Kansas Hospital Association Survey - Roger Marshall

1. Besides the COVID-19 pandemic, what do you believe is the most pressing health care issue facing Americans today? How would you propose to address this issue if you were elected to Congress?

After practicing as an OBGYN in rural Kansas for nearly three decades, and visiting hospitals across the state as U.S. Congressman, I hear two resounding concerns: the viability of rural hospitals and the cost of healthcare. As Chairman of the HealthCare Task Force of the Republican Study Committee, I have worked with colleagues to carefully crafted real, patient-centered health care solutions that will increase competition, promote innovation and transparency, enable patients to be informed decision-makers, and protect the sanctity of the doctor-patient relationship.

Our hospitals – especially those serving rural communities – are as much a direct reflection of the local economy as they are an economic driver and major employer. Outside of Medicare-aged patients, hospitals depend on privately insured patients that are able to pay for services, and these patients must have jobs with good wages; it's that simple. A rising tide lifts all boats, including hospitals and health clinics. That is why the Farm Bill, high speed internet , tax reform and education are all vital to ensuring rural prosperity and community growth, both of which ensure local hospitals thrive.

In order to maintain financial viability of Kansas hospitals, I will continue to work to stabilize revenue streams and to increase access to care in Kansas, and there are several areas in which we have already made significant progress. For example, I have supported funding programs to increase broadband connectivity, which not only increases access for telehealth services within hospital and clinical settings, but also benefits community businesses and schools and improves quality of life across the state. Telemedicine may be the single most important tool moving forward, as it allows hospitals to provide specialized care that would otherwise be infeasible. Further, the Mission Act allows veterans to access more convenient care through their local, trusted providers. My office worked hard to educate veterans and local hospital leaders on the program and how they can become part of the VA's network to ensure proper reimbursements for veteran care. Through the 2018 Farm Bill we allocated significant amounts of funding for rural development projects – including the construction of new hospitals. I have been in full support of record-setting funding for treatment programs for substance abuse, especially as we watch opioids ravage families and communities. And finally, I stand with other Republicans who have vowed to protect coverage for patients with pre-existing conditions. A Medicare-for-All approach will not improve healthcare conditions for anyone, especially those who need additional health care services. Instead, it will deteriorate the doctor-patient relationship, increase the cost of our entire health care system and limit choice and access to care. Medicare for all will be the end of rural hospitals as we know them.

In addressing the *cost* of health care, it's important to modernize *how* we pay for health care, and there are several viable ways to improve the system. I believe the most direct path is to move away from fee-for-service model toward programs aimed at value-based care, including alternative payment models, the Medicare Shared Savings Program, and the Bundled Care Payment Initiative. For our significant contribution to advancing value-based care, I was recently recognized by the National Association of ACOs with the *Champion of Value in Health Care Award* alongside other bipartisan Representatives whom I regularly partner with. Likewise, the 340B Drug Program has been a vital safety net for Kansas hospitals that serve vulnerable populations to purchase prescription drugs at a discount, and I have fought tooth and nail to preserve that program. Finally, I have and will continue to ensure fair payment formulas, as I did in advocating for changes to the Medicare Wage Index, which leveled the financial playing field between urban and rural hospitals and delivered hundreds of thousands of dollars to rural physicians and hospitals.

2. What policies would you support in Congress to provide hospitals the necessary resources to effectively deal with the COVID-19 pandemic in their communities?

Health care providers are facing unprecedented financial and health care delivery challenges due to the COVID-19 pandemic. I realized early in the viral outbreak just how hard this would hit the bottom lines of hospitals, so I made sure that every one of my staff re-prioritized their time to help Kansans get through the most turbulent times of the pandemic. I asked my team to focus on provisions of the CARES Act that would impact Kansans and provide regular updates on when and how to access relief funds. We also helped hospitals access personal protective equipment and testing resources, as well as new therapeutics. We regularly convened groups of doctors and nurses to discuss " lessons learned" and new treatment modalities like innovative respiratory therapy. Other staff members were in regular communication with hospitals hoping to use the Paycheck Protection Program and worked directly with the Small Business Administration and community banks to relay rules and processes. I held dozens of Zoom calls throughout the pandemic to communicate directly with various physician groups and industry leaders on how the federal government is at work to protect both lives and livelihoods. Congress and the administration responded swiftly with several programs aimed to help providers weather the storm including the Provider Relief Fund, CMS Accelerated Payments, and Uninsured claims for COVID treatment. Federally Qualified Health Centers further received COVID and testing grants to ensure that uninsured populations were cared for, removing the burden from hospitals. Currently, hospitals are receiving additional funding from the counties that have opted to use their CARES Act funding to establish testing program and better assist COVID patients.

And at this same time, through the Congressional Doc Caucus , we were in constant communication with the White House, HHS, the Treasury to help develop policy that most helped Kansan hospitals, providers and patients .

And as I continue to travel across the state, We personally check in with more than 75 hospitals and providers to see what needs and concerns still remain to ensure that no hospital is without the help necessary to survive the pandemic. And we continue to communicate with the administration to respond to the needs of health care providers by sending more funds for testing equipment and supplies and most recently announcing 150 million new tests for states to use at their discretion.
I'm very proud that to acknowledge that every nursing home in the state now has point-of-care testing to help with reopening efforts.

As a member of the GOP Doctors Caucus, I have spearheaded several initiatives to ensure hospitals receive the support they need to keep their doors open, staff employed, and serve their communities. Early into the public health emergency, we introduced H.R. 6365, the Immediate Relief for Rural Facilities and Providers Act of 2020, a bill that would address the critical operational challenges facing rural hospitals and health care providers during the outbreak. We also sent a letter to HHS Secretary Azar addressing the need for immediate relief for small and rural hospitals, to which they responded by providing targeted funding for rural providers.

Addressing the COVID-19 pandemic for hospitals requires not only a whole-of-government approach, but also a partnership with the private players within the health care industry. To this end, I engaged in productive conversations with Kansan health plans to provide financial support and have met with manufacturers to prioritize newly made COVID-19 testing tools and equipment to Kansan hospitals. While not advertised, I did send a letter to two major health plans including Blue Cross and Blue Shield of Kansas asking them to consider providing accelerated payments – similar to the CMS program – to Kansan hospitals and other health care providers. Following the letter and several meetings, they established a $35 million Advanced Payment Program to offer relief to contracted providers in their service area.

3. The 340B drug pricing program has been essential for many Kansas hospitals that serve a high proportion of low-income Kansans. Do you support this program as it is or are would you be recommending any changes to it like those being sought by pharmaceutical companies?

Since 1992, the 340B Drug Pricing Program has served as a vital safety-net that allows Kansas hospitals serving vulnerable populations to purchase prescription drugs at a discount. I recognize how essential it is for rural hospitals to achieve financial sustainability and am proud to lend my strong support to ensuring the long-term viability of this program. Over the summer, I was proud to assist in expediting a hospital's application to enter the 340B program so they could use drug discount savings toward their core operational costs.

One of my goals is to make the 340B program more efficient and equitable for both covered entities and manufacturers, as it is mutually beneficial. This program was established with health care providers and pharmaceutical manufacturers at the table and it is important to advance policies that have common ground for the overall benefit of serving vulnerable populations and underserved communities. In doing so, I recommend HHS has sufficient funds and staff to oversee the program, disallow duplicate discounts, stop the increasing discriminatory practice of pharmacy benefit managers taking essential 340B savings from covered entities, and codify a hospital's ability to contract with outside pharmacies so vulnerable patients – especially those living in rural communities – can see their trusted community pharmacists.

4. What changes would you champion to reduce the regulatory burden for hospitals under the Medicare and Medicaid programs?

When speaking with hospitals in all parts of the state, I am reminded that this administration has delivered on its promise to slow and roll back red tape and regulations. I have made it a priority to repeatedly remind the administration that they must continue their fight to reduce the regulatory barrier, especially for our smallest providers. As a former rural provider, I can use my own experiences

to continue to tell the story of our rural hospitals and the changes that must continue to ensure our providers can sustain their work.

Last year, the American Hospital Association published a report to showcase the cost of regulations, and it is staggering. In summary, hospitals, health systems, and post-acute care providers must comply with 629 regulatory requirements, totaling nearly $39 billion across the United States. For the average size community hospital, these largely duplicative and inefficient regulatory requirements require 59 FTEs and cost $7.6 million. The two regulatory domains that require almost two-thirds of the financial and FTE commitment are Cost of Participation and billing and coverage verification. I believe if we look at the low hanging fruit of regulatory burden, we can lessen the load for hospitals.

I whole-heartedly believe that we can accomplish such goals in a bi-partisan manner. One of the most frequently cited and long-standing regulatory issues is cost utilization management tools like prior authorization (PA). During the past three years, I have been hard at work to address prior authorization and am a co-lead of H.R. 3107, the Improving Seniors' Timely Access to Care Act of 2019. This bipartisan legislation would streamline the approval process by moving PA to an electronic standard. This legislation is the first of its kind to address PA and has gained support from the majority of members in the House. My team has also worked to secure support from over 420 national and state organizations, including the American Hospital Association.

5. What steps would you take to provide relief for small and rural hospitals to ensure they can continue to provide health care services to their communities?

As I noted above, our rural hospitals are dependent on the success of our rural economies. That means lawmakers must work just as hard at keeping the agriculture and oil industries profitable as making changes to health care services. Our most successful rural hospitals serve communities that have likewise succeeded.

I believe we need to take a careful look at the size and scope of services that can be appropriately offered based on the size and location of each hospital. The mission of critical hospitals is different from those of specialty acute care hospitals. I believe we can take a regional approach to healthcare, wherein larger hospitals within a region provide specialized care such as surgery or obstetrics, and rural providers offer rehabilitative or post-operative care. This allows patients to receive non-acute care close to home and the local health clinic revenue streams.

We must also continue to look to new technologies, such as telehealth and increased care coordination to keep our patients closer to home and health care dollars in rural communities. I advocated for Medicare to pay for virtual check-ins that allow a patient to speak with their clinician to allow the clinician to decide whether they need to make a trip to be seen in-person – making it more convenient and cost-efficient for both patient and provider.

Congress must also continue to fix issues within the Medicare and Medicaid programs. I was successful in closing the Medicare wage index gap between rural and urban hospitals. Looking forward, I would highlight the bipartisan bill I co-sponsored H.R. 5212, the Accountable Care in Rural America Act. This legislation fixes a flaw in the Medicare Shared Savings program, which systemically disadvantages ACOs in rural areas. I am grateful for the American Hospital Association's support of this bill.

6. How do you view the role of telemedicine in our current health care system? Do you support any federal telehealth policy changes to make it more accessible?

Telemedicine and telehealth has the potential to be the single most important technology for the long-term survival of our state's healthcare industry. While screens are not always equivalent to the in-person consultation – where a physician can touch and hear the patient before them – telehealth can both offer protection during public health emergencies and also allow small hospitals some reimbursement for services they could not otherwise offer. This will also help mitigate the issues faced by aging providers and patients that we are seeing in many parts of the state. As more seniors opt to age-in-place, telehealth can become instrumental in allowing them to receive regular, necessary services from their kitchen table.

The pandemic forced everyone to quickly take a different approach, and many providers and hospitals learned how much could be done via FaceTime and Zoom. The administration responded to the outbreak by providing CMS with the flexibility to issue many temporary waivers of Medicare rules and regulations that hospitals normally have to adhere to. I believe that many of these telehealth flexibilities should be made permanent and include appropriate reimbursement mechanisms that cover all of the costs associated with delivering this care.

The CARES Act included an additional $25 million for telehealth and distance learning on top of the $502 million provided for broadband projects in the 2018 Farm Bill. Local broadband providers have already started putting that money to use building out networks and improving coverage. I support providing additional funding and support to expand broadband and telehealth infrastructure to assist hospitals in building out new systems.