January 2, 2024

VIA ELECTRONIC SUBMISSION THROUGH www.regulations.gov

Dr. Micky Tripathi, National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C Street, S.W.
Washington, D.C. 20201
Attn: 21st Century Cures Act: Establishment of Disincentives for Health Care Providers that Have Committed Information Blocking

Re: 21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking Proposed Rule (RIN 0955-AA05)

Dear Dr. Tripathi,

On behalf of The US Oncology Network (The Network), which represents over 15,000 oncology physicians, nurses, clinicians, and cancer care specialists nationwide, thank you for the opportunity to comment on the "21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking Proposed Rule" (RIN 0955-AA05).

The Network is one of the nation's largest and most innovative networks of independent, community-based oncology physicians, treating more than 1.4 million cancer patients annually at approximately 600 sites of care in 30 states. The Network unites over 2,400 like-minded physicians around a common vision of expanding patient access to the highest quality, state-of-the-art care close to home and at lower costs for patients and the health care system. We are committed to working with the Department of Health and Human Services to enhance the delivery of cancer care and protect patient access to high-quality, affordable care in the most efficient manner.

The proposed rule aims to deter healthcare providers from engaging in information blocking activities; however, The Network is concerned that the practice of information-blocking to control patient referrals is not directly addressed in this rule. This issue was identified in the 2015 Report to Congress on Health Information Blocking prepared by ONC[1] which noted complaints received of this practice by hospitals and coordination between developers and their provider customers to restrict exchange with unaffiliated providers.

Reducing time to treatment is critical in cancer care. Network practices maintain close relationships with local referring physicians so newly diagnosed patients can be seen as quickly as possible. Unfortunately, we continue to see hospitals engage in information bocking-type behavior to control referrals and enhance market dominance at the expense of patient care. This is a significant concern for patient choice and prompt patient care.

For example, several oncologists recently left a hospital system in a small market to create an independent group practice. These physicians had been ingrained in the community for years and were focused on maintaining unfettered patient access throughout the transition. After this occurred, the hospital system declined to inform existing patients how they could continue seeing their physician for ongoing treatment, even going as far as to switch them to a new, temporary doctor when they showed up for an appointment. Additionally, the hospital system set up multiple onerous roadblocks to prevent referring physicians at the hospital from making referrals to external providers for newly diagnosed patients. Specifically, a referring

[1] https://www.healthit.gov/sites/default/files/reports/info_blocking_040915.pdf

physician now must complete multiple extra steps in the electronic health record (EHR) in order to refer the patient externally and even then, the EHR sends a dual referral to both an oncologist affiliated with the hospital system and the unaffiliated oncologist preferred by the referring physician. This malfeasance creates confusion and anxiety for patients who understood they would be seeing a different physician. It can delay time-sensitive care. It can also be quite costly for both the patient and their insurer, as cancer care provided in the hospital-based setting is significantly more expensive than care provided in the community-based setting.[2]

It is concerning to us that despite the agency's efforts on interoperability and the clear direction of prohibiting information blocking, that without penalties and enforcement, many of these activities still take place. This is especially true when it comes to controlling referrals, which oftentimes deliberately disregards the medical decision-making of the referring providers. As the practice of information blocking with the intention of maintaining referrals ultimately leads to an increase of payments, the penalties to deter this activity must be more valuable than maintaining that business. Otherwise, an actor with that intention would benefit from overlooking the information blocking rules and accepting any relevant penalty.

The 2015 ONC Report to Congress also notes in its first scenario a case of information blocking from one provider who refused to share core clinical information with a rival provider except by fax. It describes that sometimes it can be a blatant policy while other times it's a subtle practice. We believe that subtlety must be better defined in order for this behavior to not continue flying under the radar.

The report flags that for information blocking to occur there must be interference, a "course of conduct that interferes with the ability of authorized persons or entities to access, exchange, or use electronic health information. This interference can take many forms, from express policies that prohibit sharing information to more subtle business, technical, or organizational practices that make doing so more costly or difficult." It goes on to indicate the activity is "likely to substantially increase the costs, complexity, or burden of sharing electronic health information." We believe this review originally conducted by ONC shows that activities like the above examples we've witnessed in our practices are blatant violations of information blocking and should be acknowledged and penalized.

With that said, it is not directly apparent what business practices prompting information blocking in order to maintain referrals may be considered information blocking, incurring penalties under the proposed rule. While we believe it could fit in the definition, it remains unclear. In the spirit and intent of the original statute and final rule, we encourage CMS/ONC to categorically state this behavior is information blocking and consider future guidance or rulemaking to prohibit it. Without doing so, the penalties in this proposed rule will leave out a deceptive practice that will impact patient care.

Conclusion

On behalf of The US Oncology Network, thank you for the opportunity to provide comments on this proposed rule. We welcome the opportunity to discuss the issues outlined above and any other critical issues impacting community cancer care with you and your staff. Should you have any questions, please contact Ben Jones, Vice President of Government Relations and Public Policy at Ben.Jones@usoncology.com.

Sincerely,

Marcus Neubauer, MD
Chief Medical Officer
The US Oncology Network

[2] https://www.fightcancer.org/sites/default/files/acs_can_site_neutral_issue_brief_-_final_10-19-23.pdf