Dialing into Telehealth for Cancer Care: Strategies to Promote Equitable Access

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Introduction

Telehealth policy is in search of a new normal post-COVID. Legislators and regulators are actively deciding whether and how to maintain the slate of COVID-era flexibilities such as expansive originating site rules,[1] reimbursement parity,[2] and the acceptance of a broad range of modalities.[3] Health care C-suite executives are working through whether to expand or contract investments in telehealth infrastructure. While UnitedHealth Group's Optum and Walmart have shut down their virtual care business in 2024,[4] major health systems including University of Chicago Medicine and Mass General Brigham have launched new or expanded hospital-at-home programs.[5]

It is at this critical inflection point that the Center for Health Law and Policy Innovation of Harvard Law School (CHLPI), in partnership with the Memorial Sloan Kettering Cancer Center Immigrant Health and Cancer Disparities Center, undertook a review of the telehealth and cancer care landscape in New York State. Between Fall 2023 and Spring 2024, CHLPI spoke with a series of community leaders about ways in which telehealth supports patients and families affected by cancer across the care continuum, barriers to programming, and recommendations to ensure equitable access to telehealth. **The ultimate goal was to identify a series of shared considerations to inform policy priorities and advocacy strategy.**

This report describes the importance of telehealth to cancer care (p.2) and project methodology (p.3), lays out core insights for equitable implementation (p.4), and identifies implications for policy advocacy (p.6).

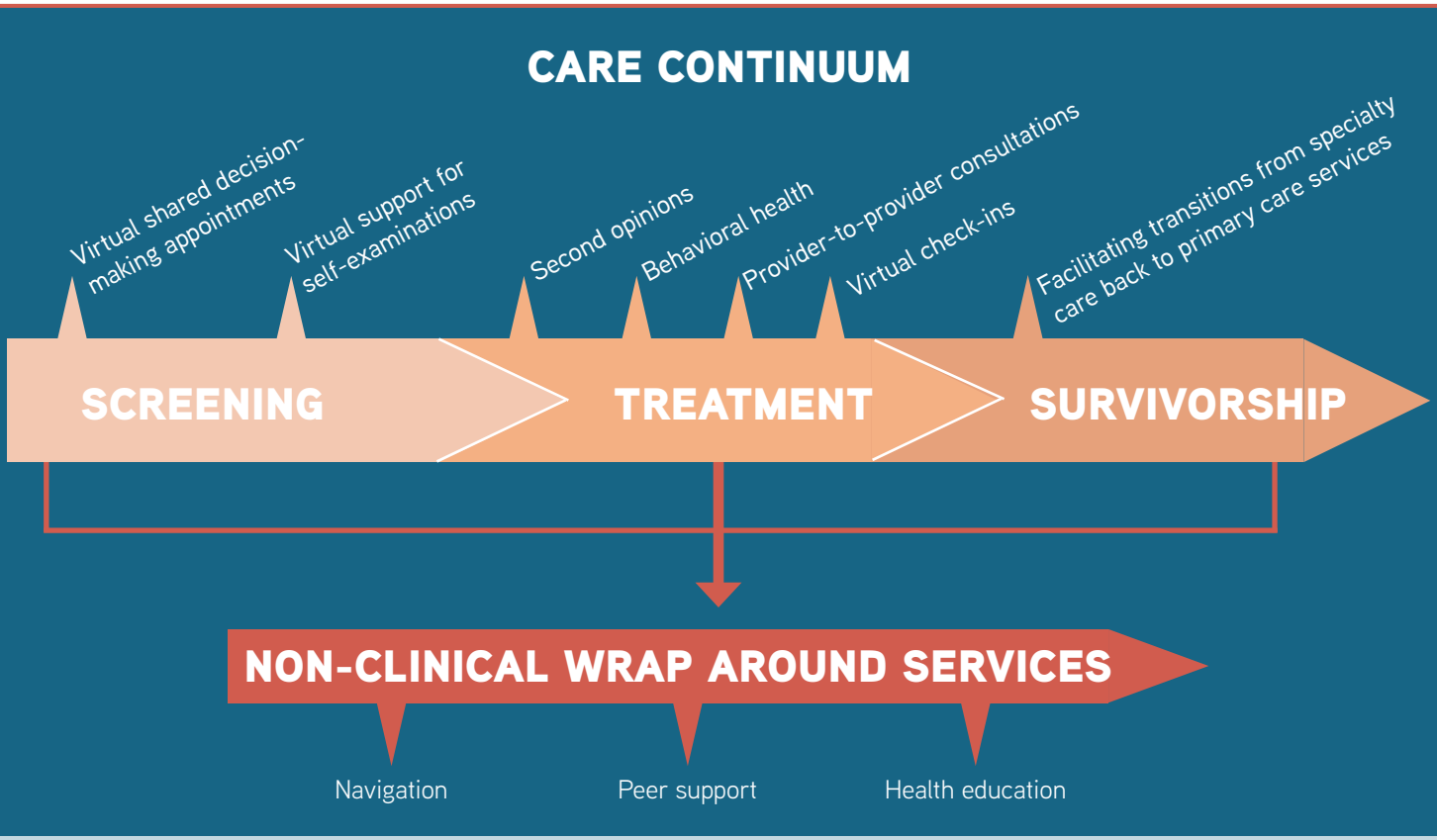
Why Focus on Telehealth in Cancer Care?

There are several reasons to identify and amplify best practices in leveraging telehealth as a mode of cancer care delivery.

First, research shows that telehealth can improve access to health care, care quality, patient/provider communication and, ultimately, health outcomes.[6] Within the context of cancer care, telehealth has applications across the care continuum; telehealth can be deployed as part of **screening** (e.g., virtual shared decision-making appointments), **treatment** (e.g., second opinions, behavioral health, provider-to-provider consultations, virtual check-ins), **survivorship** (e.g., facilitating transitions from specialty care back to primary care), and in **non-clinical, wrap around services** (e.g., navigation, peer support, health education).

Second, cancer care is often extremely resource intensive for patients and their families, leading to both "time toxicity"[7] and "financial toxicity."[8] Because of this, there is significant interest in strategies to reduce direct and indirect costs. Research shows that telehealth has a positive impact on patients by saving them time and money traveling to and from medical visits.[9]

Finally, significant racial and ethnic disparities persist in rates of cancer diagnosis and worsening cancer outcomes. In New York State, for example, non-Hispanic Black individuals have higher incidence rates of regional and distant stage disease for female breast cancer, cervical cancer, and colorectal cancer.[10] And non-Hispanic Black women have the highest breast cancer mortality—but not incidence—rate.[11] Without special attention and intention, telehealth as a care tool may exacerbate, rather than narrow, disparities.



Methodology

Over the course of several months, CHLPI spoke with an array of large, comprehensive cancer centers, community-based cancer care providers, and community-based organizations that provide a broad range of supports to people affected by cancer, patient advocacy groups, and other stakeholders. (*See* Table 1.)

Table 1: Examples of Participants

Cancer Care Providers	Community-based Organizations/Patient Advocacy Organizations	Other Experts
Mount Sinai Tisch Cancer Center	American Cancer Society Cancer Action Network	A2 Associates
Northwell Health	SHARE Cancer Support	University at Buffalo
Roswell Park Comprehensive Cancer Center		
University of Rochester Medical Center		

Interviews consisted of both structured and open-ended questions. Examples include:

- What do you view as the primary benefits of telehealth in cancer care?
- How is your organization leveraging telehealth? How do you approach this work with an equity mindset?
- How do you think telehealth measures instituted during the pandemic impacted access to cancer care or otherwise impacted health equity among people affected by cancer?
- Do you experience any challenges or concerns relating to telehealth and, e.g., reimbursement, patient access, patient choice, etc.?

Core Insights for Equitable Telehealth Implementation

The New York State cancer care community is engaged in creative, bold, impactful, and equity-driven work at the intersection of telehealth and cancer care. CHLPI's conversations with stakeholders uncovered six commonly expressed, key considerations for public policy and surrounding advocacy:

1. **Longstanding barriers to health care access (e.g., high rates of uninsured and underinsured individuals) stymie the effective, equitable realization of telehealth's full potential.** Telehealth cannot alone solve historical challenges to health equity.

2. **Some patients, including many older adults, low-income individuals, and people for whom English is a second language, have greater difficulty and/or discomfort utilizing telehealth.** Investments in digital inclusion—i.e., "activities necessary to ensure equitable access to and use of information and communication technologies"[12]—are important.

Telehealth Advocacy in Practice! Digital Inclusion

Several New York State stakeholders are experimenting with strategies to support digital inclusion. Approaches include device distribution to patients with demonstrated financial need, the deployment of digital health navigators and other digital literacy interventions, and the development of free, community-based telehealth access points (e.g., libraries).

3. **Telehealth can be useful for patients in both urban and rural settings; however, program design, needs, and investment priorities might differ between settings**. For example, New York City has access to broadband (high-speed internet) throughout the region, however, there are still some rural areas in upstate New York that are in need of adequate infrastructure to make broadband available.[13] But availability and affordability are distinct issues. With the recent wind-down of the Affordable Connectivity Program (ACP), more than 1 million people in NYC are set to lose access to affordable internet,[14] including the 44% of households in the Bronx, 25% in Brooklyn, 25% in Queens, and 22% in Manhattan that were enrolled in the ACP and saving utility costs on internet service providers. The service provided significant discounts to households that rely on affordable high-speed internet for their basic social and economic needs.[15]

4. **Stable, flexible, strong reimbursement policy promotes stable, flexible, and strong institutional investment.** The current state of uncertainty, real or perceived, chills investment by hospitals, community providers, and other stakeholders in developing out their technological and administrative infrastructure around virtual models of care.

Telehealth Advocacy in Practice! Insurance Coverage

New York State recently expanded Medicaid telehealth coverage to include eVisits and eConsults.[16] eVisits refer to patient-initiated communications with a medical provider through a text-based and HIPAA-compliant digital platform, such as a patient portal. They are used to remotely assess non-urgent conditions and prevent unnecessary in-person visits. eConsults refer to interprofessional consultations between a treating or requesting provider and a consultative provider. eConsults are used to answer patient-specific treatment questions in which a consultative provider can reasonably answer, from information provided in the request for consultation and the electronic health record, without an in-person visit. In 2022, out of 128,651 Medicaid members with cancer, 49,910 were telehealth utilizers, with statewide telehealth use being the highest among females (60%), individuals aged between 22 and 64 (62%), and non-rural (92%) regions in New York State.[17]

5. **The "right" or "best" care for a patient might be located across state lines.** Barriers to multi-state licensing are barriers to community-based care and barriers to specialized expertise.

Telehealth Advocacy in Practice! Multi-State Licensing

New York State is not part of the Interstate Medical Licensure Compact (for physicians) or the Nurse Licensure Compact. Advocates have tried to change this through both legislative[18] and administrative avenues.[19] Joining a Compact makes it easier for providers licensed in other states to practice in New York, either physically or virtually; and makes it easier for New York providers to offer virtual care to patients who reside in other states.[20] Currently, there are 40 states that are part of the Interstate Medical Licensure Compact[21] and 42 states that are part of the Nurse Licensure Compact.[22]

6. **Telehealth should not supplant in-person care.** Patient choice is critical, and not all aspects of cancer care can or should be delivered via telehealth.

Conclusion: Implications for Policy Advocacy

The considerations laid out above help to distill and inform priorities for cancer care advocates amid emerging policy and funding opportunities. The recent approval of the New York State Digital Equity Plan, for example, ushers in new commitments to digital equity, with a focus on features such as (1) broadband affordability and availability, (2) device accessibility and support, (3) digital literacy, and (4) privacy and cybersecurity.[23] Given the prominence of digital inclusion in stakeholder conversations, the New York cancer community may have a particular interest in the Plan as the State moves into investments and other implementation activities.

Further, while this report is based on conversations with stakeholders about the Empire State, the learnings and their applications need not be so limited. As of April 2024, for example, all 50 states, including Washington D.C. and Puerto Rico have had their digital equity plans approved by the federal government, creating an opportunity for cancer care stakeholders to improve access across the care continuum and preserve and expand access to telehealth services across the nation.[24]

Endnotes

1 For e.g., Texas under HB 4 expanded originating sites to include rural health clinics (RHCs) and allows for telemonitoring services to be provided at the patient's home, https://www.cchpca.org/texas/?category=medicaid-medicare&topic=remote-patient-monitoring.

2 For e.g., Florida passed HB 267 in 2023, which amended the definition of "telehealth" to include audio-only. *See* https://legiscan.com/FL/text/H0267/2023?web=1&wdLOR=cD6648321-3EFA-4C23-ABB2-9DEE5E3EF5E9. Hawai'i passed HB 907, which allows audio-only consults for the purposes of diagnosis, evaluation, or treatment of a mental health disorder at 80% of comparable in-person rates, https://legiscan.com/HI/text/HB907/2023. *See also* https://www.ama-assn.org/system/files/ama-state-telehealth-policy-trends-2023.pdf.

3 For e.g., Colorado's SB 20-212 has allowed for multiple different telehealth modalities such as audio-visits, video calls, live chat options, and reimbursement for remote-patient monitoring.

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13 Office of the New York State Comptroller, Broadband Availability and Access Across New York State, https://www.osc.ny.gov/reports/broadband-map (last visited Aug. 13, 2024).

14 John Dias, Nearly 1 million New Yorkers could soon lose affordable internet access. Here's why, *CBS News* (May 28, 2024), https://www.cbsnews.com/newyork/news/affordable-internet-program-ending-nyc/.

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