March 20, 2023

The Honorable Bernie Sanders
Chairman
Senate Committee on Health, Education, Labor and Pensions
U.S. Senate
428 Senate Dirksen Office Building
Washington D.C. 20510

The Honorable Bill Cassidy
Ranking Member
Senate Committee on Health, Education, Labor and Pensions
U.S. Senate
428 Senate Dirksen Office Building
Washington D.C. 20510

Dear Chairman Sanders and Ranking Member Cassidy:

Thank you for the opportunity to weigh in on the critical issue of health care workforce shortages. The Association for Clinical Oncology (ASCO)[1] appreciates the committee's efforts to address workforce shortages to protect the integrity and stability of the U.S. health care system.

ASCO is a professional organization representing physicians who care for people with cancer. With nearly 45,000 members worldwide, our core mission is to ensure that cancer patients have meaningful access to high quality, equitable cancer care.

Protecting the vitality of the health care workforce is critical to the U.S. health care system. For years, data from our affiliate organization, the American Society of Clinical Oncology (the Society), the American Association of Medical Colleges (AAMC), the American Cancer Society (ACS) and other stakeholders have shown a steady decline in supply of practicing health care providers to meet the demand of the evolving needs of U.S. patients. Like the broader health care workforce, oncology is also facing shortages across care teams. These shortages are driven by several factors, including an aging population, increased demand for cancer care, and a limited number of physicians choosing to specialize in

[1] The Association for Clinical Oncology, referred to as the "Association" is an affiliate organization of the American Society of Clinical Oncology, referred to as the "Society".

oncology. The shortage of oncology providers has significant implications for patients, as delays in diagnosis and treatment can have a substantial impact on outcomes. To address this issue, organizations like ASCO are advocating for policies that support and encourage more physicians to specialize in oncology, as well as for increased funding for graduate medical education slots and workforce programs that aim to train and retain the next wave of the oncology workforce. The Society currently offers several award and mentorship opportunities to aid new physicians into the oncology workforce.

A Glance at the Oncology Workforce

Currently, the U.S. population is aging, with people age 65 and older expected to grow from 19% of the population in 2019 to 21.6% by 2040.[2] Not only is the population aging, but cancer cases are also on the rise. In 2023, 1,958,310 new cancer cases are projected to occur in the U.S. – up from 1.9 million in 2022.[3] The oncology workforce treating this population is also aging and retiring at a faster rate than the workforce pipeline can maintain. Currently, 22% of practicing oncologists are nearing retirement age.[4] In contrast, 13.9% of the oncology workforce is age 40 and under. Workforce shortage concerns extend beyond physicians to include the broader group of cancer care delivery professionals. From nurses to physician assistants and technicians, the consequences of workforce shortages are being felt throughout the community. The consequences of shortages—less time with patients, increased workload, stress, and access challenges—may lower quality of care. It could even discourage clinicians from entering or remaining in the field.

In the research field, early career investigators are also struggling to enter the workforce due to a lack of resources. The National Cancer Institute (NCI) is the largest funder of cancer research in the world, but its funding has not kept pace with opportunities for innovative research. Between FY2013 – FY2022, R01 and R37 grant applications rose by 45%, but today only 14% percent of life-saving research can be funded. Apart from these missed opportunities, we lose early career investigators who choose other careers when grant submissions are not funded, disrupting the workforce pipeline.

Physician Burnout

Oncology care teams face significant clinician burnout, leading to early retirement or individuals leaving the field. Burnout in oncology has been linked to provider shortages and the increased demand for health care services from an aging population. Providers of all types report stress and burnout directly stemming from increased administrative and financial burdens from payer policies, such as prior authorization, step therapy, and copay accumulator/maximizer programs.

ASCO recently published the results of a member survey[5] that assessed the impact of prior authorization on cancer care. The survey results show prior authorization is delaying patient care, impacting cancer care outcomes, and diverting providers from patient care. Nearly all survey participants reported that a patient has experienced harm because of prior authorization

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[2] Administration for Community Living. 2020 PROFILE OF OLDER AMERICANS. https://acl.gov/sites/default/files/aging%20and%20Disability%20In%20America/2020Profileolderamericans.final .pdf

[3] Siegel RL, Miller KD, Wagle NS, Jemal A. Cancer statistics, 2023. CA Cancer J Clin. 2023 Jan;73(1):17-48. doi: 10.3322/caac.21763. PMID: 36633525.

[4] 2022 Snapshot: State of the Oncology Workforce in America. JCO Oncol Pract. 2022 May;18(5):396. doi: 10.1200/OP.22.00168. PMID: 35544658.

[5] ASCO Prior Authorization Survey Summary. 2022 Nov; https://old-prod.asco.org/sites/new-www.asco.org/files/ASCO-Prior-Auth-Survey-Summary-November-2022.pdf

processes, including significant impacts on patient health such as disease progression (80%) and loss of life (36%). The most widely cited harms to patients reported were delays in treatment (96%) and diagnostic imaging (94%); patients being forced onto a second-choice therapy (93%) or denied therapy (87%); and increased patient out-of-pocket costs (88%).

The survey responses also reflected the unnecessary complexity of the prior authorization requirements. Nearly all respondents reported onerous administrative requirements, delayed payer responses, and a lack of clinical validity in the process. The survey also found that, on average:

- It takes a payer five business days to respond to a prior authorization request from a physician.
- A prior authorization request is escalated beyond the staff member who initiates it 34% of the time.
- Prior authorizations are perceived as leading to a serious adverse event for a patient with cancer 14% of the time.
- Prior authorizations are "significantly" delayed (by more than one business day) 42% of the time.

Pharmacy Benefit Manager (PBM) policies are also contributing to workforce burnout. Data collected during the 2018 ASCO Practice Survey[6] showed PBMs may reduce access and quality of care while increasing burdens on providers. For example, three-quarters of practices surveyed said PBMs interfered with patient care and/or made it difficult to deliver care, and 56% say that PBMs disrupted practice workflow. The significant erosion of time spent delivering care stands in direct opposition to the most common reason clinicians cite as their motivation for entering practice: helping patients.

To address burnout, the Association recommends continued federal investments for programs authorized under the *Dr. Lorna Breen Health Care Provider Protection Act* that aid physicians in combatting and coping with burnout in the workplace. The Association also recommends enactment of policy solutions to address administrative burdens, which impede the delivery of quality patient care and lead to burnout. Legislative solutions include the *Safe Step Act* (S. 652), the *Help Ensure Lower Patient (HELP) Copays Act* (H.R. 830), and the *Pharmacy Benefit Manager Transparency Act* (S. 127). Advancement of pending regulatory solutions under the Centers for Medicare and Medicaid Services on prior authorization[7][8][9] could also reduce burdens for providers. The Society has developed several oncology-specific resources to assist physicians with burnout and the organization recently launched access to an 18-month pilot program, Safe Haven, which offers wellbeing resources, such as counseling and mental health access.

Workforce Diversity

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[6] Royce TJ, Schenkel C, Kirkwood K, Levit L, Levit K, Kircher S. Impact of Pharmacy Benefit Managers on Oncology Practices and Patients. JCO Oncol Pract. 2020 May;16(5):276-284. doi: 10.1200/JOP.19.00606. Epub 2020 Apr 20. PMID: 32310720; PMCID: PMC7351331.

[7] https://www.federalregister.gov/documents/2022/12/27/2022-26956/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

[8] https://www.federalregister.gov/documents/2022/12/21/2022-27437/administrative-simplification-adoption-of-standards-for-health-care-attachments-transactions-and

[9] https://www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

The physician workforce continues to struggle with adequate representation of racial and ethnic minorities, as well as females, with hematology and oncology not keeping pace with medicine in general. Increased oncology workforce diversity and representation is correlated with increased equity in cancer prevention, screening, care, and patient outcomes. In a recent analysis, only 4.7% of oncologists identify as Hispanic or Latinx; 3% identify as Black or African American; and 0.1% identify as American Indian or Alaskan Native. Regarding Black representation in the oncology workforce, at each step to becoming an oncologist, the percent of Black participation decreases. Of the U.S. population, 13.4% of people identify as Black. Eleven percent of recent college graduates; 8.4% of recent medical school applicants; 6.2% of recent medical school graduates; 3.9% of oncology fellows; and 3% of oncologists identify as Black.[10] Looking closer at Hispanic or Latinx oncologists and patients, the provider to cancer care needs ratio further emphasizes the underrepresentation in oncology.[11] As mentioned, only 4.7% of U.S. oncologists identify as Hispanic or Latinx, while 9.3% of new cancer cases are among patients that identify as Hispanic or Latinx. A similar trend can be observed with gender representation, as women comprise roughly one-third of the oncology workforce. According to an AAMC analysis, women represent only 35% of hematology and oncology specialists; and only 27.7% of radiation oncologists.[12] When considering race and gender, the underrepresentation gap widens as only 4.2% of oncologist/hematologists in 2018 identity as Black females, down from 5.3% in 2008.[13]

Minority physicians have a greater tendency than non-minority physicians to practice in communities designated as physician shortage areas, according to a 2008 report from the U.S. Health Resources and Services Administration.[14] In an AAMC report, Hispanic or Latinx medical students and Black medical students showed growing willingness to practice medicine in underserved communities, increasing from 39% in 2015 to 41.9% in 2019 for Latinx students and increasing from 51.1% in 2015 to 60.5% in 2019 for Black students.[15][16] A diverse physician workforce also strengthens cultural competency and engenders trust and comfort in patients. Therefore, recruiting oncologists from diverse backgrounds can provide increased and improved clinical oncology care to underserved communities.

ASCO recognizes additional work is needed to achieve greater workforce diversity and representation in oncology across race, ethnicity, gender/gender identity and sexual orientation. To that end, the Society has implemented several programs and initiatives to improve the current status. Of note, the Society's Equity, Diversity and Inclusion (EDI) strategic plan outlines specific objectives, such as improving and expanding mentoring opportunities and career development for oncologists and trainees from populations that are underrepresented in medicine (UIM); assessing policy solutions that could increase the proportion of oncologists who

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[10] 2021 Snapshot: State of the Oncology Workforce in America. JCO Oncol Pract. 2021 May;17(5):249. doi: 10.1200/OP.21.00166. PMID: 33974817.
[11] 2022 Snapshot: State of the Oncology Workforce in America. JCO Oncol Pract. 2022 May;18(5):396. doi: 10.1200/OP.22.00168. PMID: 35544658.
[12] Association of American Medical Colleges 2022 Physician Specialty Data Report; https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-sex-specialty-2021
[13] 2021 Snapshot: State of the Oncology Workforce in America. JCO Oncol Pract. 2021 May;17(5):249. doi: 10.1200/OP.21.00166. PMID: 33974817.
[14] U.S. Department of Health and Human Services. The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand. 2008. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/physiciansupplyissues.pdf
[15] Association of American Medical Colleges. Report on diversity and medicine: Facts and Figures 2019. https://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019.
[16] Association of American Medical Colleges. Report on diversity and medicine: Facts and Figures 2016. https://www.aamcdiversityfactsandfigures2016.org/report-section/section-3/#figure-29.

are UIM; and increasing racial/ethnic diversity among the organization's leadership. The strategic plan will guide overall workforce diversity efforts and build on existing programs, including the Society's Diversity in Oncology Initiative, which offers award, internship and mentorship opportunities for medical students and residents who are underrepresented in oncology. The Association recommends increasing federal investments in health care workforce programs to train and retain UIM providers as a policy solution to improve workforce diversity.

Oncology Workforce Distribution

Oncology workforce shortages are more significant in rural and underserved areas, as many facilities have difficulty attracting and retaining health care providers. According to workforce data from the U.S. Health Resources and Services Administration, non-metro oncology supply will only meet 37% of demand by 2035.[17] Additionally, only 10.5% of oncology practices are located in rural geographic areas. A 2021 study shows that 64% of counties in the U.S. had no oncologists with a primary practice location in that county. Twelve percent had no oncologists, either within the county or in adjacent counties. When cross referenced by the corresponding cancer rates, the study found a negative association between the availability of oncology workforce and cancer rates.[18]

Building on its longstanding commitment to health equity, the Society launched a multi-year pilot program to increase access to high-quality, equitable cancer care in rural Montana. The pilot program, referred to as the Increasing Access to Cancer Care in Rural Montana pilot program, will enable patients to receive cancer care in their own community through a hub-and-spoke care delivery model, a proven method of extending access to cancer care in rural and remote areas. This initiative aims to reduce patients' commute to treatment locations, enable rural sites to be primary points of contact, improve care delivery through education and training, and encourage patient engagement throughout the cancer care continuum. The hub and spoke model leverages community resources, clinician experts in "hub" centers, and all members of the care team to provide care in "spoke" areas where workforce shortages have created access barriers.

The Increasing Access to Cancer Care in Rural Montana pilot program includes Bozeman Health Cancer Center, located at Bozeman Health Deaconess Hospital, a regional facility that serves as the initiative's "hub," and Barrett Hospital & HealthCare, a community-based non-profit Critical Access Hospital and medical clinic provider in Dillon that serves as the "spoke." It will enlist the assistance of the Mark and Robyn Jones College of Nursing at Montana State University, the only nursing graduate program in Montana, offering a potential pipeline to build a trained nursing workforce to increase capacity and care delivery at participating community-based, or spoke, clinics.

Due to the diverse and community-dependent challenges in delivering oncology care to rural areas, multiple strategies are necessary to address workforce shortages and ultimately decrease nationwide rural disparities in cancer care. The experiences of the Montana pilot program suggest that increasing patient access to care requires creating partnerships between providers and community leaders to address local workforce shortages.

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[17] https://data.hrsa.gov/topics/health-workforce/workforce-projections

[18] Shih YT, Kim B, Halpern MT. State of Physician and Pharmacist Oncology Workforce in the United States in 2019. JCO Oncol Pract. 2021 Jan;17(1):e1-e10. doi: 10.1200/OP.20.00600. Epub 2020 Dec 3. PMID: 33270520; PMCID: PMC8189614.

Moreover, a team-based approach to delivering care has been an effective solution for oncology teams struggling with workforce shortages. The integration of advanced practice providers (APPs) into oncology practice offers a reliable means to address increased demand for oncology services without adding physicians. According to a 2011 Society study on Collaborative Practice Arrangements[19], practices in which the APP worked with all practice physicians showed significantly higher productivity than those practices in which the APP worked exclusively with a specific physician or group of physicians.

In addition to strategies outlined above, telemedicine has also helped, not only to bridge the gap in care for rural patients but also enhancing access to care in general. This was especially important during the recent public health emergency, when face to face interactions were limited. The Association appreciates Congress' extension of telehealth flexibilities for services through 2024 and would encourage policymakers to make these flexibilities permanent.

ASCO is pleased to serve as a resource to you and your colleagues as you develop and advance innovative legislative solutions to ensure we have the health care workforce needed to serve our patients. Should you have any follow-up questions or concerns, please do not hesitate to contact Kristine Rufener at Kristine.Rufener@asco.org.

Sincerely,

Lori Pierce, MD, FASTRO, FASCO
Chair of the Board
Association for Clinical Oncology

[19] Towle EL, Barr TR, Hanley A, Kosty M, Williams S, Goldstein MA. Results of the ASCO Study of Collaborative Practice Arrangements. J Oncol Pract. 2011 Sep;7(5):278-82. doi: 10.1200/JOP.2011.000385. PMID: 22211119; PMCID: PMC3170055.