I am just going to say, I also have personal experience with this. After my husband contracted COVID–19 from me, after I got it when some colleagues on the other side of the aisle did not want to wear masks on January 6 in the safe room, he, unfortunately had a series of heart attacks and had to have a series of heart operations last year.

Every single doctor said to us, we need more research on exactly what the causal relationship is. And this is the reality of where we are today; and I think that this amendment by Representative SHERRILL is a very good addition to the bill.

Mr. CARTER of Georgia. Madam Speaker, I oppose this amendment. I think it is duplicative, and I think it is a waste of taxpayers' money.

Madam Speaker, I yield back the balance of my time.

Mr. PALLONE. Madam Speaker, I would urge support for the amendment, as well as the underlying bill, and I yield back the balance of my time.

The SPEAKER pro tempore. Pursuant to the rule, the previous question is ordered on the amendment offered by the gentleman from New Jersey (Mr. PALLONE).

The question is on the amendment.

The amendment was agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT

Mrs. MILLER-MEEKS. Madam Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mrs. MILLER-MEEKS of Iowa moves to recommit the bill H.R. 3771 to the Committee on Energy and Commerce.

The material previously referred to by Mrs. MILLER-MEEKS is as follows:

At the end of the bill, add the following new section:

SEC. 4. REPORT ON THE COVID–19 EDUCATION CRISIS IN PUBLIC SCHOOLS.

Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall provide to Congress a report on the COVID–19 education crisis in public schools during the period between March 1, 2020, and March 1, 2022. Such report shall include—

(1) the average number of days elementary and secondary education schools were closed to in-person classroom instruction;

(2) the average amount of time intended for in-person classroom instruction that was lost;

(3) the participation rates in remote-learning programs;

(4) the impact of school closures on children, including the disproportionate impact on children in low-income, disadvantaged, or vulnerable communities, with regard to—

(A) academic achievement;

(B) mental health and well-being; and

(C) social development;

(5) a detailed accounting of the Centers for Disease Control and Prevention's decision-making process and data used for the creation of the ''Operational Guidance for K–12 Schools and Early Care and Education Programs to Support Safe In-Person Learning''; and

(6) a detailed accounting of unspent Federal dollars directed to school districts that were authorized by the American Rescue Plan Act.

The SPEAKER pro tempore. Pursuant to clause 2(b) of rule XIX, the previous question is ordered on the motion to recommit.

The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mrs. MILLER-MEEKS. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to section 8 of rule XX, further proceedings on this question will be postponed.

ADVANCING TELEHEALTH BEYOND COVID–19 ACT OF 2021

Mr. PALLONE. Madam Speaker, pursuant to House Resolution 1256, I call up the bill (H.R. 4040) to amend title XVIII of the Social Security Act to extend telehealth flexibilities under the Medicare program, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolution 1256, an amendment in the nature of a substitute consisting of the text of Rules Committee Print 117–59, modified by the amendment printed in part B of House Report 117–444, is adopted. The bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

H.R. 4040

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 ''Advancing Telehealth Beyond COVID–19 Act of 2022''.

SEC. 2. REMOVING GEOGRAPHIC REQUIREMENTS AND EXPANDING ORIGINATING SITES FOR TELEHEALTH SERVICES.

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

(1) in paragraph (2)(B)(iii)—

(A) by striking ''With'' and inserting ''In the case that the emergency period described in section 1135(g)(1)(B) ends before December 31, 2024, with''; and

(B) by striking ''that are furnished during the 151-day period beginning on the first day after the end of the emergency period described in section 1135(g)(1)(B)'' and inserting ''that are furnished during the period beginning on the first day after the end of such emergency period and ending December 31, 2024''; and

(2) in paragraph (4)(C)(iii)—

(A) by striking ''With'' and inserting ''In the case that the emergency period described in section 1135(g)(1)(B) ends before December 31, 2024, with''; and

(B) by striking ''that are furnished during the 151-day period beginning on the first day after the end of the emergency period described in section 1135(g)(1)(B)'' and inserting ''that are furnished during the period beginning on the first day after the end of such emergency period and ending on December 31, 2024''.

SEC. 3. EXPANDING PRACTITIONERS ELIGIBLE TO FURNISH TELEHEALTH SERVICES.

Section 1834(m)(4)(E) of the Social Security Act (42 U.S.C. 1395m(m)(4)(E)) is amended by striking ''and, for the 151-day period beginning on the first day after the end of the emergency period described in section 1135(g)(1)(B)'' and inserting ''and, in the case that the emergency period described in section 1135(g)(1)(B) ends before December 31, 2024, for the period beginning on the first day after the end of such emergency period and ending on December 31, 2024''.

SEC. 4. EXTENDING TELEHEALTH SERVICES FOR FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

Section 1834(m)(8)(A) of the Social Security Act (42 U.S.C. 1395m(m)(8)(A)) is amended by striking ''during the 151-day period beginning on the first day after the end of such emergency period'' and inserting ''in the case that such emergency period ends before December 31, 2024, during the period beginning on the first day after the end of such emergency period and ending on December 31, 2024''.

SEC. 5. DELAYING THE IN-PERSON REQUIREMENTS UNDER MEDICARE FOR MENTAL HEALTH SERVICES FURNISHED THROUGH TELEHEALTH AND TELECOMMUNICATIONS TECHNOLOGY.

(a) DELAY IN REQUIREMENTS FOR MENTAL HEALTH SERVICES FURNISHED THROUGH TELEHEALTH.—Section 1834(m)(7)(B)(i) of the Social Security Act (42 U.S.C. 1395m(m)(7)(B)(i)) is amended, in the matter preceding subclause (I), by striking ''on or after the day that is the 152nd day after the end of the period at the end of the emergency sentence described in section 1135(g)(1)(B))'' and inserting ''on or after January 1, 2025 (or, if later, the first day after the end of the emergency period described in section 1135(g)(1)(B))''.

(b) MENTAL HEALTH VISITS FURNISHED BY RURAL HEALTH CLINICS.—Section 1834(y) of the Social Security Act (42 U.S.C. 1395m(y)) is amended—

(1) in the heading, by striking ''TO HOSPICE PATIENTS''; and

(2) in paragraph (2), by striking ''prior to the day that is the 152nd day after the end of the emergency period described in section 1135(g)(1)(B))'' and inserting ''prior to January 1, 2025 (or, if later, the first day after the end of the emergency period described in section 1135(g)(1)(B))''.

(c) MENTAL HEALTH VISITS FURNISHED BY FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1834(o)(4) of the Social Security Act (42 U.S.C. 1395m(o)(4) is amended—

(1) in the heading, by striking ''TO HOSPICE PATIENTS''; and

(2) in subparagraph (B), by striking ''prior to the day that is the 152nd day after the end of the emergency period described in section 1135(g)(1)(B))'' and inserting ''prior to January 1, 2025 (or, if later, the first day after the end of the emergency period described in section 1135(g)(1)(B))''.

SEC. 6. ALLOWING FOR THE FURNISHING OF AUDIO-ONLY TELEHEALTH SERVICES.

Section 1834(m)(9) of the Social Security Act (42 U.S.C. 1395m(m)(9)) is amended by striking ''The Secretary shall continue to provide coverage and payment under this part for telehealth services identified in paragraph (4)(F)(i) as of the date of the enactment of this paragraph that are furnished via an audio-only telecommunications system during the 151-day period beginning on the first day after the end of the emergency period described in section 1135(g)(1)(B)'' and inserting ''In the case that the emergency period described in section 1135(g)(1)(B) ends before December 31, 2024, the Secretary shall continue to provide coverage

and payment under this part for telehealth services identified in paragraph (4)(F)(i) that are furnished via an audio-only communications system during the period beginning on the first day after the end of such emergency period and ending on December 31, 2024''.

SEC. 7. USE OF TELEHEALTH TO CONDUCT FACE-TO-FACE ENCOUNTER PRIOR TO RECERTIFICATION OF ELIGIBILITY FOR HOSPICE CARE DURING EMERGENCY PERIOD.

Section 1814(a)(7)(D)(i)(II) of the Social Security Act (42 U.S.C. 1395f(a)(7)(D)(i)(II)) is amended by striking ''and during the 151-day period beginning on the first day after the end of such emergency period'' and inserting ''and, in the case that such emergency period ends before December 31, 2024, during the period beginning on the first day after the end of such emergency period described in such section 1135(g)(1)(B) and ending on December 31, 2024''.

SEC. 8. FUNDING FROM MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395jjj(b)(1)) is amended by striking ''$7,500,000,000'' and inserting ''$5,153,000,000''.

SEC. 9. PROGRAM INSTRUCTION AUTHORITY.

Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the provisions of, including amendments made by, sections 2 through 7 through program instruction or otherwise.

SEC. 10. DETERMINATION OF BUDGETARY EFFECTS.

The budgetary effects of this Act, for the purpose of complying with the Statutory Pay-As-You-Go Act of 2010, shall be determined by reference to the latest statement titled ''Budgetary Effects of PAYGO Legislation'' for this Act, submitted for printing in the Congressional Record by the Chairman of the House Budget Committee, provided that such statement has been submitted prior to the vote on passage.

The SPEAKER pro tempore. The bill, as amended, shall be debatable for 1 hour equally divided and controlled by the chair and ranking minority member of the Committee on Energy and Commerce or their respective designees.

The gentleman from New Jersey (Mr. PALLONE) and the gentleman from Georgia (Mr. CARTER) each will control 30 minutes.

The Chair recognizes the gentleman from New Jersey (Mr. PALLONE).

GENERAL LEAVE

Mr. PALLONE. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and add extraneous material on H.R. 4040.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. PALLONE. Madam, I yield myself such time as I may consume.

I rise in support of H.R. 4040, the Advancing Telehealth Beyond COVID–19 Act, bipartisan legislation, introduced by Representatives CHENEY and DINGELL.

Over the course of this pandemic, telehealth has served as an important tool for staying connected to care without increasing the risk of exposure to COVID–19. And in the Medicare program, millions have utilized telehealth for the first time during the pandemic, thanks to actions taken early on by Congress and the administration.

When the pandemic was beginning to take hold in America, Congress moved quickly to significantly expand access to telehealth for Medicaid beneficiaries. And this was critically important because Medicare beneficiaries are some of the most vulnerable to COVID–19.

The waiver of Medicare's originating site and geographic restrictions during the public health emergency has allowed millions of Medicare beneficiaries nationwide to receive telehealth services, including audio-only services, without ever having to leave their homes.

Now, the Energy and Commerce Committee has a long history of working to expand access to telehealth services in the Medicare program. For example, the SUPPORT Act expanded access to substance use disorder services delivered via telehealth.

The Consolidated Appropriations Act of 2021 permanently expanded access to telemental health services and Medicare. And most recently, the Consolidated Appropriations Act of 2020 extended key telehealth flexibilities for an additional 5 months after the end of the public health emergency.

So H.R. 4040 builds on the bipartisan telehealth extension included in the Consolidated Appropriations Act of 2022. The bill extends the same key telehealth flexibilities as the previous legislation, but now would extend them until December 31, 2024, essentially 2 more years. And this longer-term extension will provide beneficiaries and stakeholders with more certainty.

It will also give policymakers time to assess the impact expanded telehealth services have had on the Medicare program and on beneficiaries' health and well-being, and the quality of care that they are receiving.

So I thank the many Energy and Commerce Committee members who have been leaders on this issue over the years, such as Representatives DINGELL, ESHOO, MATSUI, WELCH, BLUNT-ROCHESTER, KELLY, and many more.

And I also commend Representative CHENEY and DINGELL for their bipartisan leadership on this legislation today.

I look forward to working with all Members on a permanent solution to address telehealth coverage under Medicare but, in the meantime, this multi-year extension is critical for preserving access to telehealth services.

The language included in the bill is the same bipartisan language previously negotiated by the House and Senate committees and the bill—and I stress, Madam Speaker, that the bill is fully paid for.

So I hope we can, once again, extend these flexibilities with strong bipartisan support.

I urge all my colleagues to support this bill, and I reserve the balance of my time.

Mr. CARTER of Georgia. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, one of my top priorities since I have been a Member of Congress has been to make sure that healthcare is accessible and available for all Americans. Telehealth has played a critical role for patients to access the care they desperately need.

□ 1245

On the Energy and Commerce Committee, we have been discussing the importance of telehealth flexibilities for years. It is bringing doctors right into families' living rooms and is an example of how innovation can improve and save people's lives.

As the coronavirus spread and providers closed their doors, patients and providers were forced to adapt and utilize telehealth services. Just months into the public health emergency, Medicare was receiving over a million telehealth visits a week, an almost 3,000 percent increase. Those without adequate transportation or in rural areas were still able to visit with their doctor.

While we have made great strides in making telehealth more broadly available, we know that Congress can do more. Increasing access to telehealth means increasing access to quality care for all patients.

I often discuss how, before the pandemic, we had a lot of regulations and red tape that piled up over the years. So while I will support this legislation, it is a shame that we did not take something as important as this through committee to make sure it could be the best possible product.

Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield 3 minutes to the gentlewoman from Michigan (Mrs. DINGELL).

Mrs. DINGELL. Madam Speaker, I rise in support of this legislation, which would provide critical extensions of existing telehealth flexibilities that have been in place during the COVID–19 pandemic.

The Advancing Telehealth Beyond COVID–19 Act of 2021, which I co-led with my colleague, Congresswoman CHENEY, will do just that. It will extend a broad range of telehealth flexibilities that are central to enabling access to care via telehealth from any location through December 31, 2024.

This includes allowing any site in the United States, including a patient's home, to be considered an eligible originating site for the delivery of telehealth services. It also extends other vital services, including coverage of certain telehealth services delivered via audio-only format.

Collectively, these changes will build on what has worked during the pandemic. It will expand access to quality, affordable healthcare across the country, particularly in rural and underserved communities.

It will also, Madam Speaker, allow those who have been afraid to go to the doctor, who haven't been able to get in, to be able to consult with medical professionals as they need it.

I thank my colleague, Congresswoman CHENEY, for partnering with me on this effort, as well as Chairman PALLONE for his thoughtful leadership and input on the legislation before us today.

It is also important to recognize other leading voices on the telehealth issue in the Congress, including Congressman MIKE THOMPSON for his pioneering efforts on this issue.

This legislation is a bipartisan win for the American people. Madam Speaker, I urge my colleagues to support it.

Mr. CARTER of Georgia. Madam Speaker, I yield 2 minutes to the gentlewoman from Washington (Mrs. RODGERS), the ranking member of the Energy and Commerce Committee.

Mrs. RODGERS of Washington. Madam Speaker, I appreciate the gentleman yielding.

I grew up in a small town, Kettle Falls, and I have lived through the challenges that people face in rural communities.

I have also visited hospitals and healthcare facilities all throughout my district. During the pandemic, Providence Health System scaled up their telehealth services with a 1,000 percent increase in volume.

Telehealth visits by seniors on Medicare increased from 840,000 in 2019 to 52.7 million in 2020 nationwide. Many of these visits were from seniors' homes, which were not paid for by Medicare prior to the pandemic.

Congress and the Trump administration, by action, required Medicare to pay for more telehealth services, reducing out-of-pocket costs and expanding the availability of telehealth services and long-term care where people are especially vulnerable to COVID–19. This bill today makes some of those actions last beyond the public health emergency through 2024.

While I support this legislation, I do think this is a missed opportunity to do more. Republicans on the Energy and Commerce Committee have many solutions to not just look at telehealth and Medicare for a couple of years but to look also at how we incentivize employers to provide access to telehealth for an estimated 156 million people with employer health insurance.

We have examined and worked on solutions to address both where telehealth may not be appropriate and where it drives better outcomes for patients.

Healthcare providers and patients need certainty. The pandemic has made it clear that telehealth can and should be a part of modernizing healthcare.

I plan to support this legislation and hope to continue to work to unwind the public health emergency in a way that provides patients and our healthcare providers the certainty that they need. I do think that we could have done more on this and hope that this process won't be a model for the rest.

Mr. PALLONE. Madam Speaker, I yield 3 minutes to the gentlewoman from California (Ms. MATSUI), a member of the Energy and Commerce Committee.

Ms. MATSUI. Madam Speaker, I rise today in support of H.R. 4040, the Advancing Telehealth Beyond COVID–19 Act, legislation to further extend telehealth policies that have been critical to providing care during the pandemic through the end of 2024.

Since long before the COVID pandemic, I worked closely with my Energy and Commerce Committee colleague, Representative BILL JOHNSON, in crafting legislation to remove barriers to telehealth and advancing policies that expand access and improve the quality of care for Medicare beneficiaries.

As a cosponsor of this bill, I am pleased to see some of that important work make progress today. This legislation builds on Congress' efforts to give patients and providers the certainty they need that telehealth is here to stay.

While this bipartisan telehealth bill meets many of our shared objectives, we also must recognize that our work on telehealth is not done. There are vital telehealth priorities still demanding our attention that will truly shape care delivery for the future, including the need to extend the DEA in-person waiver for remote prescribing of controlled substances after the public health emergency ends.

Likewise, while this bill continues a crucial delay of the in-person telemental health requirement, we cannot allow an arbitrary and clinically unsupported in-person requirement to act as a barrier to mental health care when the pandemic extensions run out.

I look forward to continuing this work with my colleagues. This is a really good bill, but we want to ensure that permanent Medicare policy supports telehealth in ways that ensure beneficiaries can continue to get the right care in the right place at the right time.

Mr. CARTER of Georgia. Madam Speaker, I yield 2 minutes to the gentleman from Utah (Mr. CURTIS), an important member of the Energy and Commerce Committee.

Mr. CURTIS. Madam Speaker, I thank Mr. CARTER for his support.

I rise today in support of the Advancing Telehealth Beyond COVID–19 Act. There is no putting the genie back in the bottle. COVID–19 highlighted the importance of telehealth, especially in providing quality care for rural communities. This bill would extend telehealth offered through Medicare through the end of 2024.

Like many of my colleagues, I would like to see that go longer. This bill includes a provision I have supported in my bill, the Protecting Mental Health Services Act, which extends mental health services delivered through telehealth.

While Utah has, for the most part, returned to regular life, it is important that we keep in place those flexibilities that give Utahns control over their healthcare decisions.

I support this bill and am pleased the Protecting Mental Health Services Act was included. Madam Speaker, I urge my colleagues to support its passage.

Mr. PALLONE. Madam Speaker, I yield such time as she may consume to the gentlewoman from Wyoming (Ms. CHENEY).

Ms. CHENEY. Madam Speaker, I thank the chairman for yielding. I appreciate it.

I am very pleased, Madam Speaker, that today the House will have the opportunity to vote on this important bipartisan legislation. It is an unusual circumstance to have a bill that has such broad bipartisan support.

I know many of my colleagues have worked on many different aspects of the bill that we are going to consider and vote on today. I am honored to be an original cosponsor of this bill, along with my good friend from Michigan, Congresswoman DINGELL, who spoke earlier.

All of us, I think, around the country, especially in rural America, saw the impact of COVID on the ability of our constituents to get the treatment that they need. We first began working on legislation to expand telehealth capabilities more than 2 years ago, following the onset of the pandemic.

In Wyoming, we have long known how important it is for citizens to be able to take advantage of the technology that exists today, how crucial telehealth services are in allowing all of our citizens to interact with their doctors and their other healthcare providers, and we saw this, in particular, during the pandemic.

We know it is vital that Medicare adapt to the ever-changing innovation in medical technology that allows telehealth services, and this legislation really will expand freedom for patients by giving them more flexibility and more capability to use telehealth services.

Specifically, the legislation removes geographic requirements, and it expands originating sites so that Medicare beneficiaries can receive care at any site. It can expand the practitioners who are able to furnish telehealth services, and it also provides for audio-only telehealth.

I am very pleased that this extension through 2024 was fully paid for using the Medicare Improvement Fund, and the CBO has shown that it will not increase direct spending.

Madam Speaker, in Wyoming, especially, we know how important this is, how important telehealth access is. Many of our citizens live hours away, hundreds of miles away, from their closest medical provider. I am very proud that this bill has the support of the Wyoming Hospital Association, in addition to the American Medical Association and a number of other crucial groups whose mission is to serve patients and provide quality care.

While I know we in this body will continue to have legitimate and important ongoing policy debates about

healthcare, there is, as I said, broad bipartisan agreement for expanding access so that all of our citizens can receive high-quality care. That needs to continue to be a top priority. This bill does just that by allowing more Americans to utilize telehealth services.

Madam Speaker, I thank my colleagues from both sides of the aisle for joining me in advancing our bill to this point, and I urge all Members to vote in favor of this legislation so more citizens can connect and receive care from the medical professionals of their choice.

Mr. CARTER of Georgia. Madam Speaker, I yield 2 minutes to the gentleman from Texas (Mr. BURGESS).

Mr. BURGESS. Madam Speaker, I thank the gentleman for yielding.

One of the many lessons we learned during the pandemic is the ability to take care of patients who are safely in their own homes. It was truly a highlight.

Understanding that we will not be going back to the status quo of 2019, we must recognize how telehealth has allowed our country to take a monumental step forward toward digitally enabled care.

Telehealth has allowed Americans to take care of immediate and necessary health needs from their homes without the costs and health risks that are often associated with an in-person visit. They don't incur costs for parking. They don't have to take time off from work. They don't have to hire a babysitter.

While I am in support of this legislation, it does not go far enough. We do need to provide a permanent solution for Medicare providers and, most importantly, their patients.

It is important that providers are given long-term certainty when taking care of their Medicare patients and are technologically capable of delivering the best care possible.

Yesterday, I introduced, along with Representatives GREG MURPHY and YVETTE HERRELL, H.R. 8506 to permanently extend Medicare coverage of telehealth services for federally qualified health centers and rural health clinics.

This important permanent extension would ensure that following the pandemic, providers and patients continue to have access to telehealth flexibilities, especially in rural and underserved areas. These are arguably communities that have benefited the most from an increase in telehealth access.

We will continue to see innovation and technology that will further influence how we deliver care to American patients. We need to keep up with the times. This bill is an important step, but it is not the end of the discussion.

□ 1300

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Madam Speaker, with telehealth helping so many throughout this pandemic, we should certainly continue its benefits, as I proposed in bipartisan legislation last year, and for which I secured the support of 22 health-related stakeholders. But we don't have to accept billions of dollars of fraud, of theft of taxpayer funds as the price for maintaining telehealth.

Here is what has been happening: Information for some patients who wanted a COVID–19 test was used fraudulently to bill Medicare for expensive cancer genetic tests and allergy tests without any medical necessity or any knowledge of the patient. In other cases, expensive medical equipment in no way needed by the patient was ordered.

The wrongdoing has been exposed by the General Accountability Office, the Health and Human Services inspector general, and is the subject of Justice Department prosecutions for literally billions of taxpayer dollars. Through no fault of the gentlewoman from Wyoming (Ms. CHENEY) or Chairman PALLONE, this bill fails to address this theft. I offered an amendment to the bill that was recommended by an independent, nonpartisan commission called MedPAC, mandating reasonable steps to prevent or at least significantly reduce this telehealth fraud. Outrageous interference with the consideration of this bill is denying the House today any opportunity to consider this antifraud amendment.

My amendment would have required in-person visits within 6 months prior to ordering this high-cost lab testing or DME—medical equipment—as well as an audit of outlier clinicians whose orders for these very high-cost services and devices are largely made through a telehealth appointment. This has to stop, and we need to prevent the fraud, not just prosecute it and get back a few pennies for the taxpayer per dollar after it has occurred.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. PALLONE. Madam Speaker, I yield the gentleman an additional 1 minute.

Mr. DOGGETT. Madam Speaker, this bill costs $132 million per month. Without these targeted provisions to prevent Medicare from being looted, I must vote against it.

Mr. CARTER of Georgia. Madam Speaker, I yield 2½ minutes to the gentleman from Ohio (Mr. JOHNSON), another valuable member of the Energy and Commerce Committee.

Mr. JOHNSON of Ohio. Madam Speaker, this should be a happy occasion because major telehealth legislation is being brought to the floor on its own. Finally.

As a co-chair of the bipartisan Congressional Telehealth Caucus, my fellow caucus members and I have been pushing for telehealth to be recognized for its true value for years. Years.

So here we are, and those of us who are leaders on the Congressional Telehealth Caucus, the Energy and Commerce Committee, Ways and Means, and are all longtime champions for telehealth reforms, we have been completely left out of the process.

The product we have before us today is a small step in the right direction, but the American people deserve better. This legislation, conceived in a last-minute deal, is, sadly, a missed opportunity.

This legislation, well, frankly, it looks familiar. It removes geographic restrictions, enables telehealth access in the home, protects telemental health services—reforms we have been seeking for years now.

But it is time to decouple important telehealth reforms from this never-ending public health emergency. Kicking the can down the road another year-and-a-half, as this legislation does, just isn't sufficient.

During COVID–19, temporary telehealth expansion was a real bright spot. It eased burdens on a strained medical system, protected at-risk patients, and in rural Appalachian districts like mine, I heard from countless constituents who were very relieved that they could access care from their home instead of the common half hour or even longer to drive to the appointments they needed.

Now, Madam Speaker, it is time for permanent reforms. I am proud to have introduced H.R. 8493 with my colleagues VERN BUCHANAN and MICHELLE STEEL to make real long-term reforms to telehealth. This, coupled with the additional alternative proposals my colleagues have offered today, would do just that.

Clearly, as you can see, Madam Speaker, the Speaker of the House has the will to take on this challenge. But this bill on the floor today? Well, I am going to support it, but I am afraid it is just a start. We have more to do.

Mr. PALLONE. Madam Speaker, I have no additional speakers at this time. We may have one more, but not at this time. I reserve the balance of my time.

Mr. CARTER of Georgia. Madam Speaker, I yield 1 minute to the gentleman from California (Mr. VALADAO).

Mr. VALADAO. Madam Speaker, I appreciate the opportunity to speak on this. Telehealth is critical for rural and low-income communities like many in my district, and I absolutely support this bill.

Throughout the COVID–19 pandemic, telehealth was widely used since we were not able to see our healthcare providers in person. Even before the pandemic, many of my constituents were not able to go to their health appointments because oftentimes the office was way too far, or they did not have the transportation to get to their provider.

Through this legislation, the Advancing Telehealth Beyond COVID–19 Act, some of the healthcare flexibilities we have seen since 2020 would be extended for another 2 years. This action is very necessary, but I also believe it is in the

best interests of our constituents to take these flexibilities and make them permanent.

I introduced a companion bill with my colleagues that would make permanent the expanded list of practitioners eligible to provide telehealth services.

Congresswoman CHENEY's bill is a great starting point, but I encourage my colleagues to make these flexibilities permanent so our constituents can have access to the care even after the public health emergency declaration has ended.

Mr. PALLONE. Madam Speaker, I am prepared to close, but I think Republicans may have additional speakers.

Mr. CARTER of Georgia. Madam Speaker, I yield myself such time as I may consume.

Again, let me be clear about my standing on this bill. I support this bill. We support telehealth. We are all in favor of telehealth, but we also support the fact that we have committees that this type of legislation needs to go through, and we missed an opportunity here to make this a better bill. That is simply what we are saying.

No one is saying they are not in favor of telehealth. Telehealth has become an integral part of our healthcare system during this pandemic. There is no question about that. All of us agree on that. It needs to be extended.

But, again, the committee process is exceptionally important, and we need to make sure that we follow that, particularly when we are talking about subject matter as important as this because it is important.

Again, since I have been a Member of Congress, I have been working to make healthcare accessible and available, and telehealth does just that. This is exactly what we want, but there are ways that we could have made this better.

One example is that we need to make sure there is no waste, fraud, and abuse. That is one thing that could have been tightened up in this legislation.

Another example is to make sure that we are not having any information that is inadvertently or intentionally being released. That is extremely important as well.

So again, there are ways that we could have made this legislation better if we had gone through the committee process, which is a process that is extremely important.

Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I continue to reserve the balance of my time.

The SPEAKER pro tempore. The gentleman from Nebraska is recognized and controls the time.

Mr. SMITH of Nebraska. Madam Speaker, may I inquire how much time is remaining?

The SPEAKER pro tempore. The gentleman has 19 minutes remaining.

Mr. SMITH of Nebraska. Madam Speaker, I yield 2 minutes to the gentlewoman from Iowa (Mrs. MILLER-MEEKS).

Mrs. MILLER-MEEKS. Madam Speaker, I rise today in support of H.R. 4040. This bill would extend telehealth flexibilities under Medicare until 2024. These flexibilities allow physicians to be more widely available to patients who no longer need to wait weeks for a visit or take hours off work to sit in a doctor's office.

While I support this bill, I am disappointed that the majority did not follow the regular committee process, which could have further improved the bill in a bipartisan way.

For example, the committee could have incorporated elements of the Greater Access to Telehealth Act, which I am proud to co-lead with the gentleman from Arizona (Mr. SCHWEIKERT) and the gentleman from Georgia (Mr. CARTER). This bill would extend the telehealth flexibility until 2026 and includes policies to support health savings accounts. But the majority did not follow regular order, and that is a great disservice to a commonsense bill like H.R. 4040.

Regardless, and despite the procedural irregularities, I support the bill, and I encourage my colleagues to vote for H.R. 4040.

Mr. PALLONE. Madam Speaker, I continue to reserve the balance of my time.

Mr. SMITH of Nebraska. Madam Speaker, I yield 2 minutes to the gentleman from North Carolina (Mr. MURPHY).

Mr. MURPHY of North Carolina. Madam Speaker, I rise today in support of H.R. 4040. There have been a few silver linings that we have seen in the pandemic, and definitely telehealth has been one of them.

I will submit, I am personally thankful for this bill because I will say, maybe, perhaps I am the only sitting Member of Congress who, as a physician, has actually used telehealth.

In my surgical practice, I see patients from 2 hours north, 2 hours south, and sometimes 5 hours east out on the eastern North Carolina coast. So many of my patients who come from rural eastern North Carolina can't even afford gas in the inflationary environment we have to even travel these distances, much less sometimes across town.

While this bill is a good start, it is a very, very good start, it does not go far enough, and that is why I, with Dr. BURGESS and Congresswoman HERRELL, introduced a bill to permanently extend telehealth for federally qualified health centers and rural health centers. These are the medical practices that take care of our poorest and the most at-risk patients. These individuals need to be able to access telehealth because they have to travel long distances and don't have the resources that they need to be able to access physician care.

I subsequently urge my colleagues to support this initiative and urge them that we can do much more.

Mr. PALLONE. Madam Speaker, I continue to reserve the balance of my time.

Mr. SMITH of Nebraska. Madam Speaker, I yield myself such time as I may consume. I will be brief in my remarks here.

I know that you have heard several concerns expressed about this entire process, and I would certainly share those concerns.

I do think that this is a great opportunity to address a bipartisan issue that is important across America. But it appears this bill was negotiated quickly, in secret, and outside the committees of jurisdiction. Neither outside stakeholders nor Members who have worked extensively on telehealth policy were consulted, as far as I can tell, and the closed rule under which this is being considered has precluded any opportunity to improve or amend the bill.

An issue this important deserves an open and transparent process that follows regular order, allowing Members to offer input and highlight important needs which might otherwise have been overlooked. We call this legislating.

If we had worked together on the Ways and Means Committee with our Energy and Commerce friends and had included the various ideas and innovations, this would have been a true and real bipartisan bill. I am confident that the telehealth extension we are considering today would be even better, as has been mentioned by my colleagues.

In fact, back in May, I introduced a bipartisan bill almost identical to this one called the Connecting Rural Telehealth to the Future Act. That bill extended all the provisions included in the FY22 omnibus through at least 2024 and also included provisions to ensure critical access hospitals can continue to provide telehealth services to their patients. It also corrects a flaw in the CARES Act which shortchanges federally qualified health centers and rural health clinics which offer telehealth services.

Madam Speaker, I include in the RECORD two letters from the National Rural Health Association and the National Association of Rural Health Clinics expressing their support for both the aims of H.R. 4040 as well as the need to extend critical rural health provisions from the Connecting Rural Telehealth to the Future bill.

NATIONAL RURAL
HEALTH ASSOCIATION,
July 26, 2022.

Hon. NANCY PELOSI,
Speaker, House of Representatives.
Hon. KEVIN MCCARTHY,
Minority Leader, House of Representatives.

DEAR SPEAKER PELOSI AND MINORITY LEADER MCCARTHY: The National Rural Health Association (NRHA) applauds the House of Representatives for prioritizing telehealth flexibilities by scheduling a vote on H.R. 4040, the Advancing Telehealth Beyond COVID–19 Act of 2022. This legislation will extend important telehealth flexibilities enacted in the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and extended for 151 days post-public health emergency in the Consolidated Appropriations

Act (CAA), 2022, until December 31, 2024. NRHA supports the extension of telehealth flexibilities to show providers that telehealth is here to stay but urges rural friendly tweaks to the legislation.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We provide leadership on rural health issues through advocacy, communications, education, and research.

As the text is currently written, H.R. 4040 includes the extension of distant-site status for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) at their current reimbursement level. While continuation of this flexibility is necessary, the reimbursement level for virtual services is significantly lower than in-person services under current statute. Should reimbursement remain as it is currently written, by 2028 there will be nearly a $100 discrepancy between services provided in-person and virtually at RHCs. NRHA believes this will cause rural communities to utilize these important services less often than their urban and suburban counterparts moving forward and will cause harm to an already fragile rural safety net.

To remedy this discrepancy, NRHA urges this text be amended to incorporate reimbursement updates as reflected in Section 9 of H.R. 7876, the Connecting Rural Telehealth into the Future Act, introduced by Representatives Adrian Smith (R–NE) and Terri Sewell (D–AL). Incorporating this legislative text will bring payment parity between in-person and virtual care at RHCs and FQHCs and ensure that rural communities have access to the same health care delivery methods as their urban and suburban counterparts.

NRHA applauds the House of Representatives for acting on telehealth to show providers long-term stability. However, to ensure that rural providers, and their patients, can properly utilize these services tweaks are needed.

Sincerely,

ALAN MORGAN,
Chief Executive Officer.

NATIONAL ASSOCIATION OF
RURAL HEALTH CLINICS,
July 26, 2022.

Hon. NANCY PELOSI,
Speaker, House of Representatives, Washington, DC.
Hon. KEVIN MCCARTHY,
Republican Leader, House of Representatives, Washington, DC.

DEAR SPEAKER PELOSI AND LEADER MCCARTHY: The National Association of Rural Health Clinics (NARHC) is grateful that the House of Representatives is considering extending Medicare coverage of telehealth through 2024 but we are concerned that the current language in H.R. 4040 will perpetuate inequitable payment policies for safety-net providers.

Presently, our peers in traditional office settings are able to bill for telehealth services as if the service was provided physically in the office. In other words, they have coding and reimbursement parity between telehealth services and in-person services.

On the other hand, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) do not use their normal coding and reimbursement rules for telehealth. RHCs and FQHCs instead have a ''special payment rule'' that requires them to bill a single code, G2025, for all telehealth services which is then reimbursed at a single nationwide rate (currently $97.24).

We are concerned with this ''special payment rule'' methodology for a whole host of reasons. First and foremost, the payment is significantly less than what most RHCs and FQHCs would receive for providing the same service in person, disincentivizing safety-net providers from offering the service via telehealth. Second, the current rules require RHCs and FQHCs to ''carve-out'' all telehealth costs from their cost report, which adds significant administrative burden to the cost-reporting process. Third, the use of a single telehealth code, G2025, has prevented RHCs from tracking annual wellness visits and other services provided via telehealth severely hindering their ability to properly participate in ACOs and other quality programs.

Complicating matters is the fact that for mental health services provided via telehealth, RHCs and FQHCs do use their normal coding and reimbursement mechanisms. This policy is working well, and we believe that is should work this way for all services, not just mental health services.

NARHC strongly believes that the best way to encourage telehealth usage in underserved communities is to create parity between in-person and telehealth policies. We strongly encourage Congress to amend H.R. 4040 to include the payment policy enumerated in Section 9 of H.R. 7876, the Connecting Rural Telehealth to the Future Act introduced by Representative Adrian Smith and Representative Terri Sewell.

Please feel free to contact me if you would like to discuss this issue further.

Sincerely,

NATHAN BAUGH,
Executive Director,
National Association of Rural Health Clinics.

Mr. SMITH of Nebraska. Madam Speaker, these organizations fully understand the vital role that rural health clinics and FQHCs and critical access hospitals play in ensuring access to care for those in rural and underserved areas.

Even with the passage of this bill, the future of telehealth after the government-designated public health emergency is uncertain. More work needs to be done to assess what has worked well over the last 2 years, what can be improved, and what can safely be left behind.

While I do encourage Members to vote ''yes'' on this bill, I hope in the future we can work in a true bipartisan fashion under regular order to address the gaps that we know exist in policy and set a long-term, sustainable course for telehealth well beyond 2024.

Madam Speaker, I reserve the balance of my time.

□ 1315

Mr. PALLONE. Madam Speaker, I reserve the balance of my time.

Mr. SMITH of Nebraska. Madam Speaker, I yield 1 minute to the gentleman from Oklahoma (Mr. HERN), a member of the Ways and Means Committee.

Mr. HERN. Madam Speaker, I rise in support of H.R. 4040, which will maintain seniors' access to telehealth, or what should be more appropriately called virtual health.

In 2020, the Trump administration eliminated bureaucratic red tape so seniors could access healthcare virtually from the comfort of their homes. As a result, 52 million seniors sought their medical care virtually in 2020.

I am proud to see my bill, the Protecting Mental Health Services Act, included in this legislation to ensure seniors have virtual access to mental health and substance abuse treatment. My bill ensures all Oklahomans can access high-quality care, regardless of their physical location.

While this legislation is a step forward, it is unfortunate that it excludes employer-sponsored healthcare from the same low-cost access to telehealth. It is critical to provide folks on the job with the ability to seek flexible treatment, and I look forward to working with my colleagues on both sides of the aisle to pass this provision at a later date.

Mr. PALLONE. Madam Speaker, I reserve the balance of my time.

Mr. SMITH of Nebraska. Madam Speaker, I yield 1 minute to the gentlewoman from New Mexico (Ms. HERRELL).

Ms. HERRELL. Madam Speaker, I rise in support of the Advancing Telehealth Beyond COVID–19 Act, which would extend vital telehealth flexibilities through 2024. Expanding telehealth during the pandemic was a resounding success and has been recognized by many New Mexicans and rural Americans as a lifesaver.

Telehealth provided Americans continued access to healthcare services without being physically present and also allowed healthcare providers to remain in practice.

While this bill is an important step in the right direction, my Republican colleagues and I wish to go one step further by offering another bill, which would make permanent the extension of telehealth services for federally qualified health clinics and rural health clinics.

Madam Speaker, I urge my colleagues to support the bill on the floor, as well as our subsequent bill to permanently expand telehealth services to all Americans, regardless of ZIP Code. Access to the care they deserve is crucial.

Mr. PALLONE. Madam Speaker, I reserve the balance of my time.

Mr. SMITH of Nebraska. Madam Speaker, I yield 1 minute to the gentlewoman from California (Mrs. STEEL).

Mrs. STEEL. Madam Speaker, I rise in support of the Advancing Telehealth Beyond COVID–19 Act.

Telehealth has been life changing for so many, especially during the COVID–19 pandemic. Increased access to telehealth has benefited a wide range of Americans, from seniors to high-risk patients.

We must ensure that the millions of Americans who have utilized flexibility provisions authorized during the pandemic do not lose their access to telemedicine.

Right now, regardless of where you live, you have access to telehealth and virtual care. This bill ensures that this can continue for millions of Americans, but we should ensure that this flexibility is permanent.

That is why I introduced legislation with Mr. BUCHANAN and Mr. JOHNSON to permanently remove any geographic restrictions on telehealth services.

Madam Speaker, I urge my colleagues to support our legislation and to vote ''yes'' on today's bill so that we can continue to expand access to quality, affordable healthcare solutions.

Mr. PALLONE. Madam Speaker, I reserve the balance of my time.

Mr. SMITH of Nebraska. Madam Speaker, I yield 1 minute to the gentleman from California (Mr. OBERNOLTE).

Mr. OBERNOLTE. Madam Speaker, I represent one of the largest geographic districts in the country. Access to healthcare is a very real problem for the people I represent because many of them live hours away and hundreds of miles away from specialized healthcare.

For my constituents, one of the few positive developments that came out of COVID–19 was the expansion of the way that telehealth can be used to provide quality healthcare in districts like mine.

This bill, H.R. 4040, would take a very meaningful step in making permanent the changes to law that enable the provision of that telehealth, and I strongly urge its adoption.

Mr. PALLONE. Madam Speaker, I reserve the balance of my time.

Mr. SMITH of Nebraska. Madam Speaker, I yield 3 minutes to the gentleman from Arizona (Mr. SCHWEIKERT).

Mr. SCHWEIKERT. Madam Speaker, you hear everyone here all say something nice. We all like telehealth. I am frustrated because I can't get my head around why we are not going further.

Outside the internal political theater, those of us who have worked on this legislation since the day we got here and then all of a sudden wake up one day and it is a different bill with someone who I have never even heard of working on it, God bless. The majority gets to do things like that.

We want a change in the price of healthcare. Can we come together and unleash technology? Telehealth is more than just looking at the phone and doing FaceTime or now talking. It is the wearable. It is the thing. It is the thing you lick.

There is technology with which we could be crushing the price of healthcare, and instead, we are doing little incremental steps here.

There are a couple of problems with the bill the Democrats decided to bring to the floor. It is for 2 years. We compromised to 4. If you want capital investments in the technology, you have to give us at least 4. It should be permanent.

There is also something in here that is just frustrating. You missed the language on health savings accounts. You have 32 million people now who functionally are not going to have access to be able to use those accounts for their telehealth.

Madam Speaker, there is just a frustration here because we all talk pretty about this, and then we are unwilling to do the things that could potentially help us all by disrupting the price of healthcare and increasing access, maybe making people's lives better. Instead, it just became more political theater. We should be ashamed of ourselves.

Madam Speaker, I ask unanimous consent to insert the text of the amendment in the RECORD immediately prior to the vote on the motion to recommit.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Arizona?

There was no objection.

Mr. SCHWEIKERT. Madam Speaker, if I came to the body and said the bill we had all been working on, H.R. 8489—when you have someone like LLOYD DOGGETT and someone like me, and we are actually working together, we are working on some of the antifraud provisions, program integrity provisions, you actually had something this body was doing where we weren't beating the crap out of each other. It was something that actually might be good for people in the country. Instead, we turned it back into another opportunity for political gamesmanship.

It is my intense disappointment because it is our language, substantially something I have worked on for years, that was grabbed for the pandemic. We all know it expires the day the pandemic is declared over. It is time to take this opportunity—I know there is an army of lobbyists out there that despise telehealth because it changes the populations that walk in the threshold. To hell with them. Let's finally do what is right.

Mr. PALLONE. Madam Speaker, I reserve the balance of my time.

Mr. SMITH of Nebraska. Madam Speaker, I yield myself the balance of my time.

I think we have had a good discussion here today. I think we have laid out that we are acting in good faith, supporting an issue, moving it forward, but also posing the scenario that there are so many other things we can do to address the very matter that we are taking up here today.

The surrounding details about how this bill came up and everything, I think it is problematic for the institution. But the fact of the matter is, we have an issue here that we need to address. I hope that we can work to continue to make it permanent in the future so that we can encourage investment, as was outlined previously, and encourage bending of the cost curve, ultimately, on healthcare, which is lacking at this point in time.

Madam Speaker, I urge a ''yes'' vote on this bill, and I urge a different kind of cooperation moving forward.

Madam Speaker, I yield back the balance of my time.

Mr. PALLONE. Madam Speaker, I yield myself the balance of my time.

Since I heard every Republican who spoke say that they support the bill, I was certainly reluctant to suggest that we would have any kind of significant debate about the bill. I generally feel that if I have both sides of the aisle saying it is a good bill, I should leave well enough alone.

But I do want to say this in response to some of the comments that were made by the Republican Members. We were reluctant in the committee to move to have permanent authorization of the telehealth flexibility expansion for several reasons.

First of all, it is expensive. In other words, the Congressional Budget Office scored this bill. As I said, the bill for the 2 years is paid for. If you wanted to go permanent, I think they would have said that we needed another $20 billion. I feel very strongly that the bill should be paid for. That is part of what we believe as Democrats. We were able to get agreement with the Republicans on a pay-for for the 2 years, so that was a factor as to why it is for 2 years instead of permanent.

Beyond that, and more importantly, really, is the fact that a permanent expansion is a major change. I think it needs a lot of study, a lot of oversight and investigation. One of the things that I mentioned in Rules is that both HHS and the inspector general have been tasked to report back to us this spring with a report on a lot of the things that were mentioned here today, integrity issues, in terms of fraud and abuse, that were mentioned by both sides of the aisle.

I think the feeling of the committee was that this was something that needed more study before we went ahead and made this permanent. That is what we do. In other words, right now, the concern is that because the omnibus appropriations bill basically expanded the telehealth program until 5 months after the public health emergency for COVID ends, that would take us to the end of this year. But we don't have a lot of legislative days left. We figured the best thing was to at least extend it for another 2 years. We can pay for it, as was mentioned by Ms. CHENEY.

This, I think, is the best way to resolve this: Do a 2-year extend, pay for it, and let's spend the time between now and next spring having some more hearings and opportunities to talk about a further extension or possibly making it permanent.

Again, I appreciate the fact that everyone on the Republican side supports the bill, but I do want to address some of the things that you mentioned.

Madam Speaker, I yield back the balance of my time.

Ms. JACKSON LEE. Madam Speaker, I rise in support of H.R. 4040 the Advancing Telehealth Beyond COVID–19 Act of 2021, which would make permanent several telehealth flexibilities under Medicare that were initially authorized during the COVID–19 public health emergency.

This bill would extend the life-saving measures put in place by Congress during the

COVID–19 pandemic that allowed millions of American people to access telehealth-care.

Specifically, H.R. 4040 would:

permanently remove originating site and geographical restrictions that limited telehealth services to designated clinics in the event of a physician shortage,

give rural providers the ability to serve patients remotely while being properly compensated for their work,

empower providers to provide access to smart devices and innovative digital technology to their patients for monitoring purposes, and

provide coverage for audio-only evaluation, management, and behavioral health services.

H.R. 4040 would codify critical telehealth policies implemented during the pandemic for the continued benefit of all, but especially those in isolated communities, people with disabilities, and seniors.

Telehealth has dramatically improved the medical industry by making healthcare more accessible to people in rural areas, those with mobility concerns, and individuals whose work or family schedules may not accommodate an appointment at a physical location.

During the height of the pandemic, while more than 3,000 people were dying per day of the virus, telehealth served as an invaluable weapon against the spread of infectious disease.

Remote screening and care prevented undue burden on our already exhausted medical professionals and allowed patients to get the care they needed without putting themselves or their families at risk.

What began as emergency protocol then, has now emerged as best practice.

Currently, 76 percent of hospitals in the U.S. connect doctors and patients remotely via telehealth.

This is up from 35 percent a decade ago.

Remote healthcare allows for greater flexibility for patients, enables certain physicians like allergists or occupational therapists to access an individual's environmental needs, and streamlines the scheduling process to prevent long wait times and wasted time.

Telehealth has allowed doctors to monitor their patients' chronic conditions more closely, like heart or lung disease.

Better monitoring can improve patients' quality-of life and reduce hospital admissions and deaths from chronic diseases.

Additionally, telehealth is a good way to deliver care quickly in an emergency, such as a stroke or heart attack.

Telehealth has also played a significant role in expanding pediatric mental healthcare access.

As of April 2019, there were only 8,300 practicing child and adolescent psychiatrists in the U.S.

This number is dwarfed by the more than 15 million kids and teens in need of a psychiatric provider.

For over a decade, The University of Texas Medical Branch has offered telehealth services for rural patients.

After initially partnering with community mental health clinics in fringe counties, the program has since been able to expand adolescent mental health services directly to school districts.

This means children without access to a local psychiatrist can receive the care they need without being pulled from school or traveling long distances.

It also means psychiatrists can observe children in their natural setting at home or in school, rather than in an inorganic hospital environment.

Telehealth allows children to be where they ought to be—in the classroom getting an education.

These are just some of the many examples of how telehealth has aided our healthcare system in providing the quality medical services that our constituents deserve.

The passage of H.R. 4040, the Advancing Telehealth Beyond COVID–19 Act of 2021, would ensure that these positive developments continue to benefit communities across the country.

It is important to note, however, that telehealth has not always served all people equally.

Historical data shows that People of Color have long faced obstacles to getting the critical health care services they need.

Unfortunately, the rapid implementation of telemedicine hasn't bridged the equality divide as much as one would have hoped.

A study led by the University of Houston College of Medicine found that African Americans were 35 percent less likely to use telemedicine compared to White Americans, and those in Hispanic communities were 51 percent less likely to use it.

Only 66 percent of African American and 61 percent of Hispanic households have access to broadband internet compared to 79 percent of white households.

Additionally, only a quarter of families earning $30,000 or less have smart devices, such as a phone, tablet, or laptop at home, limiting their access to telehealth services.

So, while telehealth has reduced many barriers to adequate healthcare, we must stay vigilant to the needs of our most disadvantaged community members.

We are a long way from full medical equality in this country, however, I believe that the Advancing Telehealth Beyond COVID–19 Act of 2021 is an important step in bringing us closer to that goal.

H.R. 4040 is an opportunity to connect our healthcare providers with patients who might otherwise go without the medical care they so desperately need.

It is an opportunity to lift our nation's healthcare into the 21st century and to utilize technology as a medical equalizer.

I urge all my colleagues to support H.R. 4040 the Advancing Telehealth Beyond COVID–19 Act of 2021.

Ms. ESHOO. Madam Speaker, as the Chairwoman of the Health Subcommittee and a senior member of the Communications and Technology Subcommittee, I've advanced the importance of telehealth for years.

Over the last several months, as I've talked to health care professionals and providers in my district, I've heard how the wide adoption of telehealth has been the bright spot during the pandemic.

One reason for that bright spot is that HHS waived many rules and payment policies surrounding telehealth coverage in traditional Medicare during the public health emergency. A recent HHS Office of the Inspector General report found that over 28 million Medicare beneficiaries used telehealth during the first year of the pandemic, demonstrating the long-term potential of telehealth to increase access to health care for beneficiaries.

Now that beneficiaries have received this important benefit, they fully appreciate what telehealth does for them. We must find a way to continue telehealth access for seniors and all Americans. That's why I'm proud to support Representatives LIZ CHENEY and DEBBIE DINGELL's bipartisan H.R. 4040, the ''Advancing Telehealth Beyond COVID–19 Act of 2022.'' The bill will allow Medicare beneficiaries to use telehealth services after the public health emergency ends by eliminating geographical restrictions on Medicare coverage for telehealth services and expand Medicare coverage to include audio-only telehealth. I urge my colleagues to support this important, bipartisan bill.

Mr. THOMPSON of California. Madam Speaker, I rise in strong support of this legislation.

I have been working on telehealth and telemedicine for nearly three decades, since my time in the California State Senate.

As founder and Co-Chair of the Congressional Telehealth Caucus, I have repeatedly introduced multiple bipartisan bills expanding access to telehealth, and have worked with my colleagues on the caucus—including Ms. Matsui, Mr. Welch, Mr. Schweikert, and Mr. Johnson of Ohio—to ensure that access to telehealth services does not disappear at the conclusion of the COVID–19 Public Health Emergency.

I was proud to author legislation two years ago expanding telehealth in Medicare for the duration of the COVID–19 pandemic. That legislation—which was included in the very first COVID–19 relief measure advanced by Congress—has allowed millions of seniors on Medicare to see their doctors over the past two years without leaving their homes.

By allowing these patients to receive the care they need remotely, we've been able to minimize transmission risk while maximizing safety for both patients and providers.

In my view, the expansion and widespread adoption of telehealth services is one of the few silver linings of COVID–19.

Americans across our country now know firsthand that by integrating technology with health care, we can bring care to underserved areas, reduce burdens on parents and caregivers, increase the efficiency of our health care system and, in many cases, save money: by ensuring that patients receive care swiftly, we can treat medical conditions early on—thereby warding off worse (and more expensive) complications down the road.

However, while the value of telehealth is particularly evident amidst a pandemic, its utility is not limited to the present circumstances.

It is critical that Congress extend telehealth flexibilities in Medicare beyond the COVID–19 public health emergency.

And that's what this bill does.

This bill includes numerous provisions of mine ensuring that seniors can continue to visit providers remotely, regardless of zip code, for two more years. It allows us to continue amassing and analyzing data, and sets the stage for telehealth to become a permanent part of the Medicare program—a goal I've long sought.

I want to thank the many, many colleagues of mine who have worked with me on this critical issue.

I urge my colleagues to vote yes.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 1256, the previous question is ordered on the bill, as amended.

The question is on engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT

Mr. SCHWEIKERT. Madam Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Schweikert of Arizona moves to recommit the bill H.R. 4040 to the Committee on Energy and Commerce.

The material previously referred to by Mr. SCHWEIKERT is as follows:

Strike all after the enactment clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Greater Access to Telehealth Act''.

SEC. 2. REMOVING GEOGRAPHIC REQUIREMENTS AND EXPANDING ORIGINATING SITES FOR TELEHEALTH SERVICES.

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

(1) in paragraph (2)(B)(iii)—

(A) by striking ''With'' and inserting ''In the case that the emergency period described in section 1135(g)(1)(B) ends before December 31, 2026, with''; and

(B) by striking ''that are furnished during the 151-day period beginning on the first day after the end of the emergency period described in section 1135(g)(1)(B)'' and inserting ''that are furnished during the period beginning on the first day after the end of such emergency period and ending December 31, 2026''; and

(2) in paragraph (4)(C)(iii)—

(A) by striking ''With'' and inserting ''In the case that the emergency period described in section 1135(g)(1)(B) ends before December 31, 2026, with''; and

(B) by striking ''that are furnished during the 151-day period beginning on the first day after the end of the emergency period described in section 1135(g)(1)(B)'' and inserting ''that are furnished during the period beginning on the first day after the end of such emergency period and ending on December 31, 2026''.

SEC. 3. EXPANDING PRACTITIONERS ELIGIBLE TO FURNISH TELEHEALTH SERVICES.

Section 1834(m)(4)(E) of the Social Security Act (42 U.S.C. 1395m(m)(4)(E)) is amended by striking ''and, for the 151-day period beginning on the first day after the end of the emergency period described in section 1135(g)(1)(B)'' and inserting ''and, in the case that the emergency period described in section 1135(g)(1)(B) ends before December 31, 2026, for the period beginning on the first day after the end of such emergency period and ending on December 31, 2026''.

SEC. 4. EXTENDING TELEHEALTH SERVICES FOR FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

Section 1834(m)(8)(A) of the Social Security Act (42 U.S.C. 1395m(m)(8)(A)) is amended by striking ''during the 151-day period beginning on the first day after the end of such emergency period'' and inserting ''in the case that such emergency period ends before December 31, 2026, during the period beginning on the first day after the end of such emergency period and ending on December 31, 2026''.

SEC. 5. DELAYING THE IN-PERSON REQUIREMENTS UNDER MEDICARE FOR MENTAL HEALTH SERVICES FURNISHED THROUGH TELEHEALTH AND TELECOMMUNICATIONS TECHNOLOGY.

(a) DELAY IN REQUIREMENTS FOR MENTAL HEALTH SERVICES FURNISHED THROUGH TELEHEALTH.—Section 1834(m)(7)(B)(i) of the Social Security Act (42 U.S.C. 1395m(m)(7)(B)(i)) is amended, in the matter preceding subclause (I), by striking ''on or after the day that is the 152nd day after the end of the period at the end of the emergency sentence described in section 1135(g)(1)(B))'' and inserting ''on or after January 1, 2027 (or, if later, the first day after the end of the emergency period described in section 1135(g)(1)(B))''.

(b) MENTAL HEALTH VISITS FURNISHED BY RURAL HEALTH CLINICS.—Section 1834(y) of the Social Security Act (42 U.S.C. 1395m(y)) is amended—

(1) in the heading, by striking ''TO HOSPICE PATIENTS''; and

(2) in paragraph (2), by striking ''prior to the day that is the 152nd day after the end of the emergency period described in section 1135(g)(1)(B))'' and inserting ''prior to January 1, 2027 (or, if later, the first day after the end of the emergency period described in section 1135(g)(1)(B))''.

(c) MENTAL HEALTH VISITS FURNISHED BY FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1834(o)(4) of the Social Security Act (42 U.S.C. 1395m(o)(4) is amended—

(1) in the heading, by striking ''TO HOSPICE PATIENTS''; and

(2) in subparagraph (B), by striking ''prior to the day that is the 152nd day after the end of the emergency period described in section 1135(g)(1)(B))'' and inserting ''prior to January 1, 2027 (or, if later, the first day after the end of the emergency period described in section 1135(g)(1)(B))''.

SEC. 6. ALLOWING FOR THE FURNISHING OF AUDIO-ONLY TELEHEALTH SERVICES.

Section 1834(m)(9) of the Social Security Act (42 U.S.C. 1395m(m)(9)) is amended by striking ''The Secretary shall continue to provide coverage and payment under this part for telehealth services identified in paragraph (4)(F)(i) as of the date of the enactment of this paragraph that are furnished via an audio-only telecommunications system during the 151-day period beginning on the first day after the end of the emergency period described in section 1135(g)(1)(B)'' and inserting ''In the case that the emergency period described in section 1135(g)(1)(B) ends before December 31, 2026, the Secretary shall continue to provide coverage and payment under this part for telehealth services identified in paragraph (4)(F)(i) that are furnished via an audio-only communications system during the period beginning on the first day after the end of such emergency period and ending on December 31, 2026''.

SEC. 7. USE OF TELEHEALTH TO CONDUCT FACE-TO-FACE ENCOUNTER PRIOR TO RECERTIFICATION OF ELIGIBILITY FOR HOSPICE CARE DURING EMERGENCY PERIOD.

Section 1814(a)(7)(D)(i)(II) of the Social Security Act (42 U.S.C. 1395f(a)(7)(D)(i)(II)) is amended by striking ''and during the 151-day period beginning on the first day after the end of such emergency period'' and inserting ''and, in the case that such emergency period ends before December 31, 2026, during the period beginning on the first day after the end of such emergency period described in such section 1135(g)(1)(B) and ending on December 31, 2026''.

SEC. 8. EXTENSION OF SAFE HARBOR FOR ABSENCE OF DEDUCTIBLE FOR TELEHEALTH.

Section 223(c)(2)(E) of the Internal Revenue Code of 1986 is amended by striking ''and before January 1, 2023,'' and inserting ''and before January 1, 2027,''.

SEC. 9. FUNDING FROM MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395jjj(b)(1)) is amended by striking ''$7,500,000,000'' and inserting ''$0''.

The SPEAKER pro tempore. Pursuant to clause 2(b) of rule XIX, the previous question is ordered on the motion to recommit.

The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. SCHWEIKERT. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to section 8 of rule XX, further proceedings on this question are postponed.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 1 o'clock and 28 minutes p.m.), the House stood in recess.

□ 1534

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Ms. KAPTUR) at 3 o'clock and 34 minutes p.m.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
HOUSE OF REPRESENTATIVES,
Washington, DC, July 27, 2022.

Hon. NANCY PELOSI,
Speaker, House of Representatives,
Washington, DC.

DEAR MADAM SPEAKER: Pursuant to the permission granted in Clause 2(h) of Rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on July 27, 2022, at 2:09 p.m.

That the Senate agrees to the House amendment to the Senate amendment with an amendment H.R. 4346.

With best wishes, I am,

Sincerely,

CHERYL L. JOHNSON,
Clerk.

MOTION TO SUSPEND THE RULES AND PASS CERTAIN BILLS

Mr. KILDEE. Madam Speaker, pursuant to section 5 of House Resolution 1254, I move to suspend the rules and pass the bills: H.R. 623, H.R. 3952, H.R. 3962, H.R. 4551, H.R. 5313, H.R. 6933, H.R. 7132, H.R. 7361, H.R. 7569, H.R. 7624, H.R. 7733, and H.R. 7981.

The Clerk read the titles of the bills.