ASSOCIATION OF CANCER EXECUTIVES UPDATE

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9 Changes, What You Need to Know – MIPS/MACRA-2019

The 2019 ACE Webinar Schedule

TUESDAY, JUNE 18
Cancer Case Management and Throughput Performance Improvement Implementation
1:00 PM EDT

Webinar presenters:
Loren Mann, MBA, MSME, Performance
Kelley D. Simpson, MBA,
Chartis Oncology Solutions

THURSDAY, JULY 18
Improving Access to Genetic Counseling and Testing
1:00 PM EDT

Webinar presenters:
Nancy Harris, Sharp HealthCare

WEDNESDAY, OCTOBER 23
Data-Driven Sustainability: 4 Practical Ways to Leverage the Power of Data
1:00 PM EDT

Webinar presenters:
Matt Mulherin, Advanced Centers for Cancer Care (AC3)
Kim Woofter, RN, Advanced Centers for Cancer Care (AC3)

For complete ACE webinar information please visit us here.

The Convergence of Community and Academic Cancer Care

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In the world of cancer care, the only constant is change.

Every year, novel therapies emerge and research generates new discoveries that help to redefine cancer care. Healthcare policy and reimbursement also shift perennially, rewriting the rules by which providers manage the business of oncology. And each year, broader industry restructuring and democratization of high-end capabilities reshape the traditional roles of academic and community providers.

The remaking of these long-established roles is not a story of divergence but rather of convergence.

The language we use to describe cancer centers can be bewildering — e.g., "Commission on Cancer-accredited" or "National Cancer Institute-designated" — but the historical rules used to be straightforward. If you had a "simple" cancer, you went to a community provider, and if you had a "complex" cancer, you went to an academic medical center (AMC)/ National Cancer Institute (NCI)-designated center. If you wanted to participate in research, you went to an academic hospital. All of that is changing.

Capabilities have migrated over the past decade with increasingly sophisticated clinical and research competencies moving to community settings.

This migration has begun to blur the conventional roles of academic and community providers and has driven the adoption of new business models designed to leverage the best of both environments and enable market differentiation and

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improved patient care. In this paper we explore the underpinnings of the role convergence as well as how some of the nation's top integrated delivery networks and academic cancer centers are responding. We conclude that the "winners" in cancer will be those that bridge traditional and non-traditional roles and lean into disruption through creative and integrated forms of partnership. We also provide five strategic imperatives for the design of successful academic and community cancer partnerships.

AGENTS OF CHANGE

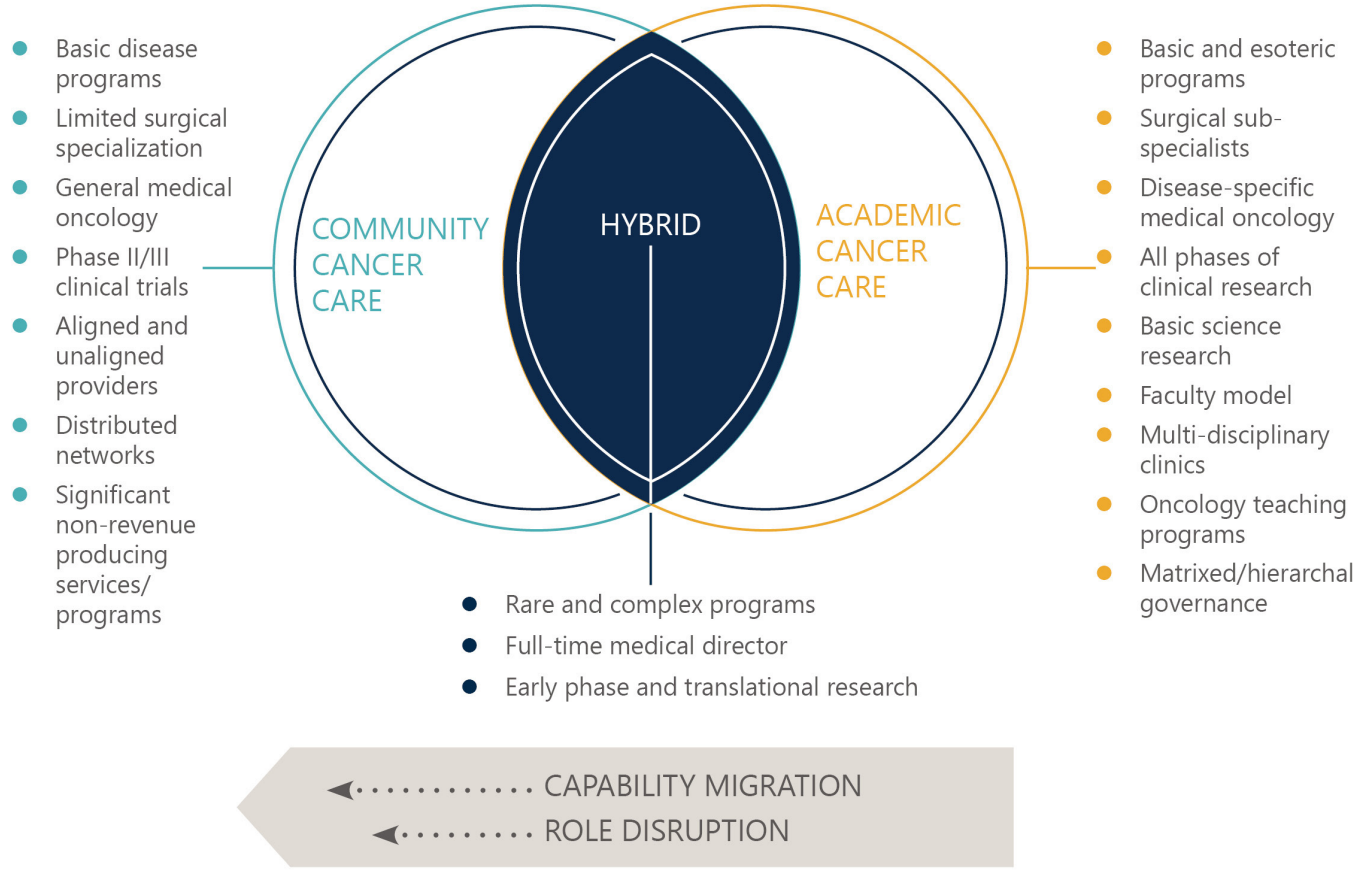
The cancer role transformation has been two decades in the making, challenging the traditional binary identity between academic and community providers. This disruption has been a byproduct of health system consolidation, vertical integration of oncologic specialists, migration of high-end capabilities and reduced information asymmetry for patients.

Consolidation. Between 2009 and 2016, over 1,500 hospitals were involved in acquisitions or mergers into larger health systems, creating integrated delivery networks (IDNs) with significant scale of populations served and geographic coverage. This scale is profoundly reshuffling the role of IDNs relative to academic providers in complex care. The impact is reflected in The Chartis Group's cancer work, which has transitioned from single hospital/single market strategies to the design of complex delivery networks that leverage quaternary, tertiary and community cancer assets toward "multi-site, single-program" networks. IDNs have also consolidated the primary care networks and specialists who provide the bulk of cancer patient referrals. Recent AMA surveys estimate that 50 percent of physicians are now employed by hospitals.[1] This integration is securing the referral base to support community cancer surgeons and medical oncologists, often at the expense of disconnected academic medical centers.

Integration. Health systems have also made significant progress in integrating the oncologic specialists who manage cancer patients. Between 2010 and 2018, 658 medical oncology practices were acquired by IDNs while 169 merged and 423 closed.[2] A similar dynamic is unfolding in radiation and surgical oncology. Radiation therapy centers across the country are being acquired or are joint ventured by IDNs, or otherwise being consolidated under mega-corporate structures chasing vertical integration (e.g., McKesson/US Oncology > Vantage Oncology). In oncologic surgery, IDNs continue to recruit and/or acquire sub-specialized surgeons. This integration risks disintermediation of those academic medical centers which fail to prepare for these changes, typically by building regional networks on their own and with affiliated health systems.

Capability. The changing roles are also being driven by a migration of high-end capabilities — enabled by scale (e.g., systems that serve more than 500K people have sufficient volume for a gynecologic oncologist) but also by a commoditization of technology. Community hospitals have

Figure 1: Traditional Community/AMC Cancer Roles



robotic surgery and immunotherapy and have even invested in single-gantry proton therapy, once confined to the halls of Massachusetts General Hospital (MGH). The proliferation of capabilities is gradually promoting a patient mindset that a tradeoff is not required between "close-to-home" and "world-class" care in some communities. It is important to note that not all community hospitals are expanding into complex cancer. There continues to be evidence that outcomes are superior in high-volume environments that support sub-specialization and economies of repetition. The migration does imply, however, that a growing number of hospitals can access these services at a tertiary hospital within their own system rather than through referral to an unaffiliated academic center.

Consumerism. The final disruptive pressure is cancer patient preference. Many patients no longer accept academic association as the sole proxy for quality or complex capability. Web search, outcome registries and online reviews are the new conduits for decision making. Those seeking high-end specialty care are a simple voice command away from a virtual Rolodex and report card on accomplished specialists. This mindset extends to patients' experiential expectations, creating a disadvantage for academic medical centers that are not organized for consumerism or a user-friendly care experience. The current generation of cancer patients seeks a care process in which they have a level of agency and care continuity that many AMCs have deemphasized relative to specialization of clinical capabilities and research.

EMERGING PARADIGM

The response to industry disruption from NCI/academic centers has included either a doubling down on legacy differentiation strategies or exploring creative partnerships. They do so while balancing a tripartite mission of patient care, research and education that creates different constraints than their community counterparts. The community providers have responded by borrowing the best from the NCI model while discarding its encumbrances (i.e., "hybrid cancer centers") or seeking tighter alignment with academic providers on new models of care. Both groups have been influenced by regulatory uncertainty, margin pressure and the reduced ability to cross-subsidize academic costs and government patients on the back of commercial insurance. Their responses also reflect the constraints of their unique structures — many academic programs have matrixed models that prevent rapid response to market change, and community hospitals often struggle to retool for management of complex conditions. In the following section we explore these responses, broadly categorized as "go it alone" or "go together."

GO-IT-ALONE MODELS

The community go-it-alone model is best described as "hybrid community–academic," a new classification in the taxonomy of cancer centers and one of the most innovative models in the past decade. These hybrid programs are nearly all multi-site, vertically integrated health systems with significant clinical scale (i.e., 4,000 –10,000 new cancer cases annually). The cancer centers leverage their scale-enabled clinical capabilities while borrowing the elements of NCI/academic care that drive oncologic reputation and performance excellence. Specifically, the programs employ sub-specialists, significantly reducing the need for a patient to leave the health system; have mature quaternary programs in all but the most esoteric diseases; have built large destination cancer center facilities patterned after large NCI cancer hospitals; conduct early-phase and translational cancer research and clinical genomic programs; and have organized "institute" models borrowed from academic organizational structures. While some of these organizations also affiliate with academic centers, the overarching vision for the hybrid centers is to provide nearly all care that a cancer patient could need, supported by robust research, often under one roof. As more IDNs achieve critical mass in cancer care, we expect to see continued interest in the hybrid model — evidenced by the inaugural Hybrid Symposium held in 2017 at the Miami Cancer Institute. The table on the following page profiles several examples.

The *go-it-alone* strategy for NCI/academic cancer centers has taken two forms. The first is expansion into wholly owned ambulatory networks. Most academic cancer centers draw patients for surgical intervention but struggle to retain them for the myriad downstream systemic and radiotherapy encounters. Memorial Sloan Kettering Cancer Center (MSKCC) addressed the access and patient retention issue by constructing a network of outpatient sites within its PPS-exempt radius in northern New Jersey and Westchester and Long Island, New York. These sites are fully equipped for infusion therapy, state-of-the-art radiation therapy, diagnostic imaging, clinical trials, limited surgical consults and supportive care. The Dana-Farber Cancer Institute (DFCI) has pursued a similar owned-network strategy with satellites in eastern Massachusetts and New Hampshire. The DFCI has branded these locations, staffed them with DFCI physicians and deployed Dana-Farber Pathways® to instill patient confidence that they are receiving equivalent clinical quality in off-campus environments.

The second strategy is a doubling down on the direct-to-consumer appeal of capability found at teaching and research institutions. This most often manifests in marketing campaigns that emphasize the importance of hyper-specialized care. The Ohio State University James Comprehensive Cancer Center (OSUJCCC) promotes the message that "There is no such thing as routine breast cancer," highlighting the benefit of a sub-specialized team in a disease that is often treated by generalists in the community. Temple Health's Fox Chase Cancer Center (FCCC) has a more explicit appeal in its campaign with "Where you start matters," implying a survival advantage if you first seek treatment within an academic center or more specifically, with a member of the Alliance of Dedicated Cancer Centers. MGH has used a similar strategy in promoting its proton therapy capabilities, advertising that "We gave Nick something he couldn't find anywhere else in the Northeast. Life without cancer." These types of messages reinforce a view of complex expertise at the NCI centers while simultaneously drawing a contrast with the more general capabilities and technologies traditionally associated with community settings.

Although the two tactics above represent an effort to maintain classic provider identities, the institutions mentioned above have also been pioneers in collaborative models with community cancer providers

Figure 2: Hybrid Cancer Program Examples

	7-HOSPITAL SYSTEM	2-HOSPITAL SYSTEM	33-HOSPITAL SYSTEM	11-HOSPITAL SYSTEM	3-HOSPITAL SYSTEM
SCALE	• $2.7B revenue • 5,500 new cancer cases	• $1.6B revenue • 8,000 new cancer cases	• $6.7B revenue • 12,000 new cancer cases	• $2.5B revenue • 4,000 new cancer cases	• $2.8B revenue • 10,000 new cancer cases
FACILITY	• 200K sq. ft. destination cancer center • Distributed network of four community cancer centers	• 200K sq. ft. Helen F. Graham Cancer Center • Pioneering multi-d clinic model	• 171K sq. ft. cancer center • Expansion from 3 to 26 program sites in < 5 years	• 400K sq. ft. destination cancer center • Advanced MRI-guided radiation therapy and proton beam therapy	• Added 20+ outpatient sites of care through agreement with 2 large metro-area practices
ALIGNMENT	• Recruited sub-specialty oncologists and sub-specialty surgeons	• Collaborated with 2 oncology practices — one fully aligned and one private practice	• Acquired several large oncology practices and subspecialized by disease site	• Employed large multi-specialty practice of medical and radiation oncologists	• Aligned 63 medical oncologists across metro-Atlanta to drive care and research
LEADER	• Recruited Roswell Park Cancer Center Director, Skip Trump, MD from his role as Medical Director	• Recruited Chief of Surgery at Roswell Park, Nick Petrelli, MD as Program Director	• Recruited Cleveland Clinic Taussig Director, Derek Raghavan, MD as Medical Director	• Recruited Dana-Farber Chief of Surgery, Michael Zinner, MD as Medical Director	• Led by community physician leadership

and affiliated health systems. The two-pronged strategy has enabled these centers to maintain market position in rare and complex diseases while expanding share in some common cancers — e.g., breast, lung, colon — and preparing for a future that is more closely aligned with regional IDNs.

COLLABORATIVE STRATEGIES

The go-it-alone strategies represent an increasingly small portion of the market. Most NCI/academic cancer centers have been active in recognizing and adapting to the new market reality and partnering with non-academic health systems on new affiliation models. The types of relationships we encounter generally vary according to the level of clinical integration and degree of strategic and financial alignment between the community and NCI/academic center (Figure 3).

Level I: Clinical and Research Affiliation

The most common form of community/academic partnership is the affiliate network. In these models, the NCI/academic center manages affiliate cancer programs that serve as an extension of the organization's brand and program identity, most typically through contractual research and clinical services agreements. For academic centers, community networks often fulfill NCI grant and mission-driven outreach responsibilities while helping to secure quaternary referral networks and patients for research. For the community hospital, an affiliation is often intended to accelerate its clinical program development, expand options for clinical trials and promote meaningful brand differentiation in a local market. The community network members are generally small-to-medium sized with 250 – 2,000 new cancer cases and often pay $250 thousand and $500 thousand per year for membership. Several affiliate subtypes exist, typically classified by the degree of proximity, clinical focus and integration.

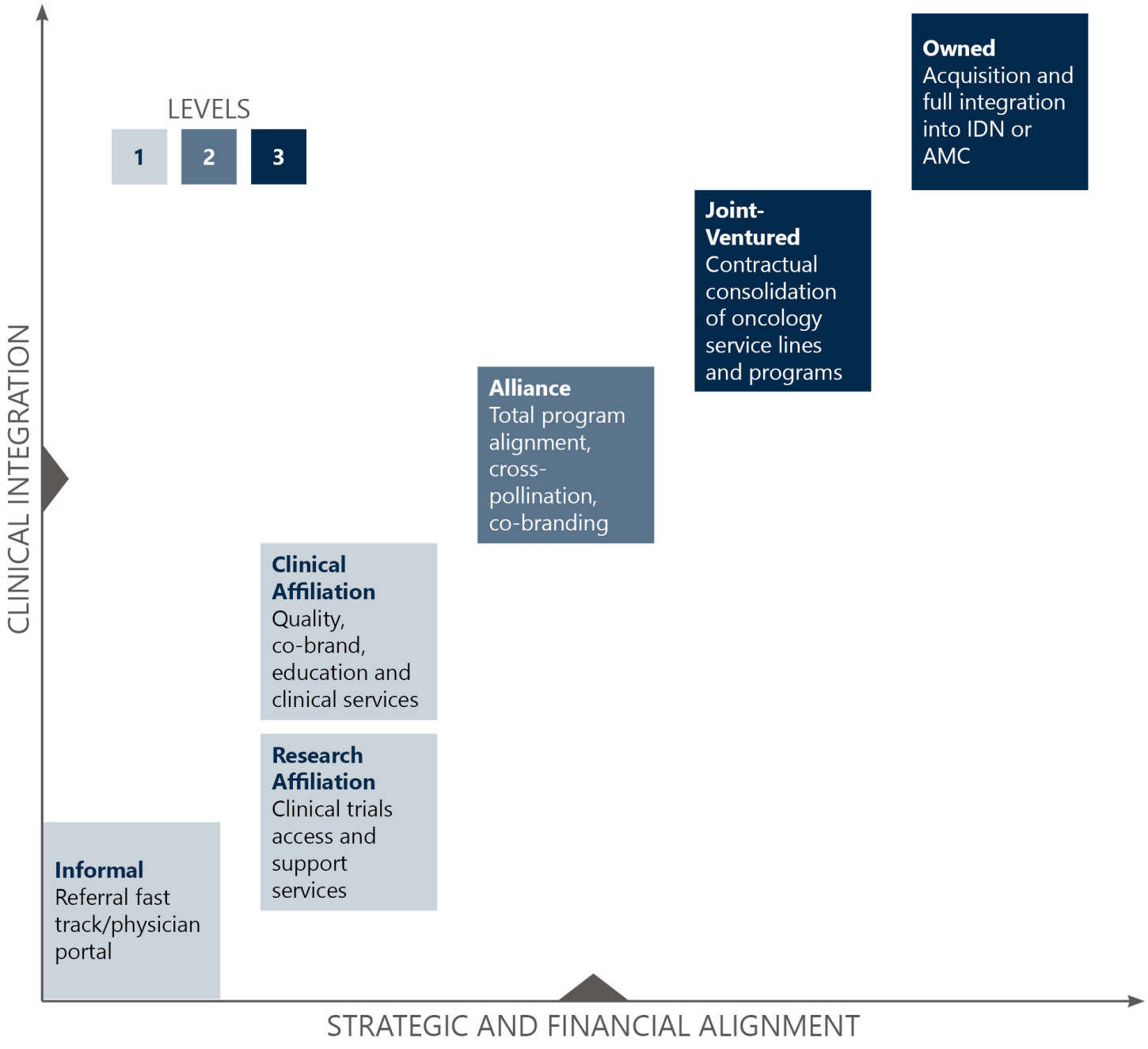
Proximity. Most NCI community networks are characterized by the proximity of members, allowing physicians, staff and patients to move easily back and forth between care environments. For an NCI center with a congested main campus/cancer hospital, affiliations offer the ability to seamlessly redirect patients to more convenient, lower-cost settings. The University of Chicago Medicine Comprehensive Cancer Center has deployed this strategy to positive effect at nearby Silver Cross Hospital, rationalizing location based on care complexity and patient convenience. Other networks have eschewed proximity in favor of superregional footprints. For the University of Alabama at Birmingham (UAB) Cancer Community Network, its 10 sites across Alabama, Florida, Georgia, Mississippi and Tennessee are organized less around quaternary draw to Birmingham than strategic partnership for care coordination and value-based initiatives. The UAB network's access to 70 thousand cancer patients gives it sufficient size to engage regional payors in alternative payment model design and to secure innovation grants from CMS for large-scale pilot projects. The Duke Cancer Network established a similar model, collecting affiliates across a wide geography. Distributed partnerships drive a unique value proposition: strengthening Duke's national reputation in cancer and medicine; enrolling patients in research trials and genomic registries; and sourcing patients for its world-class programs like the Preston Robert Tisch Brain Tumor Center.

Affiliate Type. While most affiliate relationships extend between NCI centers and community health systems, some networks have chosen to acquire or affiliate directly with independent oncology

practices. As an example of the former, Yale New Haven Health System acquired several private practice oncology groups in the early 2010s, providing Smilow-branded satellite services at 10 community locations.[3] Similarly, the Cleveland Clinic Oncology Network employs nearly all the 41 medical oncologists that staff its 10 regional hospital affiliates. The Cleveland Clinic, and others who have adopted this approach, find value in directing the oncology care being delivered in co-branded sites and assimilating them into integrated-practice units to create and maintain common clinical pathways. While less common, some academic centers affiliate directly with independent practices to access markets where medical oncology, and by extension clinical research, is controlled by independent groups. Examples of successful partnerships include Duke Cancer Network's affiliation with Virginia Oncology Associates and Thomas Jefferson Sidney Kimmel Cancer Network's affiliation with Hematology & Oncology Associates of Northeastern Pennsylvania.

Breadth of Services. The final design distinction for affiliate networks is the mix of clinical versus research focus. Some networks offer a mixed "menu" of research and clinical relationships, as OSUJCCC had with The Christ Hospital (research) and Wooster Community Hospital (clinical). Others like the Moffitt Oncology Network have opted for more research-focused partnerships. Moffitt's

Figure 3: Alignment Spectrum (Levels 1 – 3)



Clinical Care Model extends peer review and pathways to affiliates, but at present these are limited to two sites in Lakeland and Martin County, Florida, as well as through a Malignant Hematology and Cellular Therapy partnership with Memorial Healthcare System in Broward County. Moffitt's primary focus has been driving clinical care to its main campus while formalizing outreach in research through collaborations like ORIEN, M2Gen and Total Cancer Care. On a national level, affiliation models are becoming more comprehensive over time. Fox Chase Cancer Center Partners (FCCCP), the oldest NCI affiliate network in the country, leads this trend with its 30+ network members. Its legacy model of clinical and research services has transitioned to more comprehensive strategic partnerships, including embedded on-site clinical services and novel business relationships. This evolution has begun to elevate FCCCP's network toward the more sophisticated Level II/III model described next.

Level II: Cancer Alliance Models

The second tier of NCI/community collaboration is the "alliance" model — borrowed from the terminology MSKCC uses to differentiate its network design. In the alliance structure, NCI/academic centers develop community partnerships characterized by significant scale and scope, national footprint, and seamless integration of co-designed and co-managed care models. For example, the models used by MD Anderson Cancer Center (MDA) and MSKCC are described below.

MD Anderson. The MDA Cancer Network is segmented into certified, associate and partner organizations. The certified and associate members most closely resemble the network relationships described in the Level 1 affiliate discussion. The partner members include relatively large cancer programs, such as Banner MD Anderson Cancer Center (Gilbert, AZ) and Scripps MD Anderson Cancer Center (La Jolla, CA). All MDA partner organizations share a high degree of alignment with their oncologists and sophisticated physician governance models. MD Anderson reports that many of these organizations have five times as many patients as the certified/associate members, and that their "standard of care is outstanding and [they] are affiliating to sustain and exceed that standard."[4] The MDA partner model has created significant market impact in some of the regions where it has been deployed. Cooper University Health Care in New Jersey launched its partner model with MD Anderson in 2013 and saw a greater than 20 percent increase in inpatient and outpatient cancer volumes in the first year, with eight to 10 percent annual growth thereafter.[5] This growth, mimicked in other partner markets, is the result of MDA being able to export its "intellectual architecture" into large markets like San Diego, Phoenix and Jacksonville.[6] The partner model also allows MDA to export staff, fellows and physician leaders, including its physician-in-chief, Dr. Thomas Buchholz, who took the first medical director role at Scripps MD Anderson.

MSKCC Alliance. MSKCC's Alliance/Level II membership includes sophisticated, system-level programs like Hartford HealthCare, Lehigh Valley Health Network and Baptist Health South Florida. The foundational component of the MSKCC Alliance is standardized care across the network, allowing MSKCC to extend its research protocols and clinical approach in a reliable and brand-consistent fashion. The process of alignment includes extensive data measurement against a set of MSKCC best practices that represent standard competencies and outcomes across the Alliance. The Alliance was launched in 2013 with founding member Hartford HealthCare, which has cited a doubling of its clinical trial accrual volumes, the startup of in-house gene sequencing supported by MSKCC, and advanced clinical program support in immuno-oncology and ocular melanoma. They credit the partnership as enabling "an ongoing, living, breathing, dynamic partnership…to bring the newest knowledge into the community setting."[7] The Alliance found similar success with Baptist Health South Florida's Miami Cancer Institute (MCI). The MCI partnered with MSKCC as part of a transformational initiative wherein Baptist committed nearly $500 million to the development of a freestanding cancer center, proton therapy, sub-specialist programs and recruitment of Dr. Michael Zinner, Chief of Surgery at the Dana-Farber Cancer Institute, as the MCI's executive medical director. In recent remarks, Dr. Zinner acknowledged that the collective efforts of the MCI and its partner have increased patient volumes by 20 percent since the program formally launched in January 2018.[8] The relationship between the MCI and MSKCC has amplified an already outstanding foundation in oncology while allowing MSKCC to speed rapid adoption of new care standards, drive research and tissue accrual, and deliver world-class clinical outcomes.

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The requirements for a Level II relationship are immense. Aspiration to adopt the "MDA or MSK way" requires an exhaustive data collection and gap assessment effort, taking nearly 18 months in the case of the MCI. It also requires ongoing commitment to remediate identified gaps in process and capabilities and willingness to influence physician and staff behavior in a way that promotes sameness between the partners. For parties considering an alliance model, it is important to understand the investment involved. The relationships generally stop short of financial joint venturing, but the partners can expect to assume considerable mutual risk in the funding of FTEs to support relationship management, data collection and program alignment requirements. For this reason, a certain scale is required to consider an Alliance — evidenced by the profile of the current pioneers, i.e., some of the leading NCI centers and IDNs in the country.

Level III: Joint-Venturing Technical Services/Risk Sharing

The highest tier of NCI/academic and community partnership involves financial partnership. These models are still emerging but can be broadly categorized as either joint-ventured or fully integrated programs.

Joint Venture. The joint-ventured models typically involve a centralization of management of all oncology services delivered in a specific geography between an NCI/academic and community cancer program. The joint entity in some cases owns and operates the assets in the network. A "standard" model includes the creation of a ManageCo to centralize oncology management, the equity of which is determined through formal valuation of the relative contribution of each party. Clinical services generally continue to be provided under existing, separate licenses and billed under the provider numbers of the community and academic partner hospitals. At the end of each reporting period, the partners consolidate financials into a pooled cancer profit and loss statement and distribute income back to ManageCo members based on equity position.

For example, MSKCC and Hackensack Meridian Health (HMH) announced their intent in 2017 to create a joint entity to more fully align their cancer programs.

Among its objectives, the new entity intended to replicate Level II functions (i.e., guidelines/standards of care) while building a legal vehicle that establishes governing board oversight of the collective cancer program and joint ownership of any newly developed cancer center assets. The partnership stops short of full integration as both MSKCC and HMH continue to independently own and operate existing New Jersey locations.[9, 10, 11, 12] UCSF Health and John Muir Health recently announced a similar initiative called the East Bay Cancer Network (EBCN). The two parties have executed a letter of intent to jointly advance cancer care throughout the East Bay, including a significant outpatient cancer center at John Muir Health's Walnut Creek campus.

The joint-venture model is generally the best fit for partners who share geographic proximity as it resolves conflicts of interest that arise as partners rationalize the most clinically appropriate, accessible care environment for their shared patients. The model typically aligns incentives and promotes patients getting the right care in the right place, often closer to home and in community environments for high-frequency infusion and radiation therapy encounters. The joint-venture model also provides a more durable structure for collaboration as evidenced by the numerous Level I affiliation agreements which have been terminated between NCI centers and community hospitals. If the parties are committed to strategic partnership and growth, financial integration can cement a more protected return on the effort.

Merger/Acquisition. The second emerging model for financial integration is the acquisition or merger of community and NCI/academic cancer centers. These transactions, while uncommon, are being driven by health system mergers that include strong individual cancer components — e.g., The Cancer Center at Beth Israel Deaconess Medical Center and the Lahey Health Cancer Institute, or through deliberate cancer-specific acquisitions like McLaren Health Care's acquisition of the Barbara Ann Karmanos Cancer Institute. For NCI-designated Karmanos, the 2014 acquisition enabled the extension of its clinical and research capability to McLaren's network of 12 acute care hospitals, 14 cancer centers and over 14,000 annual new cancer cases, making it the single largest research provider in Michigan. For McLaren, the acquisition of Karmanos brought NCI-level quality oversight to all its facilities, created common purpose and standards for its physicians, and substantially improved access to research trials for its patients.

DESIGN RECOMMENDATIONS

The examples of Level I-III networks cited above represent a small fraction of those around the country.

Seventeen of the top 20 U.S. News & world report cancer programs have formal network strategies.

As such, the mounting evidence suggests that partnership is not a supplement to program success but integral to it. As we reflect on our experience in designing these cancer partnerships, we offer the following recommendations to community and academic organizations:

1. **Design Strategically.** Community hospitals often consider academic affiliation as a panacea for program challenges and in that context any affiliation "will do." Similarly, academic/NCI centers frequently respond in reactive fashion to requests for proposals from community hospitals, creating de novo models for each partner without thought for the broader network design and goals of the program. For each stakeholder, we encourage partnership to be approached within the broader context of a network strategy, with affiliation as a complement to the plan — not a substitute.

2. **Align Incentives.** Consider financially integrated models of collaboration. Our experience suggests a limit on the long-term durability of agreements that rely on royalty payments or service agreements. Joint ventures are complex to design and administer, but they solve for an obvious weakness in the collaboration of two entities at risk of volume cannibalization in a Level I-II relationship. If designing a non-traditional model, ensure the underlying mechanisms are easy to articulate and maintain on an ongoing basis. By simplifying these elements, the partners can increase the odds of successful collaboration and devote the bulk of time and effort toward material improvement of patient care.

3. **Gain Buy-In.** Most partnerships fail due to an underestimation of the complexity and requirements of network relationships. Institutional commitment in the form of network leadership and administrative support to execute effectively are imperative. The other critical buy-in comes from faculty involved in cancer care. Do they believe there is value in a partnership and that high-end community care and research can be conducted at partner sites? The degree to which there is agreement on this question will ultimately determine the success of the partnership, which occurs at a physician-to-physician level.

4. **Choose Wisely.** Quite simply, pick your partners carefully. The partnership needs a comprehensive framework for evaluating and improving quality. The risks of inattention to quality can be harmful to the success of a partnership and devastating to the reputation of the programs. For this reason, quality oversight needs to be the highest priority in network design, even when it increases operating expenses and creates obstacles to deal making and market expansion. The simplest way to keep quality at the center of the network is to have it managed and overseen by clinical champions and memorialized in physician-driven, disease-specific metrics.

5. **Create Value.** The most common criticism of affiliation is that it is a brand play and does not represent a true elevation of quality. "Partnership-lite" models have been tried and failed in many markets as referring physicians and patients generally require a high burden of proof to influence their perception of a program. These criticisms have been successfully dispelled in programs where the academic and community partners demonstrate visible and substantial improvements to clinical access, quality metrics, research opportunities and cost of care. For the hospital partners, the investments required to collaborate must be rationalized in the context of both growth opportunity.

GOING FORWARD

Change will remain a constant in cancer care delivery. In such an environment, leaders will be those who participate in and drive disruption. For the academic medical center, stakes are high in electing whether to "go-it-alone" or explore innovative models that challenge traditional role delineation with community providers. For community hospitals and health systems, the imperative is choosing the right partner, designing sustainable models and avoiding the pursuit of a partnership absent a meaningful program strategy.

The ultimate key to success is to embrace convergence while understanding the areas where community and academic differences will persist and add value.

The NCI/academic center will continue to drive basic and translational cancer research, advance new standards of care, support outreach and education, and lead early-phase clinical research. Community cancer programs will continue to provide high-touch, close-to-home cancer care that balances value and manages the health of entire populations of oncology patients. When fused together, the two entities can rapidly disseminate clinical innovation, optimize access and experience for patients, and harness tremendous value in the ongoing redefinition of the cancer industry.

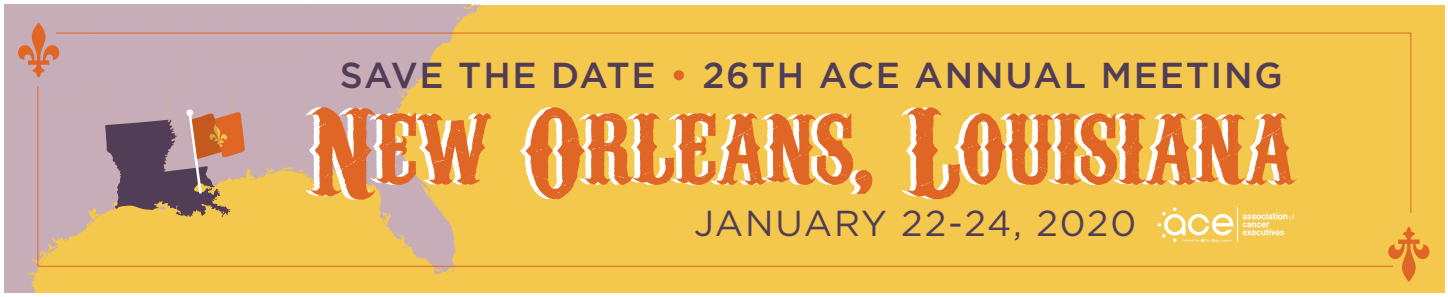
Ryan Langdale, MBA,
Principal

Resources:

1. Kane, Carol. "Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent." American Medical Association. Online. https://www.ama-assn.org/sites/default/files/media-browser/public/health-policy/PRP-2016-physician-benchmark-survey.pdf
2. 2018 Community Oncology Alliance Practice Impact Report. Community Oncology Alliance. Online. https://www.communityoncology.org/portfolio-items/2018-coa-practice-impact-report/
3. Engelking, Constance. Merging Community Practices with an Academic Cancer Center. OncLive Online. https://www.oncnursingnews.com/publications/oncology-nurse/2013/september-2013/merging-community-practices-with-an-academic-cancer-center
4. Olin, Andy. "Casting a wide network". MD Anderson. Online. https://www.mdanderson.org/publications/conquest/spring-2014/casting-a-wide-network.html
5. "MD Anderson Cancer Center at Cooper Celebrates Five-Year Anniversary." Cooper Health. Online. https://blogs.cooperhealth.org/news/2018/09/md-anderson-cancer-center-at-cooper-celebrates-five-year-anniversary/
6. Jennings, Kate. "Cooper cancer center looks to expand its research, geographic reach." Politico. https://www.politico.com/states/new-jersey/story/2016/07/

cooper-cancer-center-focuses-on-research-and-geographic-expansion-104250

7. "Four Years In: MSK Cancer Alliance Bringing More Clinical Trials for Patients, Research for Clinicians." https://webcache.googleusercontent.com/search?q=cache:jEuhNnoyKTwJ:https://integratedcarepartners.org/news-events/news-detail%3FarticleId%3D15683%-26publicid%3D464+&cd=1&hl=en&ct=-clnk&gl=us
8. Kacik, Alex. "Q&A with Miami Cancer Institute CEO Michael Zinner on the growing need for cancer care." Modern Healthcare. http://www.modernhealthcare.com/article/20180818/NEWS/180819956
9. Memorial Sloan Kettering – Hackensack Meridian Health Partnership. MSKCC Online. https://www.mskcc.org/about/innovative-collaborations/msk-hackensack-meridian-health-partnership
10. Calio, Vince. "Hackensack Meridian, Sloan Kettering to create new cancer center". Online. http://www.njbiz.com/article/20180307/NJBIZ01/180309869/exclusive-hackensack-meridian-sloan-kettering-to-create-new-cancer-center
11. Rewriting the Future with Memorial Sloan Kettering. Online. https://www.hackensackmeridianhealth.org/wp-content/uploads/2016/12/ONE_December_2016_revised.pdf
12. Bole, Kristen. "UCSF Health and John Muir Health to Build East Bay Cancer Network." UCSF Online. https://www.ucsf.edu/news/2018/09/411906/ucsf-health-and-john-muir-health-build-east-bay-cancer-network



Changes, What You Need to Know – MIPS/MACRA-2019

STEVEN CASTLE, *ACE Fellow*
MARGARET NASH, *Equicare Health*

Originally introduced in 2017, The Center for Medicare Services (CMS) Merit-based Incentive Payment System (MIPS) was developed as a new multiyear payment model used to incentivize Clinicians through a reward/penalty payment to drive wider adherence to recognized quality care standards. Under the MIPS program, a Clinician's Medicare payments are adjusted (up or down) based on their performance across three categories:

1. Quality – formerly PQRS (ie: Lung Cancer Reporting or Breast Cancer Screening),
2. Advancing Care Information (ACI) – formerly Meaningful Use (i.e.: ePrescribing/Secure Messaging), and
3. Clinical Practice Improvement Activities (CPA) – this is new (ie: Depression Screening)

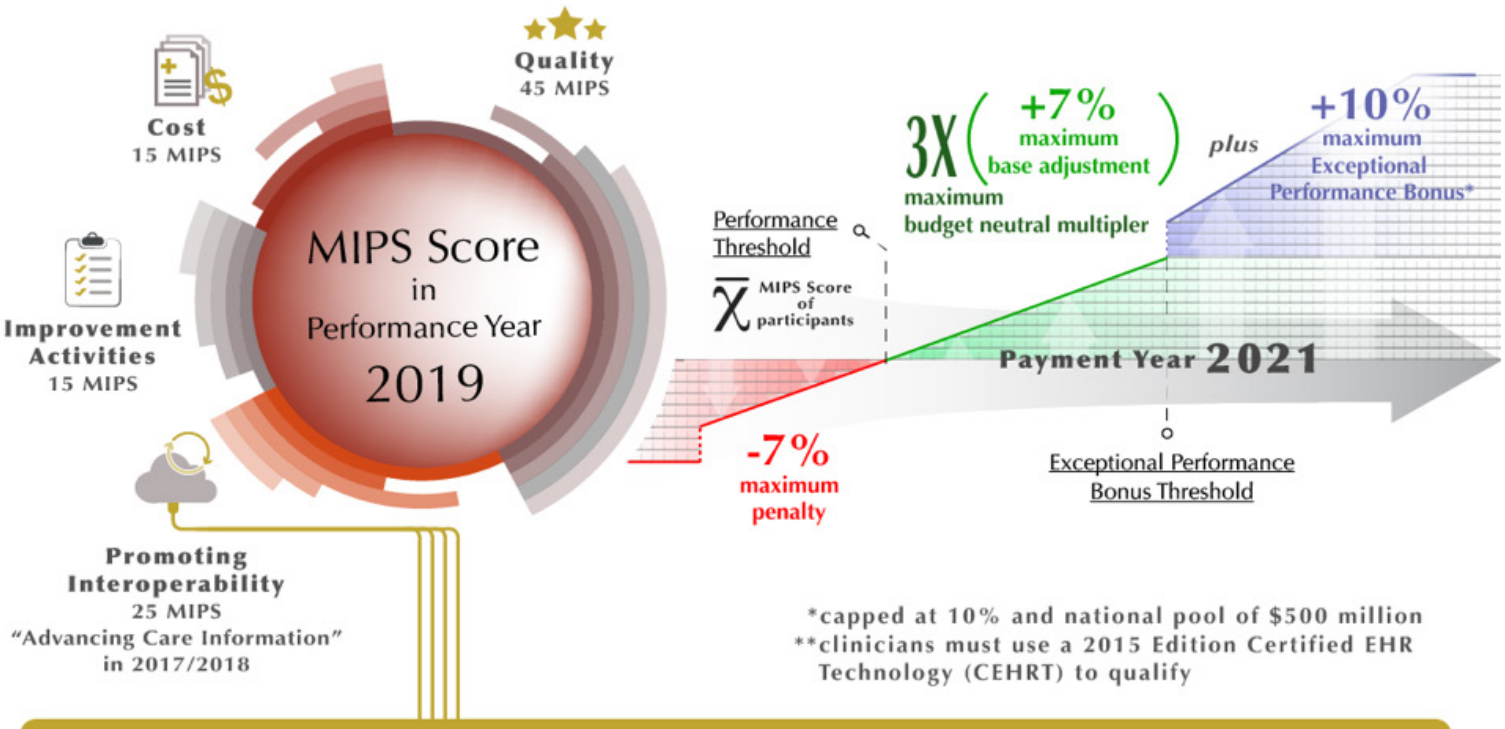
The Clinician's MIPS score (0 – 100) is derived based on their performance on a number of measures. Each year, the Clinician's score is compared to a yearly threshold set by CMS. If they're below the threshold, their Medicare payments for that year would be reduced up to -5%. If above the threshold, their Medicare payments for that year are increased up to +4%.

On November 1st, 2018, CMS published revisions to payment policies under the Medicare Part B physician fee schedule for the Quality Payment Program (QPP) that went live January 2019. The revisions include a number of changes to MIPS Performance Measures that are summarized below:

- Each Clinician's MIPS score in the 2019 Performance Year affects their Medicare payments in the 2021 Payment Year.
- In 2021, payments will be increased to a max +7% or decreased to a max -7%, depending on their MIPS score relative to other participants in 2019.
- The Clinician's MIPS score is calculated based on the following performance measure categories:
  - Quality (max 45 points)
  - Cost (max 15 points)
  - Promoting Interoperability (PI) (max 25 points) – prior known as "Advancing Care Information"
- Improvement Activities (IA) (max 15 points)
- In 2019, Clinicians must provide performance data for a minimum continuous 90-day period.
- Clinicians must use a 2015 Edition Certified EHR Technology (CEHRT) to qualify.
- The Promoting Interoperability objectives and measures finalized for 2019 are below (from the Final Rule). Note, a more detailed breakdown is below and it is possible to attain unique bonus points.

How each facility addresses the MIPS/MACRA opportunity is going to be influenced by a number of factors, including the technical resources available. For larger network systems, a team at a higher division or corporate level may have been assigned. Addressing at other medical centers/physician groups may fall solely on an administrator or member of the IT department. Regardless of level, any solution requires a combination of understanding the program, the necessary labor to develop/collect/report, and a technology component to store/organize the data. Providers may already have the tools in place to electronically collect,

TABLE 1: CMS Final Rule MIPS 2019: What You Need to Know



Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing	10 points
	BONUS: Query of Prescription Drug Monitoring Program (PDMP)	5 bonus points
	BONUS: Verify Opioid Treatment Agreement	5 bonus points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	10 points

organize, and report the data necessary. By identifying the select measures, implementing those measures into the workflow, hardwiring process to last over time, and documenting the process a high point score can be earned.

SAMPLE TO EARNING 80 POINTS

An organization must assess the four objectives and review their current capabilities and processes. Given resources and technology are already in place, a process change or documentation may be all that is necessary. Service line leaders may choose to utilize their existing ACoS Cancer Committee meeting as forum to address MIPS/MACRA as quality improvement standard goal. As a standing agenda, the cancer committee could assess their current performance, develop and implement a plan to provide patient portal to their patients, and then report performance over future meetings.

First, as a result of the Meaningful Use program, you likely have a certified patient portal. If you have a clear process established and documentation of how this portal is made available to patients as well as a systematic review; you could accrue 'Provider to Patient Exchange' points, up to 40 points. If not, drafting a document work flow and educating nurses to provide information at time of consultation could quickly and easily be enacted. The first step is to offer and then over time, discuss how to increase utilization. Your center is not held accountable that every patient utilizes. Over time, portals will grow in utilization. This alone, may be adequate to insulate providers against a penalty. If a provider does not have a certified patient portal, this can be acquired rather easily; however, recommend an oncology specific portal to drive more value and assure it has capabilities to support possible future expectations of higher patient utilization, (i.e. PROMS/patient satisfaction, etc...)

A second opportunity involves Health Information Exchange category by 'Sending Health Information' to support electronic referrals would earn an additional 20 points. With an advanced Care Coordination software that may already be in place, managing cancer conference/tumor board or sending a summary of care and care plan as part of a survivorship service to the Primary Care Physician helps to support this category. Again, documentation, the discussion and monitoring adherence over time is necessary.

Under this category, an additional 20 points can be attained by electronically 'Receiving and Incorporating Health Information'. Does your center have integration or interfaces with referral groups? An example would be a set of standard interfaces between enterprise level EMRs (i.e.: Epic/Cerner), department specialized software found in Medical and Radiation Oncology, or specific function related software like navigation/ survivorship. Some offer their own ROI based on improved operational efficiency as well as potential increased reimbursement via MIPS/MACRA.

FINANCIAL

Leaders of oncology services, have a responsibility for the financial viability of their organizations. Even with volumes flat YoY, this would prove to be a growth year financially. Added, with the financial carrot comes the quality improvements

associated with meeting the measures as well as patient satisfaction. Often challenged to identify the new revenue associated with adding navigators or tools, MIPS/MACRA could serve to justify an ROI necessary to add FTE or capital purchase. Additionally, some software offer Patient Reported Outcome (PRO) tools to promote reputation through better outcomes for particular disease sites. PRO's could contribute to improved readmission rates or reducing ER visits. Although low volume, high cost per case, may indeed guard against non-payment to ER physicians for patients currently under treatment (more to come on this at a later date).

The table below presents the financial impact, positive or negative, that a provider/group may incur for MIPS/MACRA only.

SUMMARY/FUTURE/PREDICTIONS:

Given our dynamic healthcare system and the increasingly challenging reimbursement models, few opportunities exist to receive added reimbursement (carrot). MIPS/MACRA serves as one of the few opportunities to gain additional reimbursement on existing volumes. Further, failure to meet MIPS/MACRA standards could lead to erosion of existing reimbursement. In addition, when capital requests are made, the question of offsetting revenue is often the hurdle. This is true with product or FTE's. MIPS/MACRA may serve to provide the financial justification ROI. The key question is, do you have a plan to meet the MIPS/MACRA opportunity? As MIPS/MACRA evolves, we will provide additional information and remain available to ACE members for questions and assistance.

TABLE 2: MIPS/MACRA maximum and minimum base payment adjustments (excludes exceptional performance bonus)

Performance Year	2019	#Providers	100
Payment Year	2021	Part B per Provider Pear Year	$100,000
Maximum Incentive%	7	Exceptional Performance Bonus %	5%
Budget-neutrality factor*	2	Maximum Incentive	$14,000.000
Maximum incentive%	14	Maximum Penalty	-$7,000.00
Maximum Penalty %	-7		
*arbitrary assigned value			

Base Payment Adjustment (MIPS Score v Performance Threshold)

Percentage

Points	10	20	30	40	50	60	70	80	90	100
10	0.0	1.6	3.1	4.7	6.2	7.8	9.3	10.9	12.4	14.0
30	-4.7	-2.3	0.0	2.0	4.0	6.0	8.0	10.0	12.0	14.0
50	-7.0	-4.2	-2.8	-1.4	0.0	2.8	5.6	8.4	11.2	14.0
70	-7.0	-5.0	-4.0	-3.0	-2.0	-1.0	0.0	4.7	9.3	14.0
90	-7.0	-7.0	-4.7	-3.9	-3.1	-2.3	-1.6	-0.8	0.0	14.0

Payment

Points	10	20	30	40	50	60	70	80	90	100
10	$0	$155,556	$311,111	$466,667	$622,222	$777,778	$933,333	$1,088,889	$1,244,444	$1,400,000
30	-$466,667	-$233,333	$0	$200,000	$400,000	$600,000	$800,000	$1,000,000	$1,200,000	$1,400,000
50	-$700,000	-$420,000	-$280,000	-$140,000	$0	$280,000	$560,000	$840,000	$1,120,000	$1,400,000
70	-$700,000	-$500,000	-$400,000	-$300,000	-$200,000	-$100,000	$0	$466,667	$933,333	$1,400,000
90	-$700,000	-$700,000	-$466,667	-$388,889	-$311,111	-$233,333	-$155,556	-$77,778	$0	$1,400,000