

percent of the population as a whole is Hispanic, and the CDC estimates that Hispanic-Americans accounted for 17 percent of new HIV infections in 2006;

Whereas Asian-Americans and Pacific Islanders account for 1 percent of new AIDS cases, and Native Americans and Alaska Natives account for up to 1 percent of new AIDS cases;

Whereas approximately 70 percent of new AIDS cases are racial and ethnic minorities;

Whereas, in 2008, the CDC released new estimates of HIV infection, which indicate that approximately 56,300 new HIV infections occurred in the United States in 2006;

Whereas these new estimates are approximately 40 percent higher than the CDC's previous estimates of 40,000 new infections per year;

Whereas the CDC's data confirms that the most severe impact of HIV/AIDS continues to be among gay and bisexual men of all races, and Black men and women;

Whereas the purpose of the Minority AIDS Initiative is to enable community-based organizations and health care providers in minority communities to improve their capacity to deliver culturally and linguistically appropriate HIV/AIDS care and services;

Whereas the establishment of the Minority AIDS Initiative was announced on October 28, 1998, during a "roll-out" event sponsored by the Congressional Black Caucus, which featured the participation of President Bill Clinton, Secretary of Health and Human Services Donna Shalala, Representative Maxine Waters, members of the Congressional Black Caucus, and representatives of HIV/AIDS service and advocacy organizations;

Whereas it was announced at this roll-out that the Minority AIDS Initiative would receive an initial appropriation of \$156,000,000 in fiscal year 1999;

Whereas concerned Members of Congress, including members of the Congressional Black Caucus, the Congressional Hispanic Caucus, the Congressional Asian Pacific American Caucus, and the Congressional Hispanic Conference, continue to support the Minority AIDS Initiative;

Whereas the Minority AIDS Initiative continues to provide funding to community-based organizations, research institutions, minority-serving colleges and universities, health care organizations, State and local health departments, correctional institutions, and other providers of health information and services to help such entities address the HIV/AIDS epidemic within the minority populations they serve;

Whereas Congress codified the Minority AIDS Initiative within the most recent reauthorization of the Ryan White CARE Act;

Whereas the Minority AIDS Initiative fills gaps in HIV/AIDS outreach, awareness, prevention, treatment, surveillance, and infrastructure across communities of color; and

Whereas, October 28, 2008, is the 10th anniversary of the establishment of the Minority AIDS Initiative: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That the Senate—

(1) recognizes and commemorates the 10th anniversary of the establishment of the Minority AIDS Initiative;

(2) commends the efforts of community-based organizations and health care providers in minority communities to deliver culturally and linguistically appropriate human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) care and services within the minority populations they serve;

(3) encourages racial and ethnic minorities to educate themselves about the prevention and treatment of HIV/AIDS and reduce the stigma associated with HIV/AIDS; and

(4) supports the continued funding of the Minority AIDS Initiative and other Federal programs to stop the spread of HIV/AIDS and to provide effective, compassionate treatment and care to individuals affected by HIV/AIDS.

AMENDMENTS SUBMITTED AND PROPOSED

SA 5642. Mr. DORGAN (for Mr. KENNEDY (for himself and Mr. HATCH)) proposed an amendment to the bill H.R. 1343, to provide additional authorizations of appropriations for the health centers program under section 330 of such Act, and for other purposes.

SA 5643. Mr. WYDEN (for himself and Mr. BARRASSO) submitted an amendment intended to be proposed by him to the bill S. 3268, to amend the Commodity Exchange Act, to prevent excessive price speculation with respect to energy commodities, and for other purposes; which was ordered to lie on the table.

SA 5644. Mr. SALAZAR (for Mrs. MCCASKILL (for herself, Mr. SALAZAR, Ms. COLLINS, and Mr. LIEBERMAN)) proposed an amendment to the bill H.R. 928, to amend the Inspector General Act of 1978 to enhance the independence of the Inspectors General, to create a Council of the Inspectors General on Integrity and Efficiency, and for other purposes.

TEXT OF AMENDMENTS

SA 5642. Mr. DORGAN (for Mr. KENNEDY (for himself and Mr. HATCH)) proposed an amendment to the bill H.R. 1343, to provide additional authorizations of appropriations for the health centers program under section 330 of such Act, and for other purposes; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Health Care Safety Net Act of 2008".

SEC. 2. COMMUNITY HEALTH CENTERS PROGRAM OF THE PUBLIC HEALTH SERVICE ACT.

(a) ADDITIONAL AUTHORIZATIONS OF APPROPRIATIONS FOR THE HEALTH CENTERS PROGRAM OF PUBLIC HEALTH SERVICE ACT.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by amending paragraph (1) to read as follows:

"(1) IN GENERAL.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there are authorized to be appropriated—

- "(A) \$2,065,000,000 for fiscal year 2008;
- "(B) \$2,313,000,000 for fiscal year 2009;
- "(C) \$2,602,000,000 for fiscal year 2010;
- "(D) \$2,940,000,000 for fiscal year 2011; and
- "(E) \$3,337,000,000 for fiscal year 2012."

(b) STUDIES RELATING TO COMMUNITY HEALTH CENTERS.—

(1) DEFINITIONS.—For purposes of this subsection—

(A) the term "community health center" means a health center receiving assistance under section 330 of the Public Health Service Act (42 U.S.C. 254b); and

(B) the term "medically underserved population" has the meaning given that term in such section 330.

(2) SCHOOL-BASED HEALTH CENTER STUDY.—

(A) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Comptroller General of the United States shall issue a study of the economic costs and benefits of school-based health centers and

the impact on the health of students of these centers.

(B) CONTENT.—In conducting the study under subparagraph (A), the Comptroller General of the United States shall analyze—

(i) the impact that Federal funding could have on the operation of school-based health centers;

(ii) any cost savings to other Federal programs derived from providing health services in school-based health centers;

(iii) the effect on the Federal Budget and the health of students of providing Federal funds to school-based health centers and clinics, including the result of providing disease prevention and nutrition information;

(iv) the impact of access to health care from school-based health centers in rural or underserved areas; and

(v) other sources of Federal funding for school-based health centers.

(3) HEALTH CARE QUALITY STUDY.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this Act as the "Secretary"), acting through the Administrator of the Health Resources and Services Administration, and in collaboration with the Agency for Healthcare Research and Quality, shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that describes agency efforts to expand and accelerate quality improvement activities in community health centers.

(B) CONTENT.—The report under subparagraph (A) shall focus on—

(i) Federal efforts, as of the date of enactment of this Act, regarding health care quality in community health centers, including quality data collection, analysis, and reporting requirements;

(ii) identification of effective models for quality improvement in community health centers, which may include models that—

(I) incorporate care coordination, disease management, and other services demonstrated to improve care;

(II) are designed to address multiple, co-occurring diseases and conditions;

(III) improve access to providers through non-traditional means, such as the use of remote monitoring equipment;

(IV) target various medically underserved populations, including uninsured patient populations;

(V) increase access to specialty care, including referrals and diagnostic testing; and

(VI) enhance the use of electronic health records to improve quality;

(iii) efforts to determine how effective quality improvement models may be adapted for implementation by community health centers that vary by size, budget, staffing, services offered, populations served, and other characteristics determined appropriate by the Secretary;

(iv) types of technical assistance and resources provided to community health centers that may facilitate the implementation of quality improvement interventions;

(v) proposed or adopted methodologies for community health center evaluations of quality improvement interventions, including any development of new measures that are tailored to safety-net, community-based providers;

(vi) successful strategies for sustaining quality improvement interventions in the long-term; and

(vii) partnerships with other Federal agencies and private organizations or networks as appropriate, to enhance health care quality in community health centers.