV/AIDS Treatment Extension Act of 2009 was enacted into law, reauthorizing Federal HIV/AIDS care and treatment programs for 4 years and making funding available to United States metropolitan areas, States, and service providers to assist affected families and persons living with HIV/AIDS with health care and support services.

(10) To combat the HIV epidemic in the United States, the National HIV/AIDS Strategy (NHAS) from the White House Office of National AIDS Policy provides a framework of increasing access to care, reducing new infections, and eliminating HIV-related health disparities. The vision of NHAS is: ''The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socioeconomic circumstance, will have unfettered access to high quality, life extending care, free from stigma and discrimination.''.

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

treatment through the AIDS Drug Assistance Program authorized by the provisions popularly known as the Ryan White CARE Act.

(12) The Centers for Disease Control and Prevention has determined that increasing the proportion of people who know their HIV status is an essential component of comprehensive HIV/AIDS treatment and prevention efforts and that early diagnosis is critical in order for people with HIV/AIDS to receive life-extending therapy. Additionally, the Centers for Disease Control and Prevention recommends recommend routine HIV screening in health care settings for all patients aged 13 to 64, regardless of risk.

(13) Advances in HIV diagnostic technology (such as rapid HIV testing and, recently, the availability of over-the-counter HIV tests) reduce barriers to testing and allow more people to know their status.

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

(15) Requiring health plans to cover routine HIV screening as a preventive health service without imposing cost sharing requirements could play a critical role in preventing the spread of HIV and allowing infected individuals to receive effective treatment.

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

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

(18) HIV prevalence among young people aged 15 to 24 has declined in many countries most impacted by HIV; nevertheless, young people still account for 42 percent of all new infections among individuals aged 15 and older.

(19) A substantial number of HIV-positive women in HIV care and treatment programs or prevention of mother-to-child transmission (PMTCT) programs experience an unplanned pregnancy.

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

(21) In 2008, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act was enacted into law, reauthorizing the President's Emergency Plan for AIDS Relief (PEPFAR) and continued United States participation and contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

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

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

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

(25) In most countries HIV is a disease that discriminates, disproportionately affecting society's most vulnerable. Even in generalized epidemics in which a significant share of the wider population is living with HIV/AIDS, people in vulnerable communities often have considerably higher rates of HIV infection.

(26) Reaching men who have sex with men, transgender people, people who inject drugs, sex workers, and other vulnerable populations with effective HIV prevention and treatment is critical to bringing the AIDS epidemic under control.

(27) According to the Centers for Disease Control and Prevention, approximately one-third of persons with HIV are co-infected with hepatitis B virus (HBV) or hepatitis C virus (HCV). About 80 percent of injection drug users with HIV infection also have HCV. HIV co-infection more than triples the

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

(28) The Global Commission on HIV and the Law was launched in June 2010 to examine laws and practices that criminalize people living with and vulnerable to HIV and to develop evidence-based recommendations for effective HIV responses that promote and protect human rights.

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

(30) The District of Columbia, the site of the XIX International AIDS Conference, has an HIV prevalence rate of over 2.7 percent, which far exceeds the threshold that constitutes a ''generalized and severe'' epidemic, and is comparable to the rate in many parts of the developing world.

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

tion, building consensus to improve service delivery and maximize outcomes, facilitating global civil society engagement, and accelerating momentum toward a cure.

(32) At present, 34 States and 2 United States territories have criminal statutes based on ''exposure'' to HIV. Most of these laws were adopted before the availability of effective antiretroviral treatment for HIV/AIDS.

(33) Although HIV/AIDS currently is viewed as a chronic, treatable medical condition, people living with HIV in the United States have been charged under aggravated assault, attempted murder, and even bioterrorism statutes because prosecutors, courts, and legislators continue to view and characterize the blood, semen, and saliva of people living with HIV as a ''deadly weapon''.

(34) The National Alliance of State and Territorial AIDS Directors released a statement in February 2011 saying that ''HIV criminalization undercuts our most basic HIV prevention and sexual health messages, and breeds ignorance, fear and discrimination against people living with HIV''. NASTAD further ''supports efforts to examine and support level-headed, proven public health ap-

proaches that end punitive laws that single out HIV over other STDs and that impose penalties for alleged nondisclosure, exposure and transmission that are severely disproportionate to the actual resulting harm''.

(35) In 2010, the President released a National HIV/AIDS Strategy (NHAS), which addressed HIV-specific criminal laws, stating: ''[W]hile we understand the intent behind [these] laws, they may not have the desired effect and they may make people less willing to disclose their status by making people feel at even greater risk of discrimination. In some cases, it may be appropriate for legislators to reconsider whether existing laws continue to further the public interest and public health. In many instances, the continued existence and enforcement of these types of laws run counter to scientific evidence about routes of HIV transmission and may undermine the public health goals of promoting HIV screening and treatment.''.

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

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

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

(38) According to the Centers for Disease Control and Prevention (CDC), latex condoms, when used consistently and correctly, are highly effective in preventing the transmission of HIV. Latex condoms also reduce the risk of other STIs. Despite the effectiveness of condoms in reducing the spread

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

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

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

(41) Incarcerated individuals living with HIV/AIDS who are eligible for Medicaid would benefit from prompt and automatic enrollment upon their release in order to ensure their continued ability to access health services, including antiretroviral treatment.

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

to effective treatment, but also increases the likelihood of engaging in risky behaviors leading to HIV infection. Insecure housing puts people with HIV/AIDS at risk of premature death from exposure to other diseases, poor nutrition, stress, and lack of medical care.

(43) On July 16, 2012, the Food and Drug Administration approved Truvada (emtricitabine/tenofovir disoproxil fumarate), the first drug approved to reduce the risk of HIV infection in uninfected individuals who are at high risk of HIV infection and who may engage in sexual activity with HIV-infected partners.

SEC. 5. NONDISCRIMINATION.

Programs funded under this Act shall not discriminate on the basis of actual or perceived sex, race, color, ethnicity, national origin, disability, sexual orientation, gender identity, or religion. Nothing in this Act shall be construed to invalidate or limit rights, remedies, procedures, or legal standards available to victims of discrimination under any other Federal law or any law of a State or a political subdivision of a State, including title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of

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

DIVISION A—ENDING HIV/AIDS IN THE UNITED STATES

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

SEC. 101. ADDITIONAL FUNDING FOR AIDS DRUG ASSISTANCE PROGRAM TREATMENTS.

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

''(c) ADDITIONAL FUNDING FOR AIDS DRUG ASSISTANCE PROGRAM TREATMENTS.—In addition to amounts otherwise authorized to be appropriated for carrying out this subpart, there are authorized to be appropriated such sums as may be necessary to carry out sections 2612(b)(3)(B) and 2616 for each of fiscal years 2013 through 2015.''.

SEC. 102. ENHANCING THE NATIONAL HIV SURVEILLANCE SYSTEM.

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

(1) providing technical assistance and policy guidance to State and local health departments, clinical providers, and other agencies serving individuals with HIV to improve the interoperability of data systems relevant to monitoring HIV care and supportive services;

(2) capturing longitudinal data pertaining to the initiation and ongoing prescription or dispensing of antiretroviral therapy for individuals diagnosed with HIV (such as through pharmacy-based reporting);

(3) obtaining information—

(A) on a voluntary basis, on sexual orientation and gender identity; and

(B) on sources of coverage (or the lack thereof) for medical treatment (including coverage through Medicaid, Medicare, the program

under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.; commonly referred to as the ''Ryan White HIV/AIDS Program''), other public funding, private insurance, and health maintenance organizations); and

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

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

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

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

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

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

SEC. 103. EVIDENCE-BASED STRATEGIES FOR IMPROVING LINKAGE TO AND RETENTION IN APPROPRIATE CARE.

(a) STRATEGIES.—The Secretary of Health and Human Services, in collaboration with the Director of the Centers for Disease Control and Prevention, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the Office of AIDS Research, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare & Medicaid Services, shall—

(1) identify evidence-based strategies most effective at addressing the multifaceted issues that impede disease status awareness and linkage to and retention in appropriate care, taking into consideration health care systems issues, clinic and provider issues, and individual psycho-social, environmental, and other contextual factors;

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

(3) not later than 12 months after the date of the enactment of this Act, submit a report to the Congress on the status of activities under paragraphs (1) and (2).

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

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

(a) SENSE OF CONGRESS.—It is the sense of the Congress that AIDS research has led to scientific advancements that have—

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

(2) prevented millions of people from being infected; and

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

(b) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the National Institutes of Health, shall expand, intensify, and coordinate operational and translational research and other activities of the National Institutes of Health regarding methods—

(1) to increase adoption of evidence-based adherence strategies within HIV care and treatment programs;

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

(3) to reduce HIV-related health disparities;

(4) to ensure that research to improve adherence to HIV care and treatment programs address the unique concerns of women;

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

(6) to increase knowledge on the implementation of pre-exposure prophylaxis (PrEP), including with respect to—

(A) who can benefit most from PrEP;

(B) how to provide PrEP safely and efficiently;

(C) how to integrate PrEP with other essential prevention methods such as condoms; and

(D) how to ensure high levels of adherence.

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

SEC. 105. HEALTH CARE PROFESSIONALS TREATING INDIVIDUALS WITH HIV/AIDS.

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

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

(1) Development of curricula for training primary care providers in HIV/AIDS prevention and care, including routine HIV testing.

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

(3) Training health care professionals to provide care to individuals with HIV/AIDS.

(4) Development by grant recipients under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.; commonly referred to as the Ryan White HIV/AIDS Program) and other persons, of policies for providing culturally relevant and sensitive treatment to individuals with HIV/AIDS, with particular emphasis on treatment to racial and ethnic minorities, men who have sex with men, and women, young people, and children with HIV/AIDS.

(5) Development and implementation of programs to increase the use of telehealth to respond to

HIV/AIDS-specific health care needs in rural and minority communities, with particular emphasis given to medically underserved communities and insular areas.

(6) Evaluating interdisciplinary medical provider care team models that promote high quality care.

(7) Training health care professionals to make them aware of the high rates of chronic hepatitis B and chronic hepatitis C in certain adult ethnic populations, and the importance of prevention, detection, and medical management of hepatitis B and hepatitis C and of liver cancer screening.

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

SEC. 106. HIV/AIDS PROVIDER LOAN REPAYMENT PROGRAM.

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

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

(A) at a Ryan White-funded or title X-funded facility with a critical shortage of doctors (as determined by the Secretary); or

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

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

(b) MANNER OF PAYMENTS.—The payments described in subsection (a) shall be made by the Secretary as follows:

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

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

(3) Upon completion by that individual of a third year of such service, the Secretary shall pay another 25 percent of the principal of and the interest on such loans.

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

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

(1) The number of physicians, nurse practitioners, and physician assistants enrolled in the program.

(2) The number and amount of loan repayments.

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

(4) The default rate and actions required.

(5) The amount of outstanding default funds.

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

(7) The demographics of individuals participating in the program.

(8) An evaluation of the overall costs and benefits of the program.

(e) DEFINITIONS.—In this section:

(1) The term ''HIV/AIDS'' means human immunodeficiency virus and acquired immune deficiency syndrome.

(2) The term ''nurse practitioner'' means a nurse with an advanced practice nursing licensure.

(3) The term ''physician'' means a graduate of a school of medicine who has completed postgraduate training in general or pediatric medicine.

(4) The term ''physician assistant'' means a medical provider who completed an accredited physician assistant training program and successfully passed the Physician Assistant National Certifying Examination.

(5) The term ''professional education loan''—

(A) means a loan that is incurred for the cost of attendance (including tuition, other reasonable educational expenses, and reasonable

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

(B) includes only the portion of the loan that is outstanding on the date the physician, nurse practitioner, or physician assistant involved begins the service specified in the agreement under subsection (a).

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

(7) The term ''Secretary'' means the Secretary of Health and Human Services.

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

(9) The term ''title X-funded'' means, with respect to a facility, receiving funds under title X of the Public Health Service Act (42 U.S.C. 300 et seq.).

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

SEC. 107. REDUCING NEW HIV INFECTIONS AMONG INJECTING DRUG USERS.

(a) SENSE OF CONGRESS.—It is the sense of the Congress that providing sterile syringes and sterilized equipment to injecting drug users substantially reduces risk of HIV infection , increases the probability that they will initiate drug treatment, and does not increase drug use.

(b) IN GENERAL.—The Secretary of Health and Human Services may provide grants and technical assistance for the purpose of reducing the rate of HIV infections among injecting drug users through a comprehensive package of services for such users, including the provision of sterile syringes, education and outreach, access to infectious disease testing, overdose prevention, and treatment for drug dependence.

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

SEC. 108. SUPPORT FOR EXPANSION OF COMPREHENSIVE SEXUAL HEALTH AND EDUCATION PROGRAMS.

(a) SENSE OF CONGRESS.—It is the sense of Congress that—

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

(A) reduce unintended pregnancy and sexually transmitted infections, including HIV;

(B) promote safe and healthy relationships;

(C) use, and be informed by, the best scientific information available;

(D) be built on characteristics of effective programs;

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

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

(G) build on the personal responsibility education programs funded under section 513 of the Social Security Act (42 U.S.C. 713) and the President's Teen Pregnancy Prevention program, funded under title II of the Consolidated Appropriations Act, 2010 (Public Law 111–117; 123 Stat. 3253); and

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

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

(A) deliberately withhold life-saving information about HIV;

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

(C) promote gender stereotypes;

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

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

(F) are inconsistent with the ethical imperatives of medicine and public health.

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

(1) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Director of the Office of Adolescent Health, shall award grants, on a competitive basis, to eligible entities to enable such eligible entities to carry out programs that provide adolescents with comprehensive sex education, as described in paragraph (6).

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

(3) ELIGIBLE ENTITY.—In this subsection, the term ''eligible entity'' means a public or private entity that focuses on adolescent health or education or has experience working with adolescents, which may include—

(A) a State educational agency;

(B) a local educational agency;

(C) a tribe or tribal organization, as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b);

(D) a State or local department of health;

(E) a State or local department of education;

(F) a nonprofit organization;

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

(H) a hospital.

(4) APPLICATIONS.—An eligible entity desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including the evaluation plan described in paragraph (7)(A).

(5) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to eligible entities that—

(A) are State or local public entities, with an additional priority for State or local educational agencies; and

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

(i) Unintended pregnancies.

(ii) Sexually transmitted infections, including HIV.

(iii) Dating violence and sexual assault.

(6) USE OF FUNDS.—

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

(i) replicates evidence-based sex education programs;

(ii) substantially incorporates elements of evidence-based sex education programs; or

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

(B) CONTENTS OF SEX EDUCATION PROGRAMS.—The sex education programs funded under this subsection shall include curricula and program materials that address—

(i) abstinence and delaying sexual initiation;

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

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

(I) healthy relationships between oneself and family, others, and society; and

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

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

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

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

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

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

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

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

(7) EVALUATION; REPORT.—

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

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

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

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

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

(B) SELECTION OF EVALUATED PROGRAMS; BUDGET.—

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

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

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

(C) FUNDS FOR EVALUATION.—The Secretary shall provide eligible entities who are selected under subparagraph (B)(i) with additional funds, in accordance with the budget described in subparagraph (B)(ii), to carry out and report to the Secretary on the evaluation plan described in subparagraph (A).

(D) PERFORMANCE MEASURES.—The Secretary, in coordination with the Director of the Centers for Disease Control and Prevention, shall establish a common set of performance measures to assess the implementation and impact of grant programs funded under this subsection. Such performance measures shall include—

(i) output measures, such as the number of individuals served and the number of hours of service delivery;

(ii) outcome measures, including measures relating to—

(I) the knowledge that youth participating in the grant program have gained about—

(aa) adolescent growth and development;

(bb) relationship dynamics;

(cc) ways to prevent unintended pregnancy and sexually transmitted infections, including HIV; and

(dd) sexual health;

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

(aa) negotiation and communication;

(bb) decisionmaking and goal-setting;

(cc) interpersonal skills and healthy relationships; and

(dd) condom use; and

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

(aa) age of first intercourse;

(bb) number of sexual partners;

(cc) condom and contraceptive use at first intercourse;

(dd) recent condom and contraceptive use; and

(ee) dating abuse and lifetime history of domestic violence, sexual assault, dating violence, bullying, harassment, and stalking.

(E) REPORT TO THE SECRETARY.—Eligible entities receiving a grant under this subsection who have been selected to receive funds to carry out the evaluation plan described in subparagraph (A), in accordance with subparagraph (B)(i), shall collect and report to the Secretary—

(i) the results of the independent evaluation described in subparagraph (A); and

(ii) information about the performance measures described in subparagraph (B).

(F) EFFECTIVE PROGRAMS.—The Secretary, in coordination with the Director of the

Centers for Disease Control and Prevention, shall publish on the Web site of the Centers for Disease Control and Prevention, a list of programs funded under this subsection that the Secretary has determined to be effective programs.

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

(1) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Office of Adolescent Health and the Secretary of Education, shall award grants, on a competitive basis, to institutions of higher education to enable such institutions to provide young people with comprehensive sex education, described in paragraph (5)(B), with an emphasis on reducing HIV, other sexually transmitted infections, and unintended pregnancy through instruction about—

(A) abstinence and contraception;

(B) reducing dating violence, sexual assault, bullying, and harassment;

(C) increasing healthy relationships; and

(D) academic achievement.

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

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

(4) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to an institution of higher education that—

(A) has an enrollment of needy students as defined in section 318(b) of the Higher Education Act of 1965 (20 U.S.C. 1059e(b));

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

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

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

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

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

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

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

(I) is a minority institution, as defined in section 365 of such Act (20 U.S.C. 1067k), with an enrollment of needy students, as defined in section 312 of such Act (20 U.S.C. 1058).

(5) USES OF FUNDS.—

(A) IN GENERAL.—An institution of higher education receiving a grant under this subsection may use grant funds to integrate issues relating to comprehensive sex education into the academic or support sectors of the institution of higher education in order to reach a large number of students, by carrying out 1 or more of the following activities:

(i) Developing educational content for issues relating to comprehensive sex education that will be incorporated into first-year orientation or core courses.

(ii) Developing and employing schoolwide educational programming outside of class that delivers elements of comprehensive sex education programs to students, faculty, and staff.

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

(iv) Developing and employing peer-outreach and education programs to generate discussion, educate, and raise awareness among students about issues relating to comprehensive sex education.

(B) CONTENTS OF SEX EDUCATION PROGRAMS.—Each institution of higher education's program of comprehensive sex education funded under this subsection shall include curricula and program materials that address information about—

(i) safe and responsible sexual behavior with respect to the prevention of preg-

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

(I) abstinence;

(II) a reduced number of sexual partners; and

(III) the use of condoms and contraception;

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

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

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

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

(C) OPTIONAL COMPONENTS OF SEX EDUCATION.—Each institution of higher education's program of comprehensive sex education may

also include information and skills development relating to—

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

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

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

(ii) healthy life skills, including—

(I) goal-setting and decisionmaking;

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

(III) critical thinking;

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

(V) stress management;

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

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

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

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

(1) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Director of the Centers for Disease Control and Prevention and the Secretary of Education, shall award grants, on a competitive basis, to eligible entities to enable such eligible entities to carry out the activities described in paragraph (5).

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

(3) ELIGIBLE ENTITY.—In this subsection, the term ''eligible entity'' means—

(A) a State educational agency;

(B) a local educational agency;

(C) a tribe or tribal organization, as defined in section 4 of the Indian Self-Determina-

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

(D) a State or local department of health;

(E) a State or local department of education;

(F) a nonprofit institution of higher education;

(G) a national or statewide nonprofit organization that has as its primary purpose the improvement of provision of comprehensive sex education through effective teaching of comprehensive sex education; or

(H) a consortium of nonprofit organizations that has as its primary purpose the improvement of provision of comprehensive sex education through effective teaching of comprehensive sex education.

(4) APPLICATION.—An eligible entity desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(5) AUTHORIZED ACTIVITIES.—

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

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

(B) PERMISSIBLE ACTIVITIES.—Each eligible entity receiving a grant under this subsection may use grant funds to—

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

(I) institutions of higher education;

(II) State educational agencies;

(III) local educational agencies; or

(IV) other public and private organizations with a commitment to comprehensive sex education and the benefits of comprehensive sex education;

(ii) support and promote research-based training of teachers of comprehensive sex education and related disciplines in elementary schools and secondary schools as a means of broadening student knowledge about issues related to human

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

(iii) support the dissemination of information on effective practices and research findings concerning the teaching of comprehensive sex education;

(iv) support research on—

(I) effective comprehensive sex education teaching practices; and

(II) the development of assessment instruments and strategies to document—

(aa) student understanding of comprehensive sex education; and

(bb) the effects of comprehensive sex education;

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

(vi) develop and disseminate appropriate research-based materials to foster comprehensive sex education.

(C) SUBGRANTS.—Each eligible entity receiving a grant under this subsection may award subgrants to nonprofit organizations, State educational agencies, or local educational agencies to enable such organizations or agencies to—

(i) train teachers in comprehensive sex education;

(ii) support Internet or distance learning related to comprehensive sex education;

(iii) promote rigorous academic standards and assessment techniques to guide and measure student performance in comprehensive sex education;

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

(v) develop and disseminate effective, research-based comprehensive sex education learning materials;

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

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

cation and to identify strategies for improvement.

(e) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for a period of 5 years, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the activities to provide adolescents and young people with comprehensive sex education funded under this section.

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

(A) the number of eligible entities and institutions of higher education that are receiving grant funds under subsections (b) and (c);

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

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

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

(E) the status of program evaluations described under subsections (b) and (c).

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

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

(2) are medically inaccurate or have been scientifically shown to be ineffective;

(3) promote gender stereotypes;

(4) are insensitive and unresponsive to the needs of sexually active youth or lesbian, gay, bisexual, or transgender youth; or

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

(g) DEFINITIONS.—In this section:

(1) ESEA DEFINITIONS.—The terms ''elementary school'', ''local educational agency'', ''secondary school'', and ''State educational agency'' have the meanings given the terms in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(2) AGE AND DEVELOPMENTALLY APPROPRIATE.—The term ''age and developmentally appropriate'' means suitable for a particular age or age group of children and adolescents, based on devel-

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

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

(4) CHARACTERISTICS OF EFFECTIVE PROGRAMS.—The term ''characteristics of effective programs'' means the aspects of evidence-based programs, including development, content, and implementation of such programs, that—

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

(B) are widely recognized by leading medical and public health agencies to be effective in changing sexual behaviors that lead to sexually transmitted infections, including HIV, unintended pregnancy, and dating violence and sexual assault among young people.

(5) COMPREHENSIVE SEX EDUCATION.—The term ''comprehensive sex education'' means a program that—

(A) includes age- and developmentally appropriate, culturally and linguistically relevant information on a broad set of topics related to sexuality including human development, relationships, decisionmaking, communication, abstinence, contraception, and disease and pregnancy prevention;

(B) provides students with opportunities for developing skills as well as learning information;

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

(D) aims to—

(i) provide scientifically accurate and realistic information about human sexuality;

(ii) provide opportunities for individuals to understand their own, their families', and their communities' values, attitudes, and insights about sexuality;

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

(iv) help individuals exercise responsibility regarding sexual relationships, which

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

(6) EVIDENCE-BASED PROGRAM.—The term ''evidence-based program'' means a sex education program that has been proven through rigorous evaluation to be effective in changing sexual behavior or incorporates elements of other sex education programs that have been proven to be effective in changing sexual behavior.

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

(8) MEDICALLY ACCURATE AND COMPLETE.—The term ''medically accurate and complete'', when used with respect to a sex education program, means that—

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

(B)(i) the program contains information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete; and

(ii) the program does not withhold information about the effectiveness and benefits of correct and consistent use of condoms and other contraceptives.

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

(10) YOUNG PEOPLE.—The term ''young people'' means individuals who are ages 10 through 24 at the time of commencement of participation in a program supported under this section.

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

SEC. 109. ELIMINATION OF ABSTINENCE-ONLY EDUCATION PROGRAM.

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

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

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

(c) REPROGRAM OF ELIMINATED ABSTINENCE-ONLY FUNDS FOR THE PERSONAL RESPONSIBILITY EDUCATION PROGRAM (PREP).—Section 513(f) of the Social Security Act (42 U.S.C. 713(f)) is amended by striking ''$75,000,000 for each of fiscal years 2010 through 2014'' and inserting ''$75,000,000 for each of fiscal years 2010 and 2011, an amount for fiscal year 2012 equal to $75,000,000 increased by an amount equal to the unobligated portion of funds appropriated for fiscal year 2012 under section 510(d) that are rescinded under section 109(b) of the Ending the HIV/AIDS Epidemic Act of 2012, and $125,000,000 for each of fiscal years 2013 through 2014''.

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

SEC. 201. REVIEW OF ALL FEDERAL AND STATE LAWS, POLICIES, AND REGULATIONS REGARDING THE CRIMINAL PROSECUTION OF INDIVIDUALS FOR HIV-RELATED OFFENSES.

(a) DEFINITIONS.—

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

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

(b) SENSE OF CONGRESS REGARDING LAWS OR REGULATIONS DIRECTED AT PEOPLE LIVING WITH HIV/AIDS.—It is the sense of the Congress that Federal and State laws, policies, and regulations regarding people living with HIV/AIDS—

(1) should not place unique or additional burdens on such individuals solely as a result of their HIV status; and

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

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

(B) the relative risk of HIV transmission routes;

(C) the current health implications of living with HIV;

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

(E) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities.

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

(1) REVIEW OF FEDERAL AND STATE LAWS.—

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

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

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

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

(iii) State judicial and court system officers, including judges, district attorneys, prosecutors, defense attorneys, law enforcement, and correctional officers;

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

(v) people living with HIV/AIDS, particularly those who have been subject to HIV-related prosecution or who are from communities whose members have been disproportionately subject to HIV-specific arrests and prosecutions;

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

(vii) nongovernmental health organizations that work on behalf of people living with HIV/AIDS; and

(viii) trade organizations or associations representing persons or entities described in clauses (i) through (vii).

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

ducted by any Federal or State agency or any public health, legal advocacy, or trade organization or association if the designated officials determine that such reviews were conducted in accordance with the principles set forth in subsection (b).

(2) REPORT.—No later than 180 days after initiating the review required by paragraph (1), the Attorney General shall transmit to the Congress and make publicly available a report containing the results of the review, which includes the following:

(A) For each State and for the Uniform Code of Military Justice, a summary of the relevant laws, policies, regulations, and judicial precedents and decisions regarding criminal cases involving people living with HIV/AIDS, including, if applicable, the following:

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

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

public health-oriented, evidence-based, medically accurate, and contemporary understanding of—

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

(II) the relative risk of HIV transmission routes;

(III) the current health implications of living with HIV;

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

(V) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities.

(iii) An analysis of the public health and legal implications of such laws, policies, regulations, and judicial precedents, including an analysis of the consequences of having a similar penal scheme applied to comparable situations involving other communicable diseases.

(iv) An analysis of the proportionality of punishments imposed under HIV-specific laws, policies, regulations, and judicial precedents, taking into consideration penalties attached to violation of State laws against similar degrees of endangerment or harm, such as driving while intoxicated (DWI) or transmission of other communicable diseases, or more serious harms, such as vehicular manslaughter offenses.

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

(C) A set of best practice recommendations directed to State governments, including State attorneys general, public health officials, and judicial officers, in order to ensure that laws, policies, regulations, and judicial precedents regarding people living with HIV/AIDS are in accordance with the principles set forth in subsection (b).

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

garding people living with HIV/AIDS are in accordance with the principles set forth in subsection (b).

(3) GUIDANCE.—Within 90 days of the release of the report required by paragraph (2), the Attorney General and the Secretary of Health and Human Services, acting jointly, shall develop and publicly release updated guidance for States based on the set of best practice recommendations required by paragraph (2)(C) in order to assist States dealing with criminal and related civil commitment cases regarding people living with HIV/AIDS.

(4) MONITORING AND EVALUATION SYSTEM.—Within 60 days of the release of the guidance required by paragraph (3), the Attorney General and the Secretary of Health and Human Services, acting jointly, shall establish an integrated monitoring and evaluation system which includes, where appropriate, objective and quantifiable performance goals and indicators to measure progress toward statewide implementation in each State of the best practice recommendations required in paragraph (2)(C), including to monitor, track, and evaluate the effectiveness of assistance provided pursuant to subsection (d).

(5) ADJUSTMENTS TO FEDERAL LAWS, POLICIES, OR REGULATIONS.—Within 90 days of the release of the report required by paragraph (2), the Attorney General, the Secretary of Health and Human Services, and the Secretary of Defense, acting jointly, shall develop and transmit to the President and the Congress, and make publicly available, such proposals as may be necessary to implement adjustments to Federal laws, policies, or regulations, including to the Uniform Code of Military Justice, based on the recommendations required by paragraph (2)(D), either through Executive order or through changes to statutory law.

(6) AUTHORIZATION OF APPROPRIATIONS.—

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

(B) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to the authorization of appropriations in subparagraph (A) are authorized to remain available until expended.

(d) AUTHORIZATION TO PROVIDE GRANTS.—

(1) GRANTS BY ATTORNEY GENERAL.—

(A) IN GENERAL.—The Attorney General may provide assistance to eligible State and local entities and eligible nongovernmental organizations for the purpose of incorporating the best practice recommendations developed under subsection (c)(2)(C) within relevant State laws, policies, regulations, and judicial decisions regarding people living with HIV/AIDS.

(B) AUTHORIZED ACTIVITIES.—The assistance authorized by subparagraph (A) may include—

(i) direct technical assistance to eligible State and local entities in order to develop, disseminate, or implement State laws, policies, regulations, or judicial decisions that conform with the best practice recommendations developed under subsection (c)(2)(C);

(ii) direct technical assistance to eligible nongovernmental organizations in order to provide education and training, including through classes, conferences, meetings,

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

(iii) subcontracting authority to allow eligible State and local entities and eligible nongovernmental organizations to seek technical assistance from legal and public health experts with a demonstrated understanding of the principles underlying the best practice recommendations developed under subsection (c)(2)(C).

(2) GRANTS BY SECRETARY OF HHS.—

(A) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, may provide assistance to State and local public health departments and eligible nongovernmental organizations for the purpose of supporting eligible State and local entities to incorporate the best practice recommendations developed under subsection (c)(2)(C) within relevant State laws, policies, regulations, and judicial decisions regarding people living with HIV/AIDS.

(B) AUTHORIZED ACTIVITIES.—The assistance authorized by subparagraph (A) may include—

(i) direct technical assistance to State and local public health departments in order to support the development, dissemination, or implementation of State laws, policies, regulations, or judicial decisions that conform with the set of best practice recommendations developed under subsection (c)(2)(C);

(ii) direct technical assistance to eligible nongovernmental organizations in order to provide education and training, including through classes, conferences, meetings, and other educational activities, to State and local public health departments; and

(iii) subcontracting authority to allow State and local public health departments and eligible nongovernmental organizations to seek technical assistance from legal and public health experts with a demonstrated understanding of the principles underlying the best practice recommendations developed under subsection (c)(2)(C).

(3) LIMITATION.—As a condition of receiving assistance through this subsection, eligible State and local entities, State and local public health departments, and eligible nongovernmental organizations shall agree—

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

(B) that if the entity, department, or organization promulgates any laws, policies, regulations, or judicial decisions regarding people living with HIV/AIDS, such actions shall demonstrate a public health-oriented, evidence-based, medically accurate, and contemporary understanding of—

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

(ii) the relative risk of HIV transmission routes;

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

(iv) the associated benefits of treatment and support services for people living with HIV; and

(v) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities.

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

(A) a detailed description of the progress each State has made, if any, in implementing the best practice recommendations developed under subsection (c)(2)(C) as a result of the assistance provided under this subsection, and based on the performance goals and indicators established as part of the monitoring and evaluation system in subsection (c)(4);

(B) a brief summary of any outreach efforts undertaken during the prior year by the Attorney General and the Secretary of Health and Human Services to encourage States to seek assistance under this subsection in order

to implement the best practice recommendations developed under subsection (c)(2)(C);

(C) a summary of how assistance provided through this subsection is being utilized by eligible State and local entities, State and local public health departments, and eligible nongovernmental organizations and, if applicable, any contractors, including with respect to nongovernmental organizations, the type of technical assistance provided, and an evaluation of the impact of such assistance on eligible State and local entities; and

(D) a summary and description of eligible State and local entities, State and local public health departments, and eligible nongovernmental organizations receiving assistance through this subsection, including if applicable, a summary and description of any contractors selected to assist in implementing such assistance.

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

(A) ELIGIBLE STATE AND LOCAL ENTITIES.—The term ''eligible State and local entities'' means the relevant individuals, offices, or

organizations that directly participate in the development, dissemination, or implementation of State laws, policies, regulations, or judicial decisions, including—

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

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

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

(B) STATE AND LOCAL PUBLIC HEALTH DEPARTMENTS.—The term ''State and local public health departments'' means the following:

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

and communicable disease specialists within such departments.

(ii) Local public health departments, or their equivalents, including city and county public health departments, the chief officer of such departments, and infectious disease and communicable disease specialists within such departments.

(iii) Public health departments or officials, or their equivalents, within State or local correctional facilities.

(iv) Public health departments or officials, or their equivalents, within State National Guards.

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

(C) ELIGIBLE NONGOVERNMENTAL ORGANIZATIONS.—The term ''eligible nongovernmental organizations'' means the following:

(i) Nongovernmental organizations, including trade organizations or associations that represent—

(I) State attorneys general, or their equivalents;

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

(III) State judicial and court officers, including judges, district attorneys, prosecutors, defense attorneys, law enforcement, and correctional officers;

(IV) State National Guards;

(V) people living with HIV/AIDS;

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

(VII) nongovernmental health organizations that work on behalf of people living with HIV/AIDS.

(ii) Nongovernmental organizations, including trade organizations or associations that demonstrate a public-health oriented, evidence-based, medically accurate, and contemporary understanding of—

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

(II) the relative risk of HIV transmission routes;

(III) the current health implications of living with HIV;

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

(V) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities.

(6) AUTHORIZATION OF APPROPRIATIONS.—

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

(B) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to the authorizations of appropriations in subparagraph (A) are authorized to remain available until expended.

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

SEC. 301. REPEAL OF LIMITATION AGAINST USE OF FUNDS FOR EDUCATION OR INFORMATION DESIGNED TO PROMOTE OR ENCOURAGE, DIRECTLY, HOMOSEXUAL OR HETEROSEXUAL ACTIVITY OR INTRAVENOUS SUBSTANCE ABUSE.

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

(1) by striking subsection (c); and

(2) by redesignating subsection (d) as subsection (c).

SEC. 302. EXPANDING SUPPORT FOR CONDOMS IN PRISONS.

(a) AUTHORITY TO ALLOW COMMUNITY ORGANIZATIONS TO PROVIDE STI COUNSELING, STI PREVENTION EDUCATION, AND SEXUAL BARRIER PROTECTION DEVICES IN FEDERAL CORRECTIONAL FACILITIES.—

(1) DIRECTIVE TO ATTORNEY GENERAL.—Not later than 30 days after the date of enactment of this Act, the Attorney General shall direct the Bureau of Prisons to allow community organizations to distribute sexual barrier protection devices and to

engage in STI counseling and STI prevention education in Federal correctional facilities. These activities shall be subject to all relevant Federal laws and regulations which govern visitation in correctional facilities.

(2) INFORMATION REQUIREMENT.—Any community organization permitted to distribute sexual barrier protection devices under paragraph (1) must ensure that the persons to whom the devices are distributed are informed about the proper use and disposal of sexual barrier protection devices in accordance with established public health practices. Any community organization conducting STI counseling or STI prevention education under paragraph (1) must offer comprehensive sexuality education.

(3) POSSESSION OF DEVICE PROTECTED.—No Federal correctional facility may, because of the possession or use of a sexual barrier protection device—

(A) take adverse action against an incarcerated person; or

(B) consider possession or use as evidence of prohibited activity for the purpose of any Federal correctional facility administrative proceeding.

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

(b) SENSE OF CONGRESS REGARDING DISTRIBUTION OF SEXUAL BARRIER PROTECTION DEVICES IN STATE PRISON SYSTEMS.—It is the sense of the Congress that States should allow for the legal distribution of sexual barrier protection devices in State correctional facilities to reduce the prevalence and spread of STIs in those facilities.

(c) SURVEY OF AND REPORT ON CORRECTIONAL FACILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF STIS.—

(1) SURVEY.—The Attorney General, after consulting with the Secretary of Health and Human Services, State officials, and community organizations, shall, to the maximum extent practicable, conduct a survey of all Federal and State correctional facilities, no later than 180 days after the date of enactment of this Act and annually thereafter for 5 years, to determine the following:

(A) COUNSELING, TREATMENT, AND SUPPORTIVE SERVICES.—Whether the correctional

facility requires incarcerated persons to participate in counseling, treatment, and supportive services related to STIs, or whether it offers such programs to incarcerated persons.

(B) ACCESS TO SEXUAL BARRIER PROTECTION DEVICES.—Whether incarcerated persons can—

(i) possess sexual barrier protection devices;

(ii) purchase sexual barrier protection devices;

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

(iv) obtain sexual barrier protection devices without cost.

(C) INCIDENCE OF SEXUAL VIOLENCE.—The incidence of sexual violence and assault committed by incarcerated persons and by correctional facility staff.

(D) PREVENTION EDUCATION OFFERED.—The type of prevention education, information, or training offered to incarcerated persons and correctional facility staff regarding sexual violence and the spread of STIs, including whether such education, information, or training—

(i) constitutes comprehensive sexuality education;

(ii) is compulsory for new incarcerated persons and for new staff; and

(iii) is offered on an ongoing basis.

(E) STI TESTING.—Whether the correctional facility tests incarcerated persons for STIs or gives them the option to undergo such testing—

(i) at intake;

(ii) on a regular basis; and

(iii) prior to release.

(F) STI TEST RESULTS.—The number of incarcerated persons who are tested for STIs and the outcome of such tests at each correctional facility, disaggregated to include results for—

(i) the type of sexually transmitted infection tested for;

(ii) the race and/or ethnicity of individuals tested;

(iii) the age of individuals tested; and

(iv) the gender of individuals tested.

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

prior to release about STI-related services or other health services in their communities, including free and low-cost counseling and treatment options.

(H) PRERELEASE REFERRALS MADE.—The number of referrals to community-based organizations or public health facilities offering STI-related or other health services provided to incarcerated persons prior to release, and the type of counseling or treatment for which the referral was made.

(I) REINSTATEMENT OF MEDICAID BENEFITS.—Whether the correctional facility assists incarcerated persons that were enrolled in the State Medicaid program prior to their incarceration, in reinstating their enrollment upon release and whether such individuals receive referrals as provided by subparagraph (G) to entities that accept the State Medicaid program, including if applicable—

(i) the number of such individuals, including those diagnosed with the human immunodeficiency virus, that have been reinstated;

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

(iii) the number of individuals denied enrollment.

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

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

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

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

(d) STRATEGY.—

(1) DIRECTIVE TO ATTORNEY GENERAL.—The Attorney General, in consultation with the Secretary of Health and Human Services, State officials, and community organizations, shall develop and implement a 5-year strategy to reduce the prevalence and spread of STIs in Federal and State correctional facilities. To the maximum extent possible, the strategy shall be developed, transmitted to Congress, and made publicly available no later than 180 days after the transmission of the first report required under subsection (c)(3).

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

(A) PREVENTION EDUCATION.—A plan for improving prevention education, information, and training offered to incarcerated persons and correctional facility staff, including information and training on sexual violence and the spread of STIs, and comprehensive sexuality education.

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

barrier protection devices in correctional facilities.

(C) SEXUAL VIOLENCE REDUCTION.—A plan for reducing the incidence of sexual violence among incarcerated persons and correctional facility staff, developed in consultation with the National Prison Rape Elimination Commission.

(D) COUNSELING AND SUPPORTIVE SERVICES.—A plan for expanding access to counseling and supportive services related to STIs in correctional facilities.

(E) TESTING.—A plan for testing incarcerated persons for STIs during intake, during regular health exams, and prior to release, and that—

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

(ii) includes pretest counseling;

(iii) requires that incarcerated persons are notified of their option to decline testing at any time;

(iv) requires that incarcerated persons are confidentially notified of their test results in a timely manner; and

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

(F) TREATMENT.—A plan for ensuring that correctional facilities have the necessary medicine and equipment to treat and monitor STIs and for ensuring that incarcerated persons living with or testing positive for STIs receive and have access to care and treatment services.

(G) STRATEGIES FOR DEMOGRAPHIC GROUPS.—A plan for developing and implementing culturally appropriate, sensitive, and specific strategies to reduce the spread of STIs among demographic groups heavily impacted by STIs.

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

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

(ii) may receive persons recently released from incarceration who are living with STIs; and

(iii) accept payment through the State Medicaid program.

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

(i) enrolled in their State Medicaid program prior to incarceration in a correctional facility are automatically re-enrolled in such program upon their release; and

(ii) not enrolled in their State Medicaid program prior to incarceration, but who are diagnosed with the human immunodeficiency virus while incarcerated in a correctional facility, are automatically enrolled in such program upon their release.

(J) OTHER PLANS.—Any other plans developed by the Attorney General for reducing the spread of STIs or improving the quality of health care in correctional facilities.

(K) MONITORING SYSTEM.—A monitoring system that establishes performance goals related to reducing the prevalence and spread of STIs in correctional facilities and which, where feasible, expresses such goals in quantifiable form.

(L) MONITORING SYSTEM PERFORMANCE INDICATORS.—Performance indicators that measure or assess the achievement of the performance goals described in subparagraph (I).

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

(3) REPORT.—The Attorney General shall transmit to Congress and make publicly available an annual progress report regarding the implementation and effectiveness of the strategy described in paragraph (1). The progress report shall include an evaluation of the implementation of the strategy using the monitoring system and performance indicators provided for in subparagraphs (I) and (J) of paragraph (2).

(e) APPROPRIATIONS.—

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

(2) AVAILABILITY OF FUNDS.—Amounts made available under paragraph (1) are authorized to remain available until expended.

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

(1) COMMUNITY ORGANIZATION.—The term ''community organization'' means a public health care facility or a nonprofit organization which provides health- or STI-related services according to established public health standards.

(2) COMPREHENSIVE SEXUALITY EDUCATION.—The term ''comprehensive sexuality education'' means sexuality education that includes information about abstinence and about the proper use and disposal of sexual barrier protection devices and which is—

(A) evidence-based;

(B) medically accurate;

(C) age and developmentally appropriate;

(D) gender and identity sensitive;

(E) culturally and linguistically appropriate; and

(F) structured to promote critical thinking, self-esteem, respect for others, and the development of healthy attitudes and relationships.

(3) CORRECTIONAL FACILITY.—The term ''correctional facility'' means any prison, penitentiary, adult detention facility, juvenile detention facility, jail, or other facility to which persons may be sent after conviction of a crime or act of juvenile delinquency within the United States.

(4) INCARCERATED PERSON.—The term ''incarcerated person'' means any person who is serving a sentence in a correctional facility after conviction of a crime.

(5) SEXUALLY TRANSMITTED INFECTION.—The term ''sexually transmitted infection'' or ''STI'' means any disease or infection that is commonly transmitted through sexual activity, including HIV/AIDS, gonorrhea, chlamydia, syphilis, genital herpes, viral hepatitis, and human papillomavirus.

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

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

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

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

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

''(15) ENROLLMENT OF EX-OFFENDERS.—

''(A) AUTOMATIC ENROLLMENT OR REINSTATEMENT.—

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

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

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

"(II) if such individual is to be released from a public institution on parole or on probation, as soon as possible after the date on which the determination to release such individual was made, and before the date such individual is released.

"(ii) EXCEPTION.—If a State makes a determination that an individual is not eligible to be enrolled under the State plan—

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

"(II) after such date, the State may terminate the enrollment of such individual.

"(B) RELATIONSHIP OF ENROLLMENT TO PAYMENT FOR SERVICES.—

"(i) IN GENERAL.—Subject to subparagraph (A)(ii), an eligible individual who is enrolled, or whose enrollment is reinstated, under subparagraph (A) shall be

eligible for medical assistance that is provided after the date that the eligible individual is released from the public institution.

''(ii) RELATIONSHIP TO PAYMENT PROHIBITION FOR INMATES.—No provision of this paragraph may be construed to permit payment for care or services for which payment is excluded under subparagraph (A), following paragraph (29), in section 1905(a).

''(C) TREATMENT OF CONTINUOUS ELIGIBILITY.—

''(i) SUSPENSION FOR INMATES.—Any period of continuous eligibility under this title shall be suspended on the date an individual enrolled under this title becomes an inmate of a public institution (except as a patient of a medical institution).

''(ii) DETERMINATION OF REMAINING PERIOD.—Notwithstanding any changes to State law related to continuous eligibility during the time that an individual is an inmate of a public institution (except as a patient of a medical institution), subject to

clause (iii), with respect to an eligible individual who was subject to a suspension under subclause (I), on the date that such individual is released from a public institution the suspension of continuous eligibility under such subclause shall be lifted for a period that is equal to the time remaining in the period of continuous eligibility for such individual on the date that such period was suspended under such subclause.

''(iii) EXCEPTION.—If a State makes a determination that an individual is not eligible to be enrolled under the State plan—

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

''(II) after such date, the State may terminate the enrollment of such individual.

''(D) AUTOMATIC ENROLLMENT OR REINSTATEMENT OF ENROLLMENT DEFINED.—For purposes of this paragraph, the term 'automatic enrollment or reinstatement of enrollment'

means that the State determines eligibility for medical assistance under the State plan without a program application from, or on behalf of, the eligible individual, but an individual can only be automatically enrolled in the State Medicaid plan if the individual affirmatively consents to being enrolled through affirmation in writing, by telephone, orally, through electronic signature, or through any other means specified by the Secretary.

''(E) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this paragraph, the term 'eligible individual' means an individual who is an inmate of a public institution (except as a patient in a medical institution)—

''(i) who was enrolled under the State plan for medical assistance immediately before becoming an inmate of such an institution; or

''(ii) is diagnosed with human immunodeficiency virus.''.

(b) SUPPLEMENTAL FUNDING FOR STATE IMPLEMENTATION OF AUTOMATIC REINSTATEMENT OF MEDICAID BENEFITS.—

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

(2) USE OF FUNDS.—A State may only use increased matching payments authorized under paragraph (1)—

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

(B) for medical assistance (as such term is defined in section 1905(a) of the Social Security Act) provided to such eligible individuals.

(3) APPLICATION AND AGREEMENT.—The Secretary may only make payments to a State in the increased amount if—

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

(B) the State has submitted an application to the Secretary that includes a plan for implementing the requirements of section 1902(e)(15) of the Social Security Act under the State's amended State plan before the end of the 90-day period beginning on the date that the State receives increased matching payments under paragraph (1);

(C) the State's application meets the satisfaction of the Secretary; and

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

(i) the State will only use the increased matching funds for the uses permitted under paragraph (2); and

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

report that contains the information required under paragraph (4).

(4) REQUIRED REPORT INFORMATION.—The information that is required in the report under paragraph (3)(D)(ii) includes—

(A) the results of an evaluation of the impact of the implementation of the requirements of section 1902(e)(15) of the Social Security Act on improving the State's processes for enrolling of individuals who are released from public institutions into the Medicaid program;

(B) the number of individuals who were automatically enrolled (or whose enrollment is reinstated) under such section 1902(e)(15) during the period under paragraph (1); and

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

(5) INCREASE IN CAP ON MEDICAID PAYMENTS TO TERRITORIES.—Subject to paragraph (6), the amounts otherwise determined for Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) shall each be increased by the necessary amount to allow for the increase in

the Federal matching payments under paragraph (1), but only for the period under such subparagraph for such State. In the case of such an increase for a territory, subsection (a)(1) of such section 1108 shall be applied without regard to any increase in payment made to the territory under part E of title IV of such Act that is attributable to the increase in Federal medical assistance percentage effected under paragraph (1) for the territory.

(6) LIMITATIONS.—

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

(B) MAINTENANCE OF ELIGIBILITY.—

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

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

(ii) STATE REINSTATEMENT OF ELIGIBILITY PERMITTED.—A State that has restricted eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) after the date of enactment of this Act, is no longer ineligible under subparagraph (A) beginning with the first calendar quarter in which the State has reinstated eligibility standards, methodologies, or procedures that are no more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on such date.

(C) NO WAIVER AUTHORITY.—The Secretary may not waive the application of this subsection under section 1115 of the Social Security Act or otherwise.

(D) LIMITATION OF MATCHING PAYMENTS TO 100 PERCENT.—In no case shall an increase in Federal matching payments under this subsection result in Federal matching payments that exceed 100 percent.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) shall take effect 180 days after the date of the enactment of this Act and shall apply to services furnished on or after such date.

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

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

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

SEC. 401. SUPPORT DATA SYSTEM REVIEW AND INDICATORS FOR MONITORING HIV CARE.

The Secretary of Health and Human Services, in collaboration with the Assistant Secretary for Health, the Director of the Office of HIV/AIDS and Infectious Disease Policy, the Director of the Centers for Disease Control and Prevention, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the Department of Housing and Urban Development, the Director of the Office of AIDS Research, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare & Medicaid Services, shall expand and coordinate efforts to align metrics across agencies and modify Federal data systems, to—

(1) adopt the Institute of Medicine's clinical HIV care indicators as the core metrics for monitoring the quality of HIV care, mental health, substance abuse, and supportive services;

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

(3) expand the demographic data elements to be captured by Federal data systems relevant to HIV care to permit calculation of the indicators for subgroups of the population of people with diagnosed HIV infection, including—

(A) age;

(B) race;

(C) ethnicity;

(D) sex (assigned at birth);

(E) gender identity;

(F) sexual orientation;

(G) current geographic marker of residence;

(H) income or poverty level; and

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

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

(4) streamline data collection and systematically review all existing reporting requirements for federally funded HIV/AIDS programs to ensure that only essential data are collected.

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

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

"SEC. 241A. TRANSFER OF FUNDS FOR IMPLEMENTATION OF NATIONAL HIV/AIDS STRATEGY.

''(a) TRANSFER AUTHORIZATION.—Of the discretionary appropriations made available to the Department of Health and Human Services for any fiscal year for programs and activities that, as determined by the Secretary of Health and Human Services, pertain to HIV/AIDS, the Secretary, in coordination with the Director of the Office of National HIV/AIDS Policy, may transfer up to 1 percent of such appropriations to the Office of the Assistant Secretary for Health for implementation of the National HIV/AIDS Strategy.

''(b) CONGRESSIONAL NOTIFICATION.—Not less than 30 days before making any transfer under this section, the Secretary shall give notice of the transfer to the Congress.

''(c) DEFINITIONS.—In this section:

''(1) The term 'HIV/AIDS' has the meaning given to such term in section 2689.

''(2) The term 'National HIV/AIDS Strategy' means the National HIV/AIDS Strategy for the United States issued by the President in July 2010 and includes any subsequent revisions to such Strategy.''.

SEC. 403. HIV INTEGRATED SERVICES DELIVERY MODEL DEMONSTRATION.

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

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

(b) OBJECTIVES.—The objectives of the demonstration are the following:

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

(2) To reduce new HIV infections among Medicaid and Medicare beneficiaries through routine HIV testing, prevention services for HIV negative beneficiaries, and intensive ''prevention for positive'' services for HIV positive beneficiaries.

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

(4) To promote HIV treatment adherence and retention in care through intensive case management, treatment education, and outreach services.

(5) To effectively treat behavioral health conditions among HIV positive beneficiaries that impair

their HIV treatment adherence and lead to secondary HIV infections through services funded under Medicare and Medicaid and programs administered by SAMHSA.

(6) To promote independence, treatment adherence, and stable housing for HIV positive beneficiaries through highly coordinated HIV health, housing, and support services funded by HRSA and HUD.

(c) DEMONSTRATION DESIGN.—

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

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

(B) the payment model described in paragraph (3).

(2) SERVICE DELIVERY MODEL.—

(A) IN GENERAL.—Under the service delivery model described in this paragraph, the demonstration shall test comprehensive HIV testing, linkage to care, HIV medical care, and ancillary services to individuals enrolled under Medicare, Medicaid, or both. The service delivery model will integrate services furnished under Medicare and Medicaid with prevention

services funded by CDC for HIV positive beneficiaries, intensive case management services funded by HRSA, behavioral services funded by SAMHSA, and housing assistance services funded through HUD.

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

(i) HIV testing services that apply the CDC's 2006 recommendations for universal opt-out testing among Medicare and Medicaid beneficiary populations.

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

(iii) Access to high quality HIV experienced medical care, laboratory monitoring, HIV medications, and other required services.

(iv) Routine screening and treatment for HIV-related and other chronic conditions, including behavioral health.

(v) Prevention and treatment education services, including an adapted Medi-

cation Therapy Management (MTM) program model, to optimize the benefit of HIV therapeutics.

(vi) Risk-stratified medical case management.

(vii) Provision of preventive care, including counseling to prevent secondary HIV infection.

(viii) Wrap-around support and housing services.

(3) PAYMENT MODEL.—Under the payment model described in this paragraph, the demonstration shall test the following:

(A) A prepaid capitated payment model that adjusts payment for HIV and behavioral health acuity, to be applied under contracts with managed care organizations with demonstrated HIV experience.

(B) Use of funds under the Ryan White HIV/AIDS Program to purchase capitated services from the contracted managed care organizations.

(C) Provision of additional funds to support services to the extent that Medicaid and Medicare coverage is limited, including for serv-

ices such as HIV testing (for Medicaid beneficiaries), medical case management, prevention case management, treatment education, case finding, behavioral health services, and housing assistance.

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

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

(2) DUAL ELIGIBLES.—Individuals who are—

(A) entitled to medical assistance under Medicaid; and

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

(e) ROLES AND RESPONSIBILITIES IN DEMONSTRATION.—

(1) IN GENERAL.—Consistent with the National HIV/AIDS Strategy for the United States, Federal agencies shall coordinate their funding for the selected States or cities covered under the demonstration to provide resources to fund the delivery of services within the demonstration.

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

(A) design the application process;

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

(C) with respect to the service delivery model described in subsection (c)(2), collaborate with the CDC, HRSA, and the National Institutes of Health to design a minimum service delivery model that reflects the current standard of care as established by the Public Health Service and CDC guidelines and recommendations; and

(D) fund an evaluation of the demonstration to ensure collection of system, provider, and beneficiary-level data to address their routine reporting requirements.

The Secretary may carry out the Secretary's authority under this paragraph through CMMI.

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

cluding partner notification services and communicable disease reporting. CDC and CMS shall determine the extent to which testing funds shall be supported jointly or separately by these agencies.

(4) HRSA.—HRSA shall allocate funds available through the Special Projects of National Significance (SPNS) Initiative Program (under subpart I of part F of the Ryan White HIV/AIDS Program) to support wrap-around core and support services not covered under Medicare or Medicaid and shall authorize the use of Ryan White HIV/AIDS Program funds to purchase services through capitated managed care programs that meet or exceed the services covered by the Ryan White HIV/AIDS Program at rates that are no greater than current per capita expenditures. HRSA is authorized to use funds under SPNS, and to waive such requirements of SPNS as may be necessary, to carry out the demonstration.

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

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

With AIDS (HOPWA) program to the States or cities participating in the demonstration to provide supportive housing and other housing assistance to beneficiaries who otherwise meet HOPWA eligibility criteria. HUD is authorized to use such HOPWA funds, and to waive such requirements under HOPWA as may be necessary, to carry out the demonstration.

(7) STATE MEDICAID AGENCIES.—Single State agencies responsible for administration of the Medicaid program for individuals who are accepted to participate in the demonstration shall—

(A) collaborate with CMS to design or refine a prepaid capitated payment model, to allocate and award contracts with capitated managed care plans, to ensure such plans meet State statutory or regulatory requirements, to contract with a coordinating agency to organize and deliver integrated HIV testing, medical care, support, and housing services funded under Medicare and Medicaid, other Federal, State, and local government sponsors, and to coordinate their activities with the State HIV/AIDS program; and

(B) identify and contract with a coordinating agency to organize the demonstration in the State, to establish a coordinating body representing State, local, and provider agencies participating in the demonstration, to establish systems of care that integrate HIV prevention, testing, treatment, support, and housing services, to establish mechanisms to gather evaluation data for reporting to CMMI and other participating Federal agencies, and to establish a quality management program to monitor provider performance in delivering the services provided to participating beneficiaries under the demonstration.

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

(f) DEFINITIONS.—In this section:

(1) CDC.—The term ''CDC'' means the Director of the Centers for Disease Control and Prevention.

(2) CMMI.—The term ''CMMI'' means the Director of the Center for Medicare and Medicaid Innovation.

(3) CMS.—The term ''CMS'' means the Administrator of the Centers for Medicare & Medicaid Services.

(4) DEMONSTRATION.—The term ''demonstration'' means the demonstration conducted under this section.

(5) HRSA.—The term ''HRSA'' means the Administrator of the Health Resources and Services Administration.

(6) HUD.—The term ''HUD'' means the Secretary of Housing and Urban Development.

(7) MEDICARE; MEDICAID.—The terms ''Medicare'' and ''Medicaid'' mean the programs under titles XVIII and XIX, respectively, of the Social Security Act.

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

(9) RYAN WHITE HIV/AIDS PROGRAM.—The term ''Ryan White HIV/AIDS Program'' means the

program under title XXVI of the Public Health Service Act.

(10) SAMHSA.—The term ''SAMHSA'' means the Substance Abuse and Mental Health Services Administration.

(11) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through CMMI.

SEC. 404. REPORT ON THE IMPLEMENTATION OF THE NATIONAL HIV/AIDS STRATEGY.

(a) REPORT REQUIRED.—The President, in consultation with the heads of all relevant agencies including the Department of Education, the Department of Health and Human Services, the Department of Housing and Urban Development, the Department of Justice, the Department of Labor, the Department of Veterans Affairs, and the Social Security Administration, shall enter an arrangement not later than 6 months after the date of the enactment of this Act with the Institute of Medicine of the National Academies (or, if the Institute declines to enter into such an arrangement, another appropriate entity)—

(1) to prepare a report on the status of the implementation of the National HIV/AIDS Strategy; and

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

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

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

(A) reducing the number of people who become infected with HIV;

(B) increasing access to care and optimizing health outcomes for people living with HIV; and

(C) reducing HIV-related health disparities;

(2) the extent to which the National HIV/AIDS Strategy has improved coordination of efforts to maximize the effective delivery of HIV/AIDS prevention, care, and treatment services at the community level, including coordination—

(A) within and among Federal agencies and departments;

(B) between the Federal Government and State and local governments and health departments;

(C) between the Federal Government and nonprofit foundations and civil society organizations, including community- and faith-based organizations focused on addressing the issue of HIV/AIDS; and

(D) between the Federal Government and private businesses;

(3) efforts by the Federal Government to educate, involve, and establish and strengthen partnerships with civil society organizations, including community- and faith-based organizations, in order to implement the National HIV/AIDS Strategy and achieve its goals;

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

(A) the amount of funding used to date, by each Federal agency and department, to implement the National HIV/AIDS Strategy;

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

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

Strategy, by each Federal agency and department, for the next fiscal year; and

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

(A) whether any existing statutory laws, policies, or regulations are impeding the implementation of the National HIV/AIDS Strategy, at the Federal, State, or local level, and whether any changes to such laws, policies, or regulations are necessary or recommended; and

(B) whether any Federal agencies or departments require additional statutory authority to effectively carry out their duties as part of the National HIV/AIDS Strategy.

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

DIVISION B—ENDING HIV/AIDS GLOBALLY

TITLE X—GLOBAL HIV/AIDS-FREE GENERATION STRATEGY

SEC. 1001. GLOBAL HIV/AIDS-FREE GENERATION STRATEGY.

(a) STRATEGY.—The President, acting through the Coordinator of United States Government Activities to Combat HIV/AIDS Globally, shall establish a comprehensive, integrated, 5-year strategy to expand and improve efforts to combat global HIV/AIDS, while promoting efficiency and maximizing results. The strategy shall be referred to as the ''Global HIV/AIDS-Free Generation Strategy''.

(b) CONTENTS.—The strategy shall—

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

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

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

(4) strengthen engagement with diplomatic efforts at all levels of government to—

(A) continue to identify and promote linkages between efforts to combat HIV/AIDS and other health development issues and human rights issues;

(B) encourage and assist national governments to pursue policies and legal frameworks that facilitate and enable effective responses to HIV prevention, care, and treatment services; and

(C) increase financial accountability;

(5) provide a plan to—

(A) support early diagnosis and initiation of HIV treatment to achieve accelerated reductions of incidence and morbidity;

(B) eliminate vertical transmission of HIV from mother to child and support early diagnosis and initiation of HIV treatment in infants and children;

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

other evidence-based modalities and structural interventions;

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

(E) increase gender equity in HIV/AIDS programs and services, including access to voluntary family planning and reproductive health services and reducing violence and coercion;

(F) expand partnership with implementers, researchers, and academic organizations to improve the science that guides the global response to HIV/AIDS;

(G) provide capacity development support to increase meaningful engagement of civil society, especially local indigenous organizations, that work in the areas of human rights, women's and young people's health and rights, and gay, lesbian, bisexual, and transgender rights, in the development, implementation, monitoring, and evaluation of United States-funded programs;

(H) advance the efforts of developing countries to develop health systems capable of man-

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

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

(c) CONSULTATION.—In developing the strategy, the President, acting through the Coordinator of United States Government Activities to Combat HIV/AIDS Globally, shall consult with—

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

(A) improving global health;

(B) strengthening financial management systems; and

(C) monitoring and promoting human rights and democracy;

(2) personnel at United States embassies and country missions involved in the administration of the types of United States foreign assistance described in paragraph (1);

(3) the appropriate congressional committees with jurisdiction over the agencies described in paragraph (1);

(4) civil society and nongovernmental organizations engaged in improving health care and health outcomes in developing countries, including indigenous community and faith-based organizations;

(5) international organizations engaged in improving health care and health outcomes in developing countries and of which the United States is a voting member, with which the United States coordinates the delivery of foreign assistance, or to which the United States contributes funding for the purpose of providing such assistance;

(6) academic organizations, private foundations, businesses, and other organizations engaged in improving health care and health outcomes in developing countries and not receiving United States funding for such purposes;

(7) other donor nations engaged in improving health care and health outcomes in developing countries;

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

(9) any other global, regional, or subregional organizations or partnerships engaged in improving health care and health outcomes in developing countries.

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

TITLE XI—USING FUNDS STRATEGICALLY TO MAXIMIZE RESULTS

SEC. 1101. SUPPORT FOR OPERATIONS RESEARCH TO IMPROVE PROGRAM DELIVERY, EFFICIENCY, IMPACT, AND EFFECTIVENESS.

(a) SENSE OF CONGRESS.—It is the sense of the Congress that there is a need and urgency to expand the range of interventions for preventing the transmission of HIV, including behavioral prevention research, operations research to optimize combination HIV prevention, and research on medical technology to prevent HIV infection, including microbicides, cost-effective female condoms, Pre-Exposure Prophylaxis (PrEP), multipurpose technologies for the prevention of HIV and unintended pregnancy, and vaccines.

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

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

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

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

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

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

SEC. 1102. INCREASING COORDINATION AND INTEGRATION OF HIV/AIDS PROGRAMS WITH DEVELOPMENT PROGRAMS.

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

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

(1) ensuring that women and adolescent girls with HIV or who are at risk of HIV infection and who do not wish to become pregnant have access to voluntary contraceptive services, including a range of contraceptive options, and voluntary counseling to plan families, either directly or through meaningful referrals to existing United States Agency for International Development or local family planning programs that provide counseling and a range of contraceptive options;

(2) integrating tuberculosis interventions with HIV services, including case-finding and tuberculosis treatment, expanding tuberculosis preventive therapy, and reducing other opportunistic infections that accompany HIV/AIDS;

(3) ensuring young people with HIV are provided with confidential and affordable access to youth-friendly comprehensive sexual and reproductive health services and supplies, including male and female condoms for the prevention of pregnancy and sexually transmitted diseases, as relevant; and

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

have sex with men, transgender people, people who inject drugs, sex workers, and other vulnerable populations, including indigenous people, migrants, internally displaced people, young people, incarcerated populations, and people with disabilities.

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

SEC. 1103. INCREASING PROGRAM EFFECTIVENESS AND SUSTAINABILITY TO ACHIEVE SUCCESSFUL COUNTRY OWNERSHIP.

(a) STATEMENT OF POLICY.—It should be the policy of the United States to ensure that efforts to combat HIV/AIDS globally should help developing countries significantly decrease the burden of HIV, strengthen and improve their health systems, help build country ownership, and increase financial accountability to ensure sustainability and equitable access to health services, including by—

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

(A) supporting early diagnosis and initiation of HIV and tuberculosis treatment to achieve accelerated reductions of incidence and morbidity;

(B) eliminating the vertical transmission of HIV from mother to child and supporting early diagnosis and initiation of HIV treatment in infants and children;

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

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

(E) ensuring young people are provided with comprehensive knowledge, skill-building programs, in and out of school, to make informed and responsible decisions for their sexual health, and are provided with confidential and affordable access to youth-friendly comprehensive sexual and reproductive health services and supplies, including male and female condoms;

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

(G) encouraging policy changes to eliminate discriminatory and stigmatizing polices that stand in the way of access to health services by marginalized and poor populations including punitive laws against HIV exposure and potential transmission, sex work, same-sex behavior, drug use, and gender expression;

(2) supporting meaningful community involvement and participation, inclusive of poor, vulnerable, or marginalized populations and their representative indigenous and civil society organizations, in decisionmaking related to national HIV/AIDS strategies and the delivery of health services, including in decisions related to the adoption of health policies and the total amount and distribution of health funding;

(3) assisting countries to coordinate, regulate, and harmonize the delivery of health services provided by the United States and nongovernmental organizations, including community and faith-based organizations, private foundations, international organizations, and other donors, and to coordinate or integrate such services with the health system to the maximum extent practicable;

(4) using, to the maximum extent practicable, local and regional entities for the provision of technical assistance, and where the capacity of such entities is insufficient, supporting capacity building to enable such entities to provide such assistance;

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

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

(6) providing technical assistance and support to national ministries of health, or their equivalents, and other relevant ministries in overseeing the health systems of their countries and monitoring and evaluating the effectiveness of such systems in reducing mortality and improving health outcomes, including preparing for the provision of HIV/AIDS, voluntary family planning, non-communicable diseases, and reproductive health services in emergency situations.

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

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

Subtitle A—General Provisions

SEC. 1201. SUPPORT FOR LAWS AND REGULATIONS THAT IMPROVE HEALTH OUTCOMES AND PROMOTE HUMAN RIGHTS.

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

(1) are medically accurate and evidence-based and adhere to the latest global public health standards for prevention, treatment, and care;

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

(3) work to remove criminalization of, stigmatization of, and discrimination against poor, vulnerable, or marginalized populations and enact laws

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

(4) avoid, to the maximum extent possible, reliance on criminal laws and sanctions to address health issues;

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

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

SEC. 1202. INTENSIFYING EFFORTS TO ESTABLISH EFFECTIVE PROGRAMS FOR ENGAGING KEY AFFECTED POPULATIONS.

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

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

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

jecting drug users through a comprehensive package of services;

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

(4) defending human rights and inherent dignity by addressing laws and practices that prevent people from accessing services and providing legal and social services to individuals and communities to facilitate access to services and to reduce violence, stigma, and discrimination.

SEC. 1203. ENSURING UNITED STATES TRADE POLICY DOES NOT RESTRICT ACCESS TO AFFORDABLE MEDICINES.

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

(1) promotes access to affordable HIV and opportunistic infection pharmaceuticals or medical technologies for affected populations in that country; and

(2) provides intellectual property protection consistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights referred to in section 101(d)(15) of the Uruguay Round Agreements Act (19 U.S.C. 3511(d)(15)).

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

SEC. 1211. REPEAL OF "CONSCIENCE CLAUSE" REQUIREMENT FOR ELIGIBILITY FOR ASSISTANCE.

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

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

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

SEC. 1213. REPEAL OF REPORTING REQUIREMENT ON ACTIVITIES PROMOTING ABSTINENCE AND RELATED ACTIVITIES.

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

(1) by striking ''(2) PREVENTION STRATEGY.—'' and all that follows through ''In carrying out paragraph (1)'' and inserting ''(2) PREVENTION STRATEGY.—In carrying out paragraph (1)''; and

(2) by striking subparagraph (B).

SEC. 1214. EFFECTIVE DATE.

This subtitle and the amendments made by this subtitle—

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

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

TITLE XIII—DEFINITIONS

SEC. 1301. DEFINITIONS.

In this division:

(1) APPROPRIATE CONGRESSIONAL COMMITTEES.—The term ''appropriate congressional committees'' means—

(A) the Committee on Foreign Affairs and the Committee on Appropriations of the House of Representatives; and

(B) the Committee on Foreign Relations and the Committee on Appropriations of the Senate.

(2) AIDS.—The term ''AIDS'' means the acquired immune deficiency syndrome.

(3) HIV.—The term ''HIV'' means the human immunodeficiency virus, the pathogen that causes AIDS.

(4) HIV/AIDS.—The term ''HIV/AIDS'' means, with respect to an individual, an individual who is infected with HIV or living with AIDS.

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