The US Oncology Network

March 4, 2022

The Honorable Marianette Miller-Meeks
U.S. House of Representatives
1716 Longworth House Office Building
Washington, D.C. 20515

The Honorable Mike Kelly
U.S. House of Representatives
1707 Longworth House Office Building
Washington, D.C. 20515

The Honorable Morgan Griffith
U.S. House of Representatives
2202 Rayburn House Office Building
Washington, D.C. 20515

Dear Representatives Miller-Meeks, Kelly, and Griffith,

On behalf of The US Oncology Network, which represents more than 10,000 oncology physicians, nurses, clinicians, and cancer care specialists nationwide, thank you for the opportunity to provide comments to the Healthy Future Task Force Modernization Subcommittee.

The US Oncology Network (The Network) is one of the nation's largest and most innovative networks of community-based oncology physicians, treating more than 1.2 million cancer patients annually in more than 450 locations across 25 states. We unite over 1,400 like-minded physicians around a common vision of expanding access to the highest quality, state-of-the-art care close to home and at lower costs for patients and the healthcare system. We share the goals of the Subcommittee to modernize healthcare delivery and specifically want to focus our comments on the provider perspective as it relates to telemedicine expansion. After nearly two years delivering cancer care amidst a pandemic, we believe evidence-based telehealth policies should be made a permanent flexibility available to patients and providers.

There have been numerous studies published in the last several months demonstrating thousands of Americans have deferred critical primary care and cancer screening visits due to COVID-19. Early data indicated that some types of cancer screenings fell by as much as 85% in the initial months of the pandemic.[1] Another study found that up to 98% of certain minority populations declined routine breast and cervical cancer screenings.[2] Among America's veterans there has been a drop in new cancer diagnoses of up to 23%.[3] As oncologists work to confront the backlog of new cancer diagnoses and treat more advanced-stage disease, the data also proves the benefits of telehealth access. According to one study, telehealth use was associated with higher rates of cancer screenings, suggesting that this tool can serve as a powerful weapon in the fight against cancer.[4] In addition to assisting in new cancer diagnosis, telemedicine was a useful tool to support and modify cancer therapy for hundreds of thousands of patients during the pandemic, making comprehensive cancer care a reality even in a crisis.

Telemedicine Expansion

The Network is immensely grateful to Congress and the Centers for Medicare and Medicaid Services (CMS) for the decisive action to extend telehealth flexibilities to patients and providers at the onset of the COVID-19 pandemic. These flexibilities have allowed our practices to maintain continuity of critical cancer care and

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7713534/
[2] https://www.cdc.gov/media/releases/2021/p0630-cancer-screenings.html
[3] https://www.va.gov/maryland-health-care/news-releases/va-maryland-health-care-system-researchers-conduct-national-study-examining-the-impact-of-the-pandemic-on-new/
[4] https://jamanetwork.com/journals/jamaoncology/fullarticle/2778916

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have demonstrated enduring value even as telehealth visits have plateaued from 2020 rates. While not a panacea, we believe the availability of evidence-based telehealth services enhances the delivery of cancer care and should remain an accessible tool to patients and providers on a permanent basis.

Central to the effective implementation of telehealth access has been the relaxation of geographic restrictions and limitations on originating sites. Allowing patients to see their providers from their homes, regardless of distance, should be made permanent Medicare policy. The Network urges Congress to secure beneficiary access to evidence-based telehealth services by eliminating Medicare's geographic and originating site restrictions. This change would not only align with the expectation of patients, who have expressed high satisfaction with telehealth access, but would also recognize provider investments in telehealth technology.

As you know, Congress already recognized the potential for telehealth access to reduce barriers to care by permanently eliminating geographic and site origination restrictions for mental health services in the Consolidated Appropriations Act, 2021 (CAA). This is welcome news for our practices employing clinical social workers (CSWs) who provide psychotherapy services, which can be especially impactful in helping cancer patients navigate the emotional and psychological challenges of their diagnosis and treatment. As Congress and CMS consider making telehealth access permanent, ancillary benefits should also be included. For example, in addition to psychosocial services, payment for telehealth visits should also capture educational benefits like care planning and chemotherapy education. The more clarity given to providers regarding telehealth coverage of these services, the easier it will be to streamline patient care.

In considering federal standards for telemedicine, there are some state impediments that should be clarified. As part of any move to permanently lift geographic limitations on telehealth access, Congress should ensure that patients can consult healthcare providers across state lines, especially when related to ongoing care of a known patient or for second opinion consultations. This will enhance continuity of care and help patients make informed decisions about their treatment options. Another state impediment is the regulation of narcotics in the context of patient chronic pain management. Chronic pain is well-documented as a common feature of a cancer diagnosis and treatment.[5] Given the current shortage of palliative care specialists, telehealth access can help ease this burden. Some states have regulations prohibiting the prescription of narcotics via telehealth without a recent in person visit. While not part of the current telehealth flexibilities provided under the public health emergency, this should be considered, with appropriate guardrails, under any permanent telemedicine expansion.

One of the most complex aspects of telehealth permanence is determining its relationship relative to total cost of care. It is important to understand the extent to which telehealth substitutes for in-person visits or increases overall utilization; and if the latter, the extent to which it helps deter high cost and acute episodes. This will significantly impact overall costs and the transition to value-based care. Quality is also an important component, though it is difficult to assess and is regularly undervalued. At this stage in the pandemic, The Network can confidently state that telehealth coverage has reduced patient no-shows, particularly for social work, nutrition, and educational visits. We are currently evaluating telemedicine no-show rates relative to in-person no-show rates and hope to have data on this soon.

Overhead costs associated with telemedicine are difficult to disaggregate given reimbursement is largely predicated on in-person visits. Further, while telehealth carries obvious infrastructure costs, such as platform licenses, staff training, and equipment, this alone does not suggest it is more or less expensive than in-person care. For example, community oncologists will always need physical clinic space for both in-person and virtual visits, though the amount of space may vary based on how much care can be provided virtually. The Network has not analyzed telehealth visit costs relative to in-office visits since the onset of the pandemic, primarily because the current flexibilities were extended on a temporary basis but agrees with the

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5980731/

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Subcommittee that this would be a worthwhile endeavor. We would also note that the costs discussed in this letter are specific to healthcare providers. Patient costs should also be carefully considered. For example, telehealth not only helps minimize patient stress, but it also saves patients time, travel expenses, and potentially health plan cost-sharing obligations.

As mentioned above, The Network appreciates the Subcommittee's recognition of provider shortages and agrees that it is reasonable for Congress to permit licensed healthcare providers in good standing to practice across state lines using telemedicine, particularly for known patients and second opinion consultations. Such permissions at the federal level should evaluate impact on patient complaints, stakeholder disputes, investigations, and licensure compacts. The Network believes there is a greater need for licensure compact coordination.

Finally, The Network sees how artificial intelligence (AI) and other technological advances could increase patient access to care and reduce costs in the long-term. However, current capabilities are limited. In the short-term, incremental technologies like algorithms to move patients through a virtual consultation using chat bots represent a reasonable goal. Nonetheless, as industry continues to innovate, Congress should ensure our healthcare delivery system can quickly and seamlessly adopt and implement proven new technologies. Our American healthcare system is built on innovation, with both patients and providers eager to leverage the latest advancements in science and technology to help them live healthy lives.

Conclusion

Thank you for the opportunity to comment on these important issues. We welcome the opportunity to discuss them with you or your staff in more detail. Should you have any questions, please contact Ben Jones, Vice President of Government Relations and Public Policy, at Ben.Jones@usoncology.com.

Sincerely,

Debra Patt, MD, PhD, MBA
Chair, Public Policy & Reimbursement Committee
National Policy Board
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