the 988 lifeline has received almost 5 million contacts. Nearly 1 million are from the Veterans Crisis Line, a designated part of 988. The others have consisted of 2.6 million calls, almost three-quarters of a million chats, and more than 600,000 texts.

In December 2022, the 988 lifeline experienced a cybersecurity breach, which resulted in a daylong outage across the country. This lifeline is imperative to suicide prevention and utilized by constituents in every one of our districts.

The legislation on the floor today would require better coordination and reporting on potential cybersecurity vulnerabilities within the 988 lifeline with the goal of preventing future cyberattacks and disruption of services. The bill would require coordination between the lifeline and the chief information security officer at the Department of Health and Human Services to prevent cybersecurity attacks. The suicide hotline's regional and local network administrators would also be required to notify the government of cybersecurity vulnerabilities and incidents. Finally, the Government Accountability Office would be required to conduct a study evaluating cybersecurity risks and vulnerabilities in the 988 lifeline system.

Mr. Speaker, I encourage all of my colleagues to vote ''yes'' on this important bill, and I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. OBERNOLTE), who is a leader of cybersecurity in this Congress and a member of the Energy and Commerce Committee.

Mr. OBERNOLTE. Mr. Speaker, I thank the gentleman from Kentucky, my friend and colleague, for the opportunity to present my bill, H.R. 498, the 9–8–8 Lifeline Cybersecurity Responsibility Act.

Mr. Speaker, according to the CDC, in 2022, nearly 50,000 Americans took their own lives. This is a shocking and, frankly, shameful commentary on the state of mental health in this country. Mr. Speaker, that amounts to over 100 suicides a day.

In response to this growing crisis, in 2005, Congress authorized the 988 lifeline. 988 is a 24-hour, 7-day-a-week hotline that anyone with suicidal thoughts can call to be connected to counseling and resources.

In the first year of operation, the 988 lifeline received nearly 50,000 calls, and it has continued to grow in the years since then. It has undoubtedly saved thousands of American lives.

Unfortunately, 14 months ago, the 988 lifeline was taken down by a cyberattack on its systems operator.

Mr. Speaker, every minute that lifeline is offline is the potential for the loss of American lives because those resources are not available to them. This bill is an attempt to solve that problem.

H.R. 498 would require 988 systems operators to report cybersecurity vulnerabilities and would require the Department of Health and Human Services to coordinate in addressing those vulnerabilities.

The bill would also require the Comptroller General to create a study of the cybersecurity vulnerabilities on the hotline and the ways that those vulnerabilities can be addressed.

Mr. Speaker, the 988 lifeline is a vital resource for Americans who might be having suicidal thoughts or contemplating the irrevocable act of taking their own lives. This bill is a small step in making sure that that lifeline remains available to the Americans who are depending on it.

Mr. Speaker, I thank the gentleman from Kentucky for bringing this bill forward to the floor, and I respectfully urge my colleagues to vote ''yes'' and pass this bill to the Senate.

Ms. SCHRIER. Mr. Speaker, I yield such time as he may consume to the gentleman from the State of California (Mr. CÁRDENAS) to discuss this bill.

Mr. CÁRDENAS. Mr. Speaker, I thank the gentlewoman for yielding.

Mr. Speaker, I rise today—actually, I ran over here—as a proud partner with my colleague, Representative OBERNOLTE, to support the passage of the 9–8–8 Lifeline Cybersecurity Responsibility Act, which would help to protect the 988 lifeline from any future cyber interference.

Unfortunately, suicide is the second leading cause of death among our young people in America. Prior to the COVID–19 pandemic, it was the 10th leading cause of death in our Nation. We need to treat this as the legitimate health crisis that it is.

This is one of the reasons why I believe there is so much promise in the 988 Suicide & Crisis Lifeline. Not only does the three-digit calling code provide a 24/7 lifeline to individuals in crisis from anywhere in the United States, but it also represents a change in the way we think and respond to mental illness as something that warrants help and support, just like other kinds of health conditions.

□ 1630

Mr. Speaker, 988, in its fullest form, is not just a number, but a connection to a full mental health crisis response.

Since I know that I have limited time, there is much more to be said, but let me tell my colleagues: This is a perfect example why the people of America send us to Washington, D.C.—to come together, to recognize what we need to fix, and to come together as Republicans and Democrats from both sides of the aisle to work together to create one of the best systems this country and this world will ever know.

Mr. Speaker, 911 is something that any American can take for granted, because we created that almost 70 years ago, where people will call 911, and they know somebody is going to come and save a life.

So 988 is exactly what we need to do for the American people. That is why I am so proud to work with my colleague, Congressman OBERNOLTE, to make sure that we move this forward and put our children, our country, our families, and our communities in a better place in any moment of a mental health crisis.

Ms. SCHRIER. Mr. Speaker, I yield myself the balance of my time to close.

Mr. Speaker, I have visited the 988 center in my area and seen the dedication of the providers, and we need to make sure that we protect this lifeline from cybersecurity risks.

Mr. Speaker, I encourage my colleagues to vote for this bill, and I yield back the balance of my time.

Mr. GUTHRIE. Mr. Speaker, this is an important bill. We have our two good friends from California working together across the aisle in a bipartisan way in the Energy and Commerce Committee. This is an important bill to move forward.

Mr. Speaker, in closing, I urge my colleagues to support it, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. MEUSER). The question is on the motion offered by the gentleman from Kentucky (Mr. GUTHRIE) that the House suspend the rules and pass the bill, H.R. 498, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

MEDICAID PRIMARY CARE IMPROVEMENT ACT

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3836) to facilitate direct primary care arrangements under Medicaid, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3836

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 ''Medicaid Primary Care Improvement Act''.

SEC. 2. CLARIFYING THAT CERTAIN PAYMENT ARRANGEMENTS ARE ALLOWABLE UNDER THE MEDICAID PROGRAM.

(a) RULE OF CONSTRUCTION.—Nothing in title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) shall be construed as prohibiting a State, under its State plan (or waiver of such plan) under such title (including through a medicaid managed care organization (as defined in section 1903(m)(1)(A) of such Act)), from providing medical assistance consisting of primary care services through a direct primary care arrangement with a health care provider, including as part of a value-based care arrangement established by the State. For purposes of the preceding sentence, the term ''direct primary care arrangement'' means, with respect to any individual, an arrangement under which such individual is provided medical assistance consisting solely of primary care services provided by primary care practitioners, if the sole compensation for such care is a fixed periodic fee.

(b) GUIDANCE.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall—

(1) convene at least one virtual open door meeting to seek input from stakeholders, including primary care providers who practice under the direct primary care model, state Medicaid agencies, and Medicaid managed care organizations; and

(2) taking into account such input, issue guidance to States on how a State may implement direct primary care arrangements (as defined in subsection (a)) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(c) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report containing—

(1) an analysis of the extent to which States are contracting with independent physicians, independent physician practices, and primary care practices for purposes of furnishing medical assistance under State plans (or waivers of such plans) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); and

(2) an analysis of quality of care and cost of care furnished to individuals enrolled under such title where such care is paid for under a direct primary care arrangement (as defined in subsection (a)) through a medicaid managed care organization (as so defined).

(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to alter statutory requirements under the State plan (or waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for cost-sharing requirements or be construed to limit medical assistance solely to those provided under a direct primary care arrangement.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Kentucky (Mr. GUTHRIE) and the gentlewoman from Washington (Ms. SCHRIER) each will control 20 minutes.

The Chair recognizes the gentleman from Kentucky.

GENERAL LEAVE

Mr. GUTHRIE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on the bill.

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

There was no objection.

Mr. GUTHRIE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am proud to support the work today of Congressman CRENSHAW, a fierce advocate for primary care access for patients in this country.

Primary care is the backbone of our healthcare system, and we know that investing now in connecting Americans to primary care will keep people healthier and save money along the way.

The Medicaid Primary Care Improvement Act is a straightforward bill that will help clarify current law to ensure that States have the tools and flexibility needed to offer primary care services in a variety of manners and settings through the Medicaid program.

One way to deliver primary care that shows promise is called direct primary care. Direct primary care clinics have been expanding around the country, and allow patients to pay a set amount per month for access to a primary care doctor to help address the basic need of healthcare.

This legislation makes sure that the State could explore an option like this for Medicaid enrollees in their State. It is a simple yet effective bill, and I believe it will lead to better outcomes and save taxpayers dollars in the long run.

Mr. Speaker, I urge all of my colleagues to join me in supporting this bill, and I reserve the balance of my time.

Ms. SCHRIER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 3836, the Medicaid Primary Care Improvement Act, sponsored by Representative CRENSHAW from Texas and myself.

As a primary care physician and a Congresswoman, I am excited to see the Medicaid Primary Care Improvement Act come to the floor today.

Allowing Medicaid to utilize the direct primary care model is a huge shift in the way that Medicaid patients and doctors interact for the better. Direct primary care is structurally different than traditional care models, because it is not designed around fee-for-service billing, but, rather, focused entirely on providing patients the best care possible.

This is made possible by having Medicaid pay an affordable monthly fee that, in turn, allows doctors with a set number of patients the time and flexibility to provide the best possible care and the ability to schedule appointments that are the right length in order to provide all of the support those patients need for optimal health.

Some appointments might take 90 minutes. Some might take 10. In the direct primary care model, doctors have a number of patients, or a patient panel, that they are responsible for caring for, and a smaller patient population means more time spent on things like education, preventative care measures, and being able to talk through and address critical topics like nutrition, exercise, stress, and social determinants of health that can't always be thoroughly addressed during a typical time-limited primary care appointment.

In turn, this means better patient understanding of and involvement in their own healthcare, fewer visits to the emergency room, and ideally better outcomes. Other trials of direct primary care have shown exactly those outcomes.

Dr. Garrison Bliss is a pioneer in this effort, starting up the first direct primary care practice in Washington State in 1997. His last year in practice was 2020, the year we were met with COVID. He had just 450 patients with the average patient in their midsixties. Their age put them at an increased risk for COVID morbidity and mortality, and patients in this age group generally require more care or just a smaller-sized panel.

Not a single one of his patients died from COVID during that first year, when we still didn't have vaccinations or treatments and we were still learning about the disease. He credits this to the fact that he could reach them, and they could reach him readily and have conversations about their care and talk with them about their COVID concerns.

He could send out newsletters directly with pertinent information. If his patients had a question about whether or not to go to the emergency room, he was available to give advice by being there for his patients. Consulting with him prevented ER visits with no compromise in care.

This model of care deserves to have more pilots around the country, hopefully with similar results, better outcomes, lower costs, tighter relationships between doctor and patient, and improved patient and physician satisfaction.

If these benefits are consistently achieved, then all people, no matter their level of income or insurance, deserve the option of a direct primary care model, including Medicaid.

I encourage all of my colleagues to vote ''yes'' on H.R. 3836.

Mr. Speaker, I have no further speakers, and I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. CRENSHAW), a strong proponent of this bill, and one of the strongest proponents in Congress for primary care.

Mr. CRENSHAW. Mr. Speaker, I rise today in support of my bill, the Medicaid Primary Care Improvement Act.

I thank both the chair and the ranking member for their support. I also thank Representative SCHRIER for being such an excellent co-lead and advocate; and Representatives SMUCKER, BLUMENAUER, and PETTERSEN, who continue to also champion direct primary care.

Mr. Speaker, a lot of attention gets paid to the Members who come down here and raise their voices and scream and yell about all the things they are really mad at because they want the public to know how mad they are. Every once in a while, we can raise our voices and wave our arms for some good things that we all work on together just to improve people's healthcare.

This bill is just that. It is a first step for addressing one of the most important issues in healthcare, which is access. We can promise people health insurance, and we can add more money to it, but it doesn't necessarily translate into actual access to a provider.

Direct primary care is one of the easiest and most direct ways to deliver primary care to patients. It is a payment model that makes sense to patients because it is simple. It is unlimited access to primary care providers by paying a monthly fee. It is a win-win for both patients and doctors because it simplifies and guarantees that relationship.

It keeps patients out of costly emergency rooms. It saves money for the

entire healthcare system. It encourages more efficient preventative medicine, as well. This means treating prediabetes before it becomes diabetes. This means treating heart issues before they become heart disease.

The market has already created direct primary care, and it is a model that actually thrives in districts like mine, where we have doctors like my friend, Dr. Glenn Davis, whose direct primary care practice saves businesses lots of money on their premium payments and also delivers quality care to patients, but, as usual, the government has not caught up.

This bill removes the uncertainty about whether Medicaid can pay for direct primary care access and empowers States with the necessary guidance to provide direct primary care for vulnerable patients who need it most.

It is a game changer because many Medicaid patients aren't accessing primary care right now. They are more likely to show up at an ER than schedule regular visits with a primary care physician, and ER costs keep going up because too many people are not getting the preventative care that they need.

Why? Well, because the truth is a lot of primary care doctors simply can't serve Medicaid patients due to low reimbursement rates. If we allow States to tailor their Medicare programs for direct primary care, which this bill does, we can fundamentally change this dynamic.

Our legislation is straightforward, and it has zero cost. It clarifies that current laws don't prohibit direct primary care arrangements while offering guidance for States that want to use direct primary care in their Medicaid programs, just like my home State of Texas.

Mr. Speaker, I genuinely hope that we can push this forward in a truly bipartisan way.

Ms. SCHRIER. Mr. Speaker, I have no further speakers. I am prepared to close, and I reserve the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania (Mr. SMUCKER), a member of the Ways and Means Committee and a good friend of mine.

Mr. SMUCKER. Mr. Speaker, I thank Mr. GUTHRIE for yielding.

Mr. Speaker, I rise today in support of this bill, the Medicaid Primary Care Improvement Act, which I am proud to be an original cosponsor of.

Now, we have heard of the many benefits of direct primary care. Certainly, I have seen that in my community, where we have many patients accessing their care through doctors providing direct primary care, which is receiving primary care services for a simple, flat monthly fee. We have seen that it keeps patients out of emergency rooms, improves health outcomes, and it yields savings. I also believe it will yield savings to the Medicaid program in this case.

This bill clarifies that State Medicaid programs may include direct primary care arrangements and, as I said, will help vulnerable beneficiaries access low-cost and high-quality healthcare services.

I think giving States that flexibility is a great step in the right direction as well. When State Medicaid programs innovate on behalf of their patients, especially with something like this—leveraging value-based care delivery models like direct primary care—I think patients and taxpayers will be the winners.

I would also mention a bill that I have introduced, the Primary Care Enhancement Act, which would allow patients or individuals with health savings accounts to access primary care and have that cost be included as a qualified expense in the HSA. This will be another way to expand access to primary care.

Mr. Speaker, I thank Mr. GUTHRIE for yielding time, and I thank Mr. CRENSHAW for his important work on this bill. I encourage my colleagues to vote ''yes.''

Ms. SCHRIER. Mr. Speaker, whatever we can do to expand affordable care, improve healthcare, strengthen the doctor-patient relationship, and bring down costs is a win for our constituents. That is why I am excited to sponsor this bill, the Medicaid Primary Care Improvement Act, that allows the use of direct primary care.

Mr. Speaker, I encourage my colleagues to vote for this bill, and I yield back the balance of my time.

Mr. GUTHRIE. Mr. Speaker, I appreciate Dr. SCHRIER and all the work that she has done, all the work that the two gentlemen who spoke as primary sponsors have done on this bill. It is a good bill.

Mr. Speaker, in closing, I urge my colleagues to support H.R. 3836, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Kentucky (Mr. GUTHRIE) that the House suspend the rules and pass the bill, H.R. 3836, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

□ 1645

ACTION FOR DENTAL HEALTH ACT OF 2023

Mr. GUTHRIE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3843) to amend title III of the Public Health Service Act to reauthorize grants to address dental workforce needs.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3843

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 ''Action for Dental Health Act of 2023''.

SEC. 2. REAUTHORIZATION OF GRANTS TO ADDRESS DENTAL WORKFORCE NEEDS.

Section 340G(f) of the Public Health Service Act (42 U.S.C. 256g(f)) is amended by striking ''2019 through 2023'' and inserting ''2024 through 2028''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Kentucky (Mr. GUTHRIE) and the gentlewoman from Washington (Ms. SCHRIER) each will control 20 minutes.

The Chair recognizes the gentleman from Kentucky.

GENERAL LEAVE

Mr. GUTHRIE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material in the RECORD on the bill.

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

There was no objection.

Mr. GUTHRIE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 3843, the bipartisan Action for Dental Health Act led by Representative SIMPSON.

Oral health plays an important role in the well-being of all Americans.

According to the Health Resources and Services Administration, we will be facing a shortage of close to 9,000 general dentists and more than 23,000 dental hygienists over the next 15 years.

The Action for Dental Health program directs Federal funding to State and local organizations to help support the dental workforce and improve access to care for patients.

This bill reauthorizes this important program for a 5-year period and strengthens the impact of existing resources to enhance oral healthcare.

Advancing early diagnosis and preventive dental treatments will improve the patient care and health outcomes. This reauthorization is an important step in addressing barriers to oral healthcare services.

Mr. Speaker, I urge my colleagues to support the underlying bill, and I reserve the balance of my time.

Ms. SCHRIER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 3843, the Action for Dental Health Act, sponsored by Representatives Kelly and Simpson.

Access to oral healthcare is critical to ensuring a person's overall health and well-being. Too often, however, oral healthcare is overlooked. Tooth decay is the most common chronic disease in both children and adults in the United States. In fact, more than one in four adults have untreated cavities, and nearly half of American adults show signs of gum disease.

Clearly, we need to do more to expand access to oral healthcare, including strengthening the oral healthcare workforce.