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Meeting Patients Where They Are: Policy Platform for Telehealth and Cancer Care Delivery

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The COVID-19 pandemic broadly curtailed access to cancer care and highlighted the need to meet patients "where they are," which included remote access provisions. This need triggered multiple policy changes in 2020 that have accelerated adoption of telehealth strategies and impacted how patients with cancer receive care nationwide. In a survey conducted by the Patient Advocate Foundation (PAF) from 2019 through 2020, 64% of patients with cancer changed the way they accessed/received care during the pandemic, 66% experienced their first telehealth visit, and 77% felt that telehealth was beneficial (PAF, data unpublished, 2021). The Coronavirus Aid, Relief, and Economic Security Act (CARES), signed into law on March 27, 2020, included a provision allowing the Secretary of the Department of Health & Human Services to waive certainrequirements for Medicare telehealth payment that existed prior to the pandemic, expanding the range of telehealth services qualifying for reimbursement.[1]

Although expanded coverage and reimbursement for telehealth has been instituted during the public health emergency, it remains unclear what policies will persist after this immediate crisis has subsided. The finalized 2021 Medicare Physician Fee Schedule[2] makes permanent reimbursement of select codes and extends certain temporary codes until the end of the year in which the pandemic is last declared a public health emergency by section 319 of the Public Health Service Act.

Recommendations

The following recommendations are aimed at providing actionable and clear guidance for policymakers that will allow continuation of recent gains and enable improvement in cancer care delivery. We offer these recommendations from our perspective, which includes medical oncologists, a radiologist, a pharmacist, a psychologist, an epidemiologist, health services researchers, a policy director, a patient advocacy organization, an administrator, and a patient.

Align Evidence-Based, High-Value Guidelines/Indications With Coverage and Reimbursement to Optimize Utilization

There are concerns that telehealth will lead to overuse, fraud, and/or abuse.[3] Focus on coverage of telehealth for high-value services may mitigate unnecessary overuse, improve quality of care, and also lower total costs. For example, the following scenarios constitute high-value use of telehealth: (1) specialty care that otherwise would not be available, (2) chronic illness management that requires frequent monitoring, and (3) posthospitalization visits to manage side effects and prevent readmissions. In contrast, a low-value use of telehealth would be unnecessary "check-in" calls for well-managed chronic conditions. Incorporation of telehealth services into alternative payment models using bundled or capitated models could mitigate inappropriate overuse and allow physicians flexibility.

NCCN[4] and ASCO[5] have provided guidance on specific scenarios that are appropriate for telehealth. Data exist for use of telehealth throughout the cancer care continuum, including navigation, chemotherapy toxicity management, genetic counseling, clinical trial enrollment, mental health services, survivorship care, and palliative care (Figure 1).[6–8] Guidelines need to evolve to offer evidence-based recommendations for appropriate, high-value use of telehealth visits following the pandemic period.

Align Federal and State Telehealth Policy and Mandate Coverage and Reimbursement Parity for a Standardized Set of Minimum Services

Fragmentation in the US healthcare system, especially in the overlapping federal and state regulatory roles regarding insurance coverage, presents challenges to equitable adoption of telehealth.

Payment Parity of In-Person, Video, and Audio-Only Visits

A total of 43 states and the District of Columbia currently have laws requiring coverage of telehealth; however, coverage parity does not ensure payment parity. Only a few state laws include payment parity for telehealth (and some are restricted to certain specialties, such as mental health), although many states are introducing bills. Coverage and payment parity of video and audio-only visits may be associated with improved access to care; however, concerns still exist about this creating a "2-tiered system" where "the poor get phone calls and the rich get video visits."

Audio-Only Services

At the start of the pandemic, a separate payment for audio-only telephone evaluation and management (E/M) services was established (CPT codes 99441–99443); however, in the 2021 final rule, these telephone E/M codes will expire. The 2021 final rule stated that on an interim final basis there is a new HCPCS G code describing 11 to 20 minutes of medical discussion to determine the necessity of an in-person visit. This new code should not replace coverage and reimbursement parity for audio-only visit. We recommend the temporary CPT codes 99441–99443 be permanent and covered/reimbursed on parity with both video and in-person office visits. Congress should pass legislation to allow for continued coverage and reimbursement for audio-only telehealth services to mitigate technology disparities. Example legislation is the bipartisan bill H.R. 9035, the Permanency for Audio-Only Telehealth Act, which would expand Medicare coverage for audio-only telehealth services beyond the public health emergency and remove geographic and originating site restrictions.

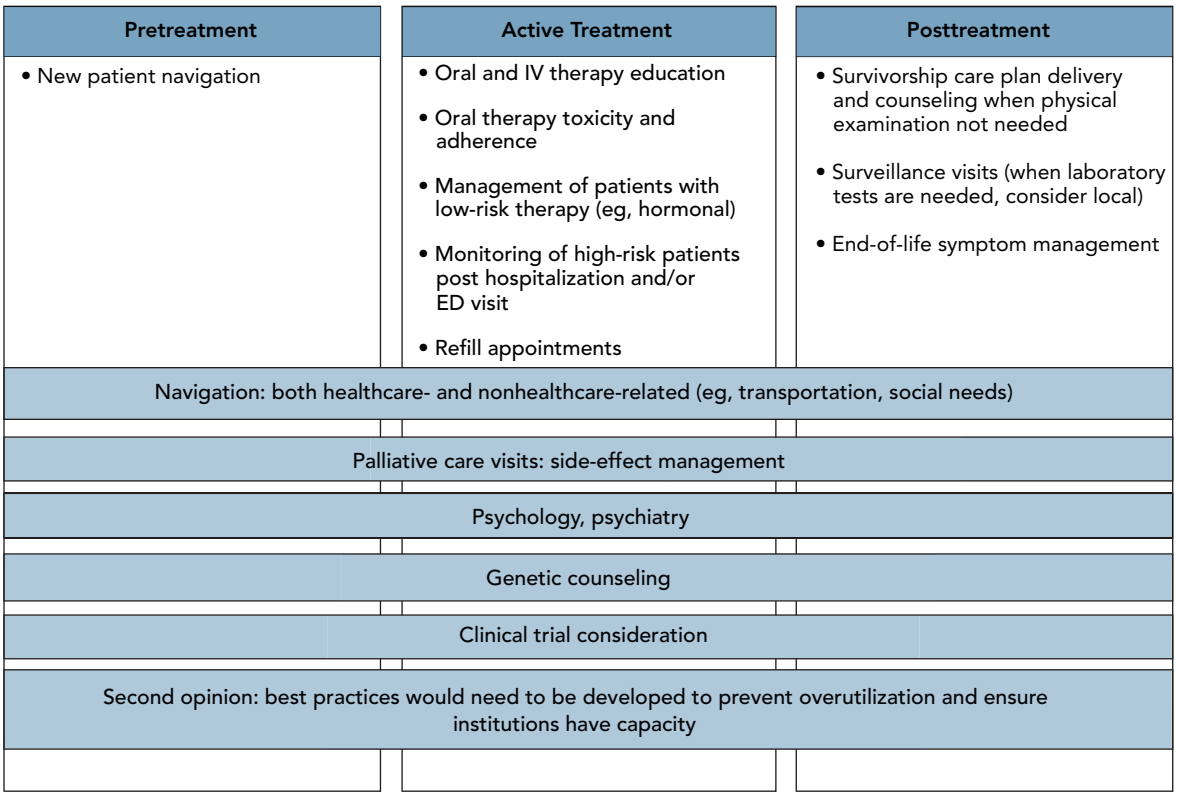

Figure 1. Examples of evidence-based utilization of telehealth within the cancer care continuum.
Abbreviations: ED, emergency department; IV, intravenous.

Originating Site

Policymakers should take steps to ensure patients can permanently access telemedicine services from their home as the "originating site" rather than requiring that they go to a healthcare facility. Twenty-six states and the District of Columbia. Medicaid programs explicitly allow the home to serve as an originating site, although it's often tied to additional restrictions. Even outside of a pandemic, allowing immunocompromised patients the opportunity to conduct visits from home can help mitigate physical, mental, and financial burdens of travel. We support policies that permanently remove geographic and originating site restrictions including both H.R. 1332, the Telehealth Modernization Act, and H.R. 9035, the Permanency for Audio-Only Telehealth Act.

Maintain a Comprehensive Cancer Team Eligible for Coverage and Reimbursement Via Telehealth

Under CMS waiver authority, all healthcare providers who are eligible to bill Medicare can bill for telehealth services throughout the public health emergency; however, under typical circumstances there is significant state variability, especially within Medicaid, regarding the types of clinicians that can be reimbursed for telehealth services. Eligible provider lists vary from being selective in the provider types (eg, Pennsylvania only allows physicians, certified registered nurse practitioners, certified nurse midwives, and select mental health facilities), to more expansive eligible provider lists, such as in Virginia, which includes >16 provider types.

Supportive oncology care is an established and essential component of cancer treatment recommended in guidelines

Table 1. Actionable Policy Recommendations for Telehealth and Cancer Care Delivery

	Policy Recommendations	Example Legislation
Coverage and Payment Parity	Establish coverage and payment parity at federal and state level for in-person, video, and audio-only visits.	H.R. 8308, Telehealth Coverage and Payment Parity Act (116th Congress): Representative Dean Phillips (D-MN-3) S.1988, The Protecting Rural Telehealth Access Act (includes an audio-only payment parity provision): Senator Joe Manchin (D-WV), Senator Joni Ernst (R-IA), Senator Jeanne Shaheen (D-NH), Senator Jerry Moran (R-KS) States with payment parity laws: Arkansas, California, Delaware, Georgia, Hawaii, Kentucky, Minnesota, Missouri, New Mexico, Texas, Utah, Vermont, Virginia, Washington
Audio-Only Visits	Allow audio-only telehealth services beyond the PHE and remove geographic and originating site restrictions.	HR 9035, the Permanency for Audio-Only Telehealth Act: Representative Jason Smith (R-MO), Representative Josh Gottheimer (D-NJ), introduced in 116th Congress
Provider Type	Permanent continuation of the flexibility that all healthcare practitioners currently authorized to bill Medicare for their professional services be allowed to bill for telehealth visits beyond the PHE. Expand Medicare Part B coverage of "medical nutrition therapy (MNT) services" to include patients with a cancer diagnosis.	There is no current federal legislation that would maintain ability for all Medicare providers to bill for telehealth beyond the PHE. We encourage inclusion of this provision into future legislation.
Geographic and Originating Site Regulation	Permanently remove geographic and originating site restrictions	H.R. 1332, the Telehealth Modernization Act: Representative Lisa Blunt Rochester (D-DE), Representative Buddy Carter (R-GA)
Broadband Access	Investment in high-speed broadband infrastructure in unserved and underserved communities.	H.R. 1783, the Accessible, Affordable Internet for All Act: Senator Lisa Klobuchar (D-MN), House Majority Whip Representative James E. Clyburn (D-SC)
Medical Licensure	Allow providers the ability to practice across state lines as long as scope of practice laws are followed. Consider implementation of a federal license to practice medicine	Proposed reforms to facilitate interstate telehealth • The Interstate Medical Licensure Compact (IMLC), established in 2017, permits physician to practice across states lines provided they comply with scope of practice laws • Reciprocity laws where states recognize out-of-state license • S.155, Equal Access to Care Act: Senator Ted Cruz (R-TX) and Senator Marsha Blackburn (R-TN), temporarily licenses the provider based on the physician's location instead of the patient's location

Abbreviation: PHE, public health emergency.

and required by accreditation bodies.[9] Allowing the full supportive oncology team continued access to telehealth coverage and reimbursement is an example of how we can leverage this pandemic experience to actually elevate and improve access to supportive oncology services.

At a minimum, we recommend permanent continuation of the flexibility to allow all healthcare practitioners who are currently authorized to bill Medicare for their professional services to also furnish and bill for telehealth services. Medicare currently has a limited scope of billable "medical nutrition therapy" services including only diabetes, chronic kidney disease, and a kidney transplant. We recommend inclusion of other chronic conditions, such as cancer, to be included in billable services to increase access to this essential service.

Engage Federal Mechanisms to Build National Infrastructure for High-Quality, Affordable Broadband Access

Disparities in cancer care exist and inequitable coverage and payment for telehealth has the potential to widen these further. In a weighted analysis of >54 million Medicare beneficiaries, 26.3% lacked digital access at home, and this lack of access was associated with individuals with low socioeconomic status, aged ≥85 years, and in communities of color.[10] We support legislation that will allow investment in high-speed broadband infrastructure, especially in unserved and underserved communities. As part of the American Rescue Plan Act of 2021 (Public Law No: 117-2), $7.17 billion was approved to an Emergency Connectivity Fund that schools and libraries can use to increase internet access. In March 2021, House Majority Whip Representative James Clyburn (D, South Carolina) and Senator Amy Klobuchar (D, Minnesota), Co-Chair of the Senate Broadband Caucus, introduced H.R. 1783, the Accessible, Affordable Internet for All Act. This bill would legislate $94 billion to provide currently unserved and underserved communities with affordable high-speed internet access.

Looking Forward

The unwanted occurrence of the COVID-19 pandemic has revealed opportunities in telehealth that can improve the delivery of care to patients with cancer as well as other chronic medical conditions. The policy landscape of telehealth is rapidly progressing, and it is important that all stakeholders offer input. Telehealth policies will likely employ strategies to encourage high-value and discourage low-value telehealth use, such as alternative payment models; use of out-of-pocket costs for "moral hazard"; limiting coverage to certain providers, patients, or conditions; differing payment rates for telehealth; and requiring in-person visits prior to a telehealth visit. Although we recognize that control of "overuse" of telehealth should be regulated, we discourage policy that is overly restrictive and limits access.

Prematurely discontinuing the expanded coverage and reimbursement of telehealth services could dampen progress. We echo the comments submitted by ASCO to Congress in response to the House Ways and Means Subcommittee on Health hearing, "Charting the Path Forward for Telehealth," in which they advocate permanent discontinuation of geographic and originating site restrictions, as well as appropriate coverage and reimbursement for audio-only televisits.[11] Policymakers can help shape the delivery of cancer care after this pandemic with legislation that will allow us to leverage the experience we have gained caring for our patients with cancer (Table 1).

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