Telehealth in Cancer Care
Community Oncology Alliance Position Statement

Community Oncology Alliance Position
Telehealth has become a valuable component in the care of patients with cancer during the COVID-19 (novel coronavirus) pandemic. Telehealth offers evaluation and treatment when an in-person visit is ill-advised, impractical, or otherwise unavailable. This could be because of issues such as patient safety and health status, geographic limitations, transportation challenges, weather emergencies, and more. Telehealth has been a valuable lifeline in oncology during the COVID-19 pandemic, where patients would not otherwise seek and/or delay needed cancer care. It has allowed clinicians to continue to provide high-quality and high-value care while mitigating the risk of exposure for patients, physicians, and their office staff.

The COVID-19 pandemic has been an impetus for the dramatic expansion of telehealth in the oncology space. As both practitioners and patients have become familiar with the technologies and their potential, the value that telehealth can play as an element of the treatment plan has become clear. While telehealth is not an option for all oncology visits and is not a replacement for many in-person treatments or visits, when telehealth is combined with in-person meetings, it offers physicians and patients the ability to more easily connect and manage their care. Additionally, as a more convenient option for certain patient visits, it contributes to more accessible and more consistent cancer care.

Background

Telehealth Before COVID-19
Prior to the COVID-19 Public Health Emergency (PHE), there were significant operational, regulatory, and perceptive obstacles to telehealth. It was rarely used in cancer care due to these unnecessary restrictions. In the Medicare program, its use was primarily limited to providing rural patients or patients in geographic regions designated as Health Professional Shortage Areas (HPSA) by federal regulators access to specialists without the burden of extensive travel.¹

For most care, including cancer care, Medicare regulations and requirements in many state Medicaid programs mandated that these visits be conducted at a designated health care facility (called the Originating Site). This necessitated that patients travel to a health care facility, such as a hospital or the office of their primary care physician, for such encounters, removing some of the convenience and access benefits of telehealth. Furthermore, reimbursement levels across all coverage programs (Medicare, Medicaid, commercial) did not reimburse telehealth at parity with in-person care. This made it challenging for oncology
practices to invest in the technologies required to utilize telehealth and from experimenting with the use of telehealth in the care of patients with cancer.

**Telehealth During COVID-19**

The COVID-19 pandemic brought significant changes in the opportunities and incentives to use telehealth services. In response to the coronavirus outbreak, the Trump administration, the U.S. Department of Health and Human Services (HHS), and Congress authorized and implemented a range of new flexibilities concerning the use of telehealth services. Many of these flexibilities were made possible by temporary legislative changes made as part of the Coronavirus Preparedness and Response Supplemental Appropriations Act (CARES) and the Families First Coronavirus Response Act (Families First). Due to these changes, many stringent Medicare payment requirements were temporarily waived, allowing Medicare and Medicaid beneficiaries to access remote care, regardless of where they live and for a significantly expanded set of services.

During the pandemic, telehealth services are also reimbursed at parity with in-person medical services. The move to accelerate the use of telehealth services also included other exemptions, including the waiving of HIPAA restrictions that had forced patients and oncologists to only use certain HIPAA-compliant technologies and platforms instead of a range of consumer telecommunication platforms, including telephone (which many, including seniors, prefer), as well as others (such as FaceTime, Google Hangouts, and the consumer versions of Zoom or Skype) that many patients were more familiar with and to which doctors had easier access. Most commercial payers mirrored the new government program flexibilities in their own coverage plans.

Widespread adoption by community oncology practices of telehealth occurred rapidly within a three to four-week period in March and early April 2020. There are multiple reasons for the rapid adoption. As “stay at home” orders were issued by all but five state governments (AR, IA, NB, ND, SD), many patients experienced challenges in or expressed fear of going to oncology offices. There were significant initial concerns about whether clinics could be made safe from the risk of COVID-19 exposure for high-risk patients, like the elderly, and those receiving active chemotherapy or immunotherapy treatments. Oncologists began to see how telehealth allowed practices to offer continuity of care that was of high quality compared to an in-person visit but was safer, easier, and often the modality preferred by patients during the PHE.

Telehealth has also proved to be an excellent way to provide other services necessary as part of high-quality cancer care and has allowed oncologists to reach patients at home without requiring the need for an in-person or face-to-face visit. This includes important services such as monitoring patient status, oral drug compliance and education, chemotherapy tolerance, and management of adverse reactions, all of which are achievable through telehealth services. Telehealth also allowed some practices to provide ancillary services such as nutrition assessment, exercise programs, and social services, including counseling, during
the trying COVID-19 pandemic. Hospital consultations, palliative care consultations, and hospice management have also been positive uses of telehealth in oncology during the crisis. In addition, delivering care in the home setting has also allowed physicians to simultaneously connect with a patient’s entire support team, including spouses, caregivers, and children when conducting patient education or assessing the patient’s status.

**Telehealth Implementation Challenges During COVID-19**

However, as with most rapidly adopted and implemented technologies and care strategies, the use of telehealth has not been without issues. For instance, technology access has been a significant burden for many patients. Not all patients have access to smart devices, such as smartphones, tablets, or computers, or broadband internet services needed to deliver care most effectively or to meet the reimbursement and coverage requirements of certain payers. This is especially true in rural areas of the United States. In addition, some patients that do have access to these technologies are not familiar with or experienced in using these devices in the ways necessary for telehealth. Most practices have been obligated to devote resources to educate patients on telehealth tools, get them signed up and connected, and support them during the initial, and some follow-up visits. This support has been essential to make telehealth visits a reality for many patients and to determine the best format for each patient based on their technology and internet access availabilities.

Many patients have had issues with using HIPAA compliant telehealth platforms that require them to complete unfamiliar tasks such as downloading software or an app. During the crisis, platforms that patients may be more familiar with, such as FaceTime, Google Hangouts, Skype, Zoom, and others, were often easier to adopt as they may already use these to communicate with children and grandchildren. This represents a challenge for the future use of telehealth when these recent HIPAA flexibilities may be terminated, preventing the use of these tools. Reasons for termination of these flexibilities include the risk of overuse of telehealth due to easy access and patient convenience (which have led to waste concerns), as well as fraud and abuse concerns regarding the privacy of information and HIPAA compliance. However, some of these platforms can meet HIPAA compliance through business associate agreements between the oncology practices and the platform along with other platform enhancements.

Telehealth technologies may also not be well connected with an oncologist’s patient information architecture, creating burdensome data entry, as well as information and scheduling barriers. Telehealth platforms have not routinely communicated well with EHR and practice management software. The scheduling of visits has been a consistent problem during the crisis. This has required additional staff and expenses for the duplicate work to roll out new technologies and revamp internal procedures to accommodate telehealth. Using staff resources to ensure that telehealth visits occur to the satisfaction of both patients and their oncologists has been a significant issue, especially given the lack of familiarity with using telehealth visits in the past.
The experience of clinicians and community oncology practices during the COVID-19 PHE has been that providing telehealth services is demanding for practices. These visits are both resource and time-consuming. It has been shown that up to one third fewer patients can be seen in a day compared to in-person visits due to all the technical challenges of these visits. It has also been observed that the actual time in direct communication with the patient can occasionally be a bit less than during an in-person visit, although the preparation time for the visit remains similar and the resource expenditure per visit is equivalent or more. There is a learning curve to the use of telehealth services and practices are seeing improvement in the value of providing these services over time. Reimbursement parity has made developing and implementing this new value-driven service reasonable. In the future, sustained reimbursement parity for appropriate services will need to continue taking into consideration the investment in technologies and the total resource utilization for such visits.

Another issue during the crisis, one likely to be a continuing problem post-COVID, has been how to legitimately use telehealth in areas where the oncology physician is in a bordering state and the patient lives in the neighbor state. Doing telehealth to the home invokes the state laws from where the patient lives and not from the site of service in another state. Many patients choose to, or have no alternative other than to, get their oncology care in neighboring states. In the future, supporting patient choices may require a waiver mechanism to allow for continuity of care when using telehealth either mandated federally for Medicare and Medicaid patients or by alterations in state laws.

**What Should Telehealth in Oncology Look Like After COVID-19?**

While it is likely that some of the recent telehealth flexibilities will become permanent and change cancer care delivery, backtracking to some of the more restrictive pre-COVID-19 telehealth environment has been anticipated and has already begun to occur, especially with certain commercial payers. This return to the prior state will reduce access and opportunities for care and is not good for cancer care, patients, oncologists, payers, or the health care system. Those cutting back cite their concern for potential overuse of visits due to the convenience for patients in getting their questions answered and their symptoms more rapidly dealt with. This could increase E&M visit costs. Studies have consistently shown that managing patient symptoms and better educating patients lessens emergency room utilization and hospitalizations while improving compliance with lifesaving cancer therapies. Thus, any additional E&M visit costs created by telehealth are more likely to be offset by a reduction in higher-cost services like emergency room visits and hospitalizations.

The 2021 proposed Medicare Physician Fee Schedule (MPFS) includes numerous provisions addressing telehealth, acting upon President Trump’s executive order to expand telehealth services covered by Medicare. This includes proposals to make 22 codes permanently eligible for telehealth coverage. However, in the MPFS, CMS has created a temporary third category of evaluation known as Category 3 services to cover all the exceptions made during the COVID-19 PHE. As it currently stands, these Category 3 rules will remain in place until the end
of the calendar year that the current PHE ends, likely through 2021. CMS is suggesting that data derived during the PHE should be considered for additional decisions as to whether the Category 3 changes move up to Category 1 or 2 and become permanent based on the learned experience of using telehealth during the PHE. COA fully supports continuing these Category 3 conditions through 2021 and preferably through 2022 and that close scrutiny of the benefits of telehealth be thoroughly explored and adjustments made before returning to the rules in place prior to the COVID-19 PHE.

The COVID-19 crisis has revealed telehealth to be an underutilized method of improving the quality of care by adding convenience and value to the patient experience. Patient satisfaction with telehealth is high. Oncologists are overwhelmingly in favor of maintaining the expanded rules and regulations enabling them to continue to provide telehealth services when appropriate. They do not want these flexibilities to be contingent on a PHE. In a recent poll, over eight in 10 (82 percent) of those who have used telehealth services say they either love it or like it. Even non-users find the idea of telehealth services appealing, with six in 10 (61 percent) saying they love or like the idea of using telehealth services. The Harris poll concluded that the future of telehealth looks promising as satisfaction is high, and the likelihood of continued social distancing for some time means the conditions are right for telehealth to assume its place as a go-to resource for health care. Given these continued concerns and opportunities for care delivery expansion and improvement, it is important that physicians and patients not be burdened by excessive, and at times unnecessary, limitations on telehealth.

Certain conditions must remain to support the continuation of telehealth services for patients with cancer. The regulatory and statutory environment must be altered and remain conducive to allowing telehealth to be part of mainstream medical care. In oncology, appropriate use of telehealth can be classified into two categories that include essential services for appropriate use of telehealth during the PHE and thereafter and value-driven opportunities for improvement in cancer care. A clear definition of who is an appropriate provider of telehealth services is needed. This should include physicians and advanced practice providers at a minimum. Dieticians, genetic counselors, nurses, and social workers may play critical roles as well.

Essential services or uses of telehealth in cancer care into the post-COVID-19 era include:
- Continuity of cancer care and re-evaluation during this and any future PHE
- Evaluation and treatment when an in-person visit is ill-advised due to physical distancing, transportation challenges, weather emergencies, a patient's health status, or their preference in meeting their care needs
- To improve access to cancer care for patients living in rural areas of the U.S.
- Oral drug compliance and adherence evaluations
- Palliative care consultations and follow-up care, especially if a practice has no established palliative care program
• Virtual hospice consultations and follow-up visits to ensure appropriate comfort care
• Chemotherapy teaching visits to allow caregivers and family to be involved
• Discussions to ensure patients have adequate information and time to process informed consent before signing an informed consent agreement or initiating therapy
• To ensure clinicians with subspecialty expertise can partner and consult rapidly with patients and clinicians to improve access to cutting edge care provided locally, whenever possible
• To allow continued use of a combination of in-person and virtual visits for management and surveillance of a patient’s cancer, treatment, and survivorship, especially in the cases of those who are mostly homebound, at a distance, or with adverse travel needs

In addition to these, there are a number of opportunities to improve cancer care with the use of telehealth going forward, including:
• Genetics clinic visits by qualified geneticists and genetic counselors
• Virtual social work visits and counseling
• Nutrition assessment and counseling
• Survivorship visits
• To connect with a new patient who desires a brief introduction but, under special circumstances, may need to delay an initial in-person visit or where necessary additional diagnostic testing can be discussed and ordered prior to a more comprehensive in-person consultation
• To facilitate distant caregivers to attend in-person or virtual patient encounters
• For second opinions which can be done comprehensively and urgently for patients wanting a review of their treatment plan prior to starting needed therapy
• Identification of social and economic determinants of health
• Distress screening and interventions

Moving forward, it is critical that payment parity for appropriate telehealth cancer care services continue to acknowledge the care complexities, required investment in technologies, and staffing and time needed for appropriate use of telehealth visits by community oncology clinics and practitioners. Some large integrated health systems, such as Kaiser Permanente, have recognized the value of telehealth in improving patient care and patient satisfaction even prior to the PHE and pay equally for telehealth and in-person visits. Other payers must continue payment parity policies for telehealth oncology services.

In addition, HIPAA-compliant technology platforms will need to be established and operationalized with both patients and physicians in mind. These systems will need to be able to integrate with the functions of an office management system and electronic health records system and account for patient technology competence. Future regulations and reimbursement must consider the inclusion of systems to support patients who lack access or the skills to use higher-order technologies. In select cases, oral only telehealth services should continue to be an option for oncologists and their patients. This will require both
practice and payer-level regulatory and policy changes to ensure this flexibility in care delivery does not negatively impact payment or quality program performance and participation.

It is also critical to address liability issues and concerns as telehealth evolves over time. Liability insurers will need to adjust policies and cover telehealth visits in the same manner as face-to-face in-house visits without negatively impacting premiums.

Practices should have the opportunity to expand telehealth as additional uses that lead to improving cancer management and health care value reveal themselves. Payers, particularly Medicare, must establish flexibilities for the inclusion of those additional uses as they are identified. As an example, the recent expansion of telehealth for Medicare Advantage plans announced by HHS failed to include hematology or oncology as included specialties. Given the high acuity of the care required in treating cancer, such omissions will need to be corrected for the future.

An additional concern with the adoption of telehealth is the risk of patients being lured away from their primary cancer care physician by competing, unscrupulous organizations or providers who do not have an existing relationship with them and do not then establish one. For telehealth to work optimally, a previous relationship with an oncologist will remain essential, except in the case of new patient visits or second opinion consultations. Continuity of care is a hallmark of excellent cancer care and should remain so.

Although data for the rapid adoption of telehealth during the PHE is being generated from claims data and from some large organizations with health services research capabilities, there is a lack of detailed data on what the telehealth experience and overall impact have been for patients and doctors. Additional studies should be undertaken to better understand the use of telehealth in routine cancer care. The opportunity to study the experience could lead to a potential lowering of cancer care costs through better management of the care process. Hybrid models using telehealth and in-person visits should be encouraged by both community oncology physicians, as well as from the larger health systems who embrace telehealth as we continue to embark on value-driven health care delivery models.

**Summary**

Telehealth has revealed itself to be an effective way of treating and evaluating patients with cancer during a PHE and is an equivalent substitution for some, but not all, in-person visits. It enables physicians to meet with certain patients to obtain necessary information, answer questions, and monitor and assess patient status while maintaining the same high level of comprehensive care as an in-person visit. For patients unable to attend an in-person visit, telehealth offers accessible care to patients whose continuity of care and care quality might otherwise be disrupted. By combining telehealth with in-person visits, physicians can provide
a high level of care that is more easily accessed, more comprehensive, and more convenient for some patients.

COA strongly encourages continuing the new, more patient-centric COVID-19 telehealth rules, regulations, and reimbursement enacted during the COVID-19 crisis beyond the end of the PHE by both federal and commercial payers. Telehealth rules should be re-evaluated and published prior to the end of the PHE to ensure oncologists and patients are able to appropriately adjust to any revisions. These revisions should include engagement by both patients and oncologists to ensure the proposed changes consider how telehealth can be valuable to both patients and the providers of cancer care. It is incomprehensible that telehealth rules are simply reversed after the tireless efforts and countless resource allocations that were made by community oncologists and patients during the COVID-19 crisis to ensure that critical care continued without compromising the lives of Americans with cancer. A return to the pre-COVID-19 status of telehealth policies would be a backward move that will decrease the quality and value of care oncologists seek to provide.

**Date**
Approved by the COA Board of Directors on August 17, 2020.

**COA Telehealth Task Forces Members:**
Recognizing the massive potential disruption to patient care emerging during the COVID-19 pandemic, the Board of Directors of the Community Oncology Alliance created a standing Telehealth Task Force to share information, guidance, and input with this rapidly emerging area. Representatives from independent, community oncology practices across the country volunteer on the task force and provide input to COA for public policy, reports, and official position statements. This position statement reflects the Telehealth Task Force’s input on the rapid adoption and continued use of telehealth in oncology. COA thanks the members of the Telehealth Task Force for their valuable time and input:

- Miriam Atkins, MD, FACP
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1 Telemedicine in Cancer Care; S. Joseph Sirintrapun and Ana Maria Lopez; American Society of Clinical Oncology Educational Book 38; May 23, 2018.

2 Removing regulatory barriers to telehealth before and after COVID-19; Nicol Turner Lee, Jack Karsten, and Jordan Roberts; Brookings Institution; May 6, 2020.

3 Framework to Advance Oncology-Related Telehealth; Kristin L. Rising, Marcia M. Ward, Jason C. Goldwater, Divya Bhagianadh, and Judd E. Hollander; JCO Clinical Cancer Informatics; June 29, 2018.

4 Telehealth in Oncology During the COVID-19 Outbreak: Bringing the House Call Back Virtually; Raymond Liu, MD, Tilak Sundaresan, MD, Mary E. Reed, DrPH, Julia R. Trosman, Christine B. Weldon, MBA, and Tatjana Kolevska, MD; JCO Oncology Practice; May 4, 2020.

5 Telehealth Is a Sustainable Population Health Strategy to Lower Costs and Increase Quality of Health Care in Rural Utah; Ramya Thota, MBBS, David M. Gill, MD, Jamie L. Brant, MD, Timothy J. Yeatman, MD, and Derrick S. Haslem, MD; JCO Oncology Practice; May 28, 2020.

6 Telehealth in Oncology During the COVID-19 Outbreak: Bringing the House Call Back Virtually; Raymond Liu, MD, Tilak Sundaresan, MD, Mary E. Reed, DrPH, Julia R. Trosman, Christine B. Weldon, MBA, and Tatjana Kolevska, MD; JCO Oncology Practice; May 4, 2020.

7 Telehealth: The Coming ‘New Normal’ for Healthcare; Harris Poll; May 2020