Oncology Business News®

APRIL 2018

OncLive.com

INSIGHTS INTO ONCOLOGY BUSINESS PRACTICE

ALSO IN THIS ISSUE

Urology Practice Succeeds With Transparency, Upfront Payment Model

ARIELA KATZ

IT MAY BE TRUE that most people do not enjoy staff meetings, but the partners at Wichita Urology, the largest independent urology practice in Wichita, Kansas, have built their success over 60 years partly by holding frequent meetings, which they say build camaraderie and make it possible to address needs quickly.

Meetings, they say, create a transparency that prevents employees from being broadsided by any changes. "All the physicians come together at the board meetings. Even if you're not yet a partner you still attend, and we hold board meetings 3 times a month," said Twila Puritty, CEO of Wichita Urology. This makes the practice nimbler and, as a result, things that need doing don't languish on the back burner. "We are able to accomplish a lot of things in a short period of time compared with other groups who don't meet as frequently," she said. This collaborative style also allows for everyone's voice to be heard when practice-changing decisions are made.

Another pillar of the administrative structure at Wichita Urology is a collection model that ensures the physicians are fairly and efficiently paid for their hard work, Puritty explained. The practice requires payment upfront for elective surgeries—before the procedures take place. "We used to write off thousands of dollars for elective surgeries that patients didn't pay for after receiving surgery. So, we adopted a policy that surgeries would be classified as either urgent or elective, and if they're elective the surgery isn't scheduled until the patient pays the out-of-pocket amount," Puritty said. It was felt that these nonessential unpaid surgeries


Twila Puritty, CEO

CONTINUED ON PAGE 2 ▸

Advance Planning Minimized Storm Impact for Oncology Practices

ANDREW SMITH

THE STORMS WERE POWERFUL. They were headed straight for land. And the forecasts were nearly apocalyptic.

Texas Oncology and Florida Cancer Specialists (FCS) knew their ability to recover from hurricanes Harvey and Irma would hinge upon the work they did before either storm arrived. Acting on the warnings, both practices built on existing disaster plans already refined by experiences with several tropical storms each year.

Similar preparations led to similar plans and similar success in minimizing the damage to both patient health and practice prosperity, yet there is no way to perfectly protect a business against something as powerful as a hurricane.

The very different nature of the actual storms led to very different experiences in the 2 states. FCS lost power at locations from Naples to Jacksonville, but nearly all were operating again a day after Irma left. Texas Oncology felt Harvey's impact over a much smaller area, but flooding throughout the Houston region was so severe that most local offices closed for an entire week.

"The rain just kept coming, falling harder than any of the monsoons where I grew up in India for days on end," said Vivek Kavadi, MD, the medical director of Texas Oncology's Gulf Coast practices. "Some areas got 50 inches of rain, which was enough to flood interstate highways and render much of the region impassable for days after the rain stopped.


Vivek Kavadi, MD

"Our facilities escaped without too much damage—6 inches of water in Clear Lake,

CONTINUED ON PAGE 3 ▸

CONTINUED FROM PAGE 1

were not only an inefficient practice but also cost physicians time that they could have spent at home with their families.

Under the revised policy, the cost of the elective surgery is explained to patients, and numerous attempts are made to ensure payment is received upfront. The surgery will usually be rescheduled until that requirement is met. However, it sometimes happens that the practice will do an elective procedure without payment and accept the unpaid bill as a cost of doing business.

History of the Practice

Wichita Urology has grown organically, without merging with any other urology groups. It was founded by 3 urologists in 1955 and now has 9 physician partners. The support staff numbers 92 employees, including 84 who are full time and 8 who are part time. Although the practice has many employees, its efficiency is high, and this enables clinicians there to see a high volume of patients, Puritty said. From 2016 to 2017 the group saw 19,427 patients.

Wichita Urology is spread out over 3 offices in the south-central Kansas metropolis. The main office on the east side of town is large enough to have 3 clinics operating at once. By contrast, their westside office offers just 1.

Physicians at the practice see adult and pediatric patients with all stages of prostate, bladder, and kidney cancer. "We have individuals from first diagnosis to those who walk in with metastatic disease. We not only get referrals for end-stage disease, we see every type," said Timothy A. Richardson, MD, a physician partner.

Timothy A. Richardson, MD

The urology group participates in many clinical trials for prostate cancer and a smaller number for patients with renal or bladder cancer. Wichita Urology also enrolls patients in trials for general urologic disorders, such as overactive bladder and benign prostatic hyperplasia. There are no medical oncologists on staff, but the practice works closely with a local medical oncology group to address patients' needs for chemotherapy or other specialized cancer treatments. Following outside care, patients usually return to Wichita Urology to resume treatment.

The practice often can provide in-house treatment for a wide spectrum of a patient's needs. For example, the practice can provide surgical interventions for patients with resectable cancers. "For prostate cancer, we take care of those patients from diagnosis. If they need chemotherapy, we send those on, but we still try to manage everything else," Richardson explained.

In 2014, Wichita Urology opened an office that is dedicated to radiation therapy. The availability of radiation oncologists enhances the practice's ability to treat patients in-house. The practice also has an outreach program for about 15 communities. Wichita Urology physicians travel to those offices regularly for clinics that may be held multiple times per week.

Wichita Urology's commitment to these outreach clinics often stems from hospital requests for urology coverage, according to Puritty. It is not always possible to provide support for these outside clinics, either because of a lack of staff or because a location is too far from Wichita Urology's offices. "We can't always say yes," she said.

Advanced Prostate Cancer Clinic

One of the most important additions to Wichita Urology is their advanced prostate cancer clinic, which they opened in 2017 to address the increasing complexity of advanced prostate cancer care. Richardson serves as the lead physician and "champion" of that clinic. "Advanced prostate cancer has become so convoluted and confusing. There are more therapies being approved every day." To address patients' need for access to quality care and Wichita Urology's need for efficiency of operations, an advanced prostate cancer clinic was developed that could work with just 1 or 2 doctors, Richardson said.

Wichita Urology strives to offer patients cutting-edge technologies and treatments, but its doctors also want to ensure that patients get the most appropriate care. Puritty said an example of this is a current initiative to start dispensing catheters directly to patients. She said group discovered that a vendor they worked with previously was dispensing catheters based on what made good financial sense to the vendor rather than what was most appropriate for patients' needs.

The physicians pay close attention to the many drugs in development and look forward to being able to give their patients therapies that offer better outcomes. "There are about 300 drugs in development now, and there are a lot of drugs on the horizon that are going to be approved for us to use earlier and in different situations," Richardson said. He anticipates that some of those drugs will become available as soon as the first or second quarter of this year.

Richardson and his colleagues also recognize the value that genetic counseling can bring to cancer treatment. They currently offer several genetic tests to patients with prostate cancer. The practice works with several genetic counselors, including one who is associated with a hospital in Wichita and another with whom patients can speak by phone.

The practice is also investigating telemedicine and how it can reduce the distances their physicians have to travel. Because they serve so many clinics across Kansas, including some that are hours away from Wichita, telemedicine would allow physicians to treat patients remotely who may not have been reachable before. "The travel burden on a busy urologist can be a killer on their productivity," Puritty said.

Wichita Urology is vigilant about monitoring changes in payers' payment policies, and practice members are confident that their in-house efficiencies will protect them from the potential revenue losses that can result from payment policy changes. "There are all these conversations about reimbursement, such as the Medicare Access and CHIP Reauthorization Act and the Meritbased Incentive Payment System, and how are we going to be impacted—negatively or positively." Purrity said that internal policy changes can help to offset external pressures. The practice's decision to aggressively pursue payment upfront for elective surgeries is one such example, she said. ■

CONTINUED FROM PAGE 1

which is the region's largest office, and minor flooding in a few others—but we had several employees whose homes were severely damaged and many whose cars were essentially totaled," Kavadi said. "Each day brought more bad news. It seemed never-ending, and that was the worst of it. We had to summon the energy and focus to stay in full emergency mode for more than a week."

Things might have been even worse but for the fact that Texas Oncology had plenty of warning. Forecasters made unusually early and accurate predictions about the behavior of Hurricane Harvey, giving businesses across the region time to adapt normal emergency plans to a storm that was unlike anything to hit Texas in living memory.

Offices located inside the storm's predicted path prepared for potential flooding using both the latest technology (backing up computers to distant server farms) and the oldest strategies (moving valuable items as far above the floor as possible). They also took the unusual step of moving temperature-sensitive medications away from blackoutprone offices, storing them either at offices equipped with emergency generators or at local hospitals.

Around noon on Friday, August 25, Texas Oncology closed all 12 of the Houston-area offices that lay within the storm's projected path. The rain began late the next morning.

Before the first drops hit the ground, Kavadi and other regional officials had activated an emergency communications protocol designed to keep the practice's regional leadership and emergency response team fully connected to employees and patients at each location. Designated individuals served as liaisons between decision makers and the staff and patients from each office, passing information up and down the line each day.

They didn't stop there. Texas Oncology kept in touch with stakeholders every conceivable way—via landline, cell phone, text, e-mail, Facebook, Twitter, and its website—not only for the sake of convenience but also to guard against the possibility that some channels would fail, either because of storm damage or overuse.

As things turned out, Harvey did not hinder communications all that much. Its winds were relatively mild, and just 300,000 people in a metro area with 6.5 million residents lost electricity.

Texas Oncology had little trouble keeping in touch with its stakeholders, but the scope of the flooding kept all its Gulf Coast offices closed for nearly a week. When conditions finally allowed some offices to reopen, practice officials created new treatment schedules, giving available slots to patients with the most urgent treatment needs, and then alerted staff and patients.

> "You need to prepare yourself as best as you can for a wide variety of possibilities, but the specifics of any natural disaster are unpredictable, so you need a plan that allows you to adapt to whatever conditions arise and do the most with whatever resources you have at any given moment."
>
> —Kevin Vineyard

In many cases, the emergency response team had to direct patients away from the offices they normally used, because those locations were either still closed or could not accommodate all time-sensitive cases. The practice also had to transfer many employees from facility to facility to cover for people who could not make it to work. Roughly 50 of Texas Oncology's 400 Houston-area employees sustained severe damage to their homes or cars, and many others had to miss work to care for loved ones.

"It was a significant logistical challenge to match the available pool of staff members with the available facilities, and then fill all of the available appointment slots across the region with the patients who were most in need of care, but the system and the tools and the people we had in place performed almost flawlessly," said Kevin Vineyard, the executive director of Texas Oncology's Gulf Coast practices. "You need to prepare yourself as best as you can for a wide variety of possibilities, but the specifics of any natural disaster are unpredictable, so you need a plan that allows you to adapt to whatever conditions arise and do the most with whatever resources you have at any given moment."


Kevin Vineyard

Officials from FCS emerged with a similar perspective despite facing very different challenges. Irma did flood some regions of Florida—any significant rainfall can cause flooding in a state that's flat as a pancake and waterlogged even before the first drops hit the ground—but the wind caused most of the damage. Irma first hit the state as a giant Category 4 hurricane on September 10, buffeting everywhere from Miami to the Panhandle, with sustained winds in excess of 100 mph.

The size of the impact zone made disaster response harder than normal for FCS, which has more than 90 locations spread along both coasts of the state and across the Interstate-4 corridor. The practice had always been able to shift operations away from relatively small disaster areas to nearby offices that remained unscathed. It had never faced a storm that made the entire state a disaster area.

Irma's high winds hindered communications much more than Hurricane Harvey did. Some 4.4 million homes and businesses lost power at some point, and a similar percentage lost landline telephone and Internet service. Nevertheless, FCS had virtually no trouble communicating

with patients and staff because it pursued the same sort of multichannel strategy that Texas Oncology used. Many people lost access to some form of communication during the storm and its aftermath, but few people lost all access for any extended period.

Many FCS offices were ready to open a day after the storm passed, but a significant number were not. Rather than simply keep appointments as normal in the open offices, FCS took a regional perspective that prioritized patients undergoing time-sensitive forms of curative therapy. The plan: Delay appointments for less-urgent patients and send the neediest to open offices in their region. That required full integration of things like calendar software and timely communications, but it worked very well.

The other major challenge for FCS was getting medications to patients. Like Texas Oncology, FCS had moved temperature-sensitive medications to hospitals and other facilities equipped with backup generators. That turned out to be a smart tactic, because power outages would otherwise have ruined some of the $30 million in medication that FCS offices have on hand at any given time. (Texas Oncology did not face that situation.)

Proper storage ensured that patients could be treated as soon as offices reopened, but FCS never has more than a couple of days' worth of medication at the ready; without a steady supply, it could not continue offering treatment. Unfortunately, delivery services took the unprecedented step of suspending operations for a couple of days after Hurricane Irma. FCS responded successfully with an impromptu plan in collaboration with their drug distributor, Oncology Supply, to ensure that drugs were delivered in a timely fashion to all treatment locations.

"Our people did a very good job planning for the storm and then responding to events as they actually happened, but we also benefited a lot from recent improvements in communications technology. We couldn't have shifted resources around so quickly or found ways to get our medications if we had nothing to rely upon but landline telephones," said Brad Prechtl, chief executive officer of FCS.

Technology also safeguarded patient records in ways that would not have been possible when everything was kept on paper. As part of its disaster recovery plan, FCS ensures all its data and records are backed up in real time to a second data center located in the Northeast.

Officials at FCS, like those at Texas Oncology, thought the ability to transfer records might also prove valuable as a means of ensuring continuity of care to patients who evacuated to safer parts of the country, but neither practice received a significant number of data requests from practices in other states.

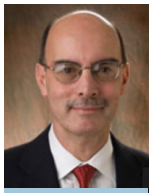
"We were very happy to be able to transfer records in the other direction on at least 1 occasion," said Todd Schonherz, chief operating officer of FCS. "We had a gentleman who worked for a power company in Illinois, who missed what was to have been his last appointment for active treatment back home, come down with an emergency crew that helped restore power in Florida [right after Irma]. His oncologist sent us the information we needed, and we were able to do that last treatment while he was here." ■

A Payer's Takeaways on the OCM

ONCOLOGY BUSINESS MANAGEMENT STAFF

OBM™: Please explain your role as a private payer in the OCM.

PETER ARAN, MD: Several years ago, CMS made a few wise decisions. One of those was creating the OCM—a multipayer initiative aimed at transforming care delivery. We do need to improve healthcare in the United States this way, so that doctors don't have to do one thing for Aetna, one thing for Blue Cross, and one thing for CMS. The goals must be aligned.


Peter Aran, MD

Of the 48 payers that wanted to be part of the OCM, CMS chose 17, along with 192 oncology practices. We have 5 OCM practices in Oklahoma. We have a university practice, a rural practice, and 3 other practices, located in the 2 largest cities of our state. We have our own care track that is not simply part of the OCM track—it's patterned 90% after that. The 1 difference is, we wanted to include the doctors, nurses, administrators, pharmacists, and social workers in our modified model because of something called the Quadruple Aim, which includes the goal of improving the work life of healthcare providers.

The OCM project is patterned after the Triple Aim—enhancing patient experience, improving population health, and reducing costs. What it doesn't do is incorporate the frontline caregivers in the design and development of this project. Blue Cross Blue Shield is including the doctors in the frontline. We think that, as a payer, we are not only part of this multipayer initiative but also part of an expanded-care initiative.

When I went to medical school, the care team might have included the nurses, the pharmacists, and maybe the social services staff, nutritionists, and doctors, and now we've expanded some 20 to 30 years later to include even the people in the community and the payers as part of the expanded care team.

Is Blue Cross Blue Shield mirroring the payments and incentives that CMS has mapped out for practices in the OCM, such as the monthly $160 care management payments?

ARAN: One of the responsibilities of payers was to outline a payment system roughly similar to the payment structure of CMS.

And we did that. We have the care management fees defined by CMS that are known as monthly enhanced oncology services (MEOS) payments. We also have a payment at the end of the care cycle that is based on quality measures and patient and family satisfaction. That's our own combination. We have a slightly different point of view from CMS regarding how the payment formula should be developed. We put more emphasis on what happens a year later by using measures of quality, such as patient and family satisfaction.

Our plan also includes a shared savings component that we think is more important for the financial viability of the practice than the MEOS care management fee. The reason we think that is because of our experience with another CMS Center for Medicare & Medicaid Innovation (CMMI) program, the Comprehensive Primary Care initiative, which was designed to strengthen primary care by offering care management fees and shared savings opportunities. That program ended on December 31, 2016, and has been followed up with Comprehensive Primary Care Plus.

What are your takeaways on the value of the OCM at this point in the pilot?

ARAN: The biggest takeaway is that this gives our patients access to care and, on the back end, payers pay nurses and pharmacies and doctors for the care received.

All insurance companies have cadres of nurse managers, transplant coordinators, physicians, pharmacists, and social workers who all interact with patients above and apart from what happens within the walls of the hospital or doctor's office. What I see happening is that, someday, all those touches that the payers have will be integrated with the care being given in the other parts of the healthcare world. So, the touches that our transplant nurses or our care managers have with patients with chronic disease or that I, as a physician in population health, have—all of that eventually will be funneled into the electronic medical record. Everybody taking care of the patient will know that Mabel has been communicated with 7 times in the last 3 months by the folks at Blue Cross Blue Shield, and what we have discussed with Mabel about her diabetes or chronic obstructive pulmonary disease or congestive heart failure is all documented in the medical record, allowing for greater continuity of care. That's the biggest takeaway. Insurance companies are part of a healthcare team, taking care of a patient outside of the walls of a hospital or doctor's office. ■

A Practice Model Designed to Reward Physician Partners Equally

ARIELA KATZ

TO THE BEST of its ability, Associated Medical Professionals (AMP) of New York, a urology and radiation oncology practice, seeks to give its physician partners an equal share of its financial success while rewarding all staff members according to their levels of responsibility and workflow intensity.

"Finding a solution to make it fair and equitable to all partners is very difficult, especially when there are different referral patterns, geographic areas that have different insurance payers, or simply various specialists in the group," said Christopher Williamson, chief operating officer.

AMP strives to achieve high standards of quality and motivated employees who commit to making a strong contribution in whatever area of skill and expertise is theirs. "From a business point of view, we want to reward the hard workers that are on the extreme side of productivity or those other physicians that perform the complicated cases, but at the same time those physicians who are in the trenches on a daily basis," Williamson said. "Every single provider and staff member works together to provide the best care for our patients and achieve financial success for the group."

AMP now has roughly 30 physicians and 10 clinical locations in 8 counties east of Lake Ontario and Lake Erie. The physicians attend at 9 hospitals throughout the area, and it is these hospital relationships that help to define the staff compensation arrangements.

AMP does not pay physicians incentives. Instead, it has developed co-management agreements with its hospital partners and incentive models are contained within those agreements. These specify goals for AMP to achieve, which are closely measured and ultimately improve patient care and monetary savings for each of the hospitals, Williamson said. "We are essentially partnering with the hospitals, with working toward a common goal."

Of course, there is no single perfect model, and AMP is always working on refinements. "Everyone contributes in a different way, and when the water rises, the boat rises," said David M. Albala, MD, medical director and co-director of research at AMP.

History of the Practice

AMP was founded 10 years ago when 2 competing urology groups merged, bringing 11 urologists and 1 radiation oncologist between them. "Essentially, there were 2 large practices that were practicing against each other, so to speak, and they sat down and talked to each other and said, 'Let's see what we can do to try to combine forces,'" Albala said.


Christopher Williamson

"The vision of AMP was to merge the urologists in the area under 1 corporate umbrella to develop AMP into a fully

integrated healthcare organization in order to provide better continuity of care to patients, while offering the most advanced treatment options and skilled specialists within the system," said Williamson, who was hired in June 2007 to help with the initial merger and build the practice.


David M. Albala, MD

In 2008, the group provided services at 3 hospitals, with the main center located in Syracuse, New York, with 4 offices. The main campus of AMP featured a radiation department and eventually developed a pathology laboratory. Albala, a specialist in robotic surgery, joined the group in 2010.

AMP steadily worked to achieve its larger business objective by combining with nearby urology groups who were competing with AMP. In 2009, 3 urologists who had been in practice together for over 20 years merged with AMP. Their office was about 30 minutes from the Syracuse clinic. From there, AMP started recruiting and adding more physicians, as some older physicians decided to retire. In 2010, 2 more urology groups merged with AMP, with 3 others following suit in the ensuing years.

"Over the course of mergers, there were several offices that were closed down due to the proximity of the other locations to increase efficiency, or for cost-saving measures. Also, by recruiting outside physicians, we were able to expand into other markets that were underserved," Williamson said. Currently, AMP is the largest urology group in its market. "Patients are able to visit the satellite offices to receive the majority of their care, but at times they need to travel to have the more specialized services," Williamson said.

"We never envisioned that we would become the only independent private practice urology group in the city of Syracuse and its surrounding counties," said Howard J. Williams, MD, FACS, CEO of AMP.

In terms of the size of its team, AMP now has 22 physician owners, 6 nonowner physicians, and 300 employees, 275 of whom are full time. AMP does not currently have a medical oncologist but is seeking to recruit one to better accommodate patient needs.

When recruiting more doctors to their group, which is typically a difficult task, AMP strives to offer compensation plans that are competitive with other large institutions across the country. "We have recruited several doctors from outside the area who have uprooted from North Carolina or South Carolina and come to the Syracuse area," Williamson said.

> We never envisioned that we would become the only independent private practice urology group in the city of Syracuse and its surrounding counties.
>
> —Howard J. Williams, MD, FACS

Offering Comprehensive Care

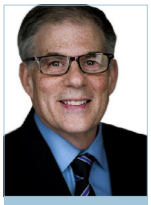
AMP offers a broad menu of diagnostics, treatments, and procedures. For diagnostic imaging, it has ultrasound and CT scan equipment, as well as an MRI fusion biopsy program for prostate cancer testing, which was started about 2.5 years ago, Albala said. However, it does not currently have nuclear medicine imaging.

There is a state-of-the-art intensity-modulated radiation therapy facility, not only for treating patients with prostate cancer, but also for patients with breast, and head and neck cancers. To raise the level of treatment for patients in need of radiotherapy, the practice has a partnership with AMP Radiation Oncology, a division of AMP, which handles the professional end of AMP's radiology needs, including reading CT scans, live ultrasounds, and administration of radiotherapies to patients. There is an onsite radiation oncologist, and any AMP office can call that doctor and receive immediate answers to questions.

AMP also offers traditional surgeries and has a robust robotic program for prostatectomies, partial nephrectomies, cystectomies, and other procedures. It also has procedures for other urologic diseases, such as UroLift and Rezūm for benign prostatic hyperplasia.

AMP's advanced prostate cancer and bone health clinics enable patients to come in for treatment and be seen at the same time by an oncologist, Albala said. When the advanced prostate cancer clinic opened, it was led by 1 physician with a keen interest in that disease state. Over time, the physicians at AMP have made that program more comprehensive and robust. According to Albala, the advanced prostate cancer clinic has enabled care from the beginning of the diagnosis through to chemotherapy. The physicians start patients with prostate cancer on sipuleucel-T (Provenge), then progress them to oral agents, including abiraterone (Zytiga) and enzalutamide (Xtandi), in a graduated program.

AMP has also started an in-office dispensing system for drugs to better manage patient adherence, and practice administrators have considered hiring an oncologist to administer chemotherapy and other infusions in the office. The bone health clinic has succeeded in managing patients who are on hormonal therapy. The practice is branching out in other ways, Albala said.


Howard J. Williams, MD, FACS

"We are starting to develop an overactive bladder clinic for patients who have overactive bladder. They can come and be treated by experts in pelvic medicine. We're starting to look at ways we can treat patients with bladder cancer and kidney cancer and how we can hang onto those patients a little bit longer than we used to."

Clinical Trials and Community Action

Because AMP aims to provide the most recent and effective treatments possible, it also has a clinical trial program. The research department is made up of 5 members, with research coordinators, including Albala, and a clinical trial manager. Although these trials include many investigative drug therapies, AMP also participates in trials of medical devices. Albala noted one study of a new biopsy device for probing the prostate that is sensitive to differences in radiofrequency and can recommend a biopsy based on results.

Over about 7 years, the clinical trial program at AMP has included as many as 48 studies, and today there are over 30 open trials that patients can participate in. The research team of physicians and coordinators meets regularly to make sure things are running smoothly in all trial activities. Practice administrators say that AMP is consistently a high enroller for clinical trials, and at large urology conferences, AMP is often asked by companies to participate in their research.

AMP makes a concerted effort to do community outreach. Physicians visit nearby primary care physicians to learn about local health issues and it holds forums for patients to promote better understanding of urologic conditions, such as erectile dysfunction and overactive bladder. AMP also partners with hospitals in other educational endeavors. The physicians at AMP participate in the ZERO Prostate Cancer Run every year, which raises funds and awareness for patients with prostate cancer and their families.

The outreach program has been successful in drawing more African American patients from the Syracuse area into AMP's offices for treatment and consultations. African American men have some of the highest rates of prostate cancer and related mortality, so this program was established to educate this at-risk population and set up screening programs, Albala said. To broaden this program, AMP has reached out to community centers and churches. "We do rectal exams and PSA screenings and try to educate these men to be more aware of their condition and what prostate cancer means in the African American community," he said.

Looking to the Future

AMP seeks to continue to grow and provide compassionate, state-of-the-art care to all members of the Syracuse community. Part of its plan to achieve this goal is to always keep up with new developments and treatments, while maintaining a robust research program. "We want to stay on the cutting edge of technology. We will spend the capital to make sure the patients can come here and have the best possible equipment available," Williamson said. Physicians at AMP also publish and present research at national meetings to further collaborate with their colleagues outside their practice.

"This practice is unique in that, I think, it's as good as any university practice in the country," Albala said. "What we've been able to do is unique. Granted, we're a large practice, so it's easier to do those things, but we really have provided comprehensive care across the board." ■

Tax Cut Proposal Seen as Endangering Access to Care

TONY HAGEN

ONCOLOGY PROVIDERS contend that the sweeping $1.5 trillion in tax cuts sought by Republicans would trigger sequester cuts that would drive more independent practices out of business and reduce patient access to care.

In statements, they noted that the Congressional Budget Office (CBO) has warned that the tax cut proposal, which passed narrowly in the House on Thursday, would require $136 billion in federal spending reductions next year, $25 billion of which would come from Medicare spending.

The spending reductions would come in the form of automatic sequester cuts designed to prevent the federal government from running out of money.

"Policymakers in Washington should note that blunt budget-cutting gimmicks like the sequester cut backfire. They have terrible unintended consequences and do more harm than good for patients and taxpayers," the Community Oncology Alliance (COA) said in a statement. The coalition of independent oncology practices stated that, according to one study, the most recent Medicare sequester cut, 5 years ago, resulted in the closure of 91 oncology practices—many consisting of multiple clinic locations—and caused another 130 to merge with hospitals in order to survive.

Republicans have argued that the broad tax cut plan would put money into the pockets of Americans, especially struggling families that are having difficulty paying their bills and don't have much saved for the future. They contend that the huge corporate tax reduction would stem the exodus of US companies that have relocated their headquarters overseas in order to benefit from lower tax rates in other countries, costing America good-paying jobs and making it less competitive. Further, they contend, the US economy has grown at a sluggish pace even though the Dow Jones Industrial Average has soared roughly 4,600 points this year.

The prior sequester cut reduced the Medicare payments doctors receive to cover costs of drug storage and management and various other services. The anticipated Medicare cut resulting from the current tax bill would cause a significant further reduction in those payments, COA stated.

The House bill passed with a 227-to-205 vote. Thirteen Republicans joined Democrats in opposing the measure. The Senate version, to be voted on next Thursday, is somewhat different, as it makes individual tax cuts temporary and delays implementation of a steep corporate tax reduction, from 35% to 20%, by 1 year. Observers speculated that with a slimmer Republican majority in the Senate, passage there would be more difficult.

In a letter to members of the Senate Finance Committee and the House Ways and Means Committee, various oncology provider groups and advocacy organizations for patients with cancer expressed concerns about the potential negative impacts of the tax reform proposal. The tax bill as proposed by House Republicans would eliminate an expense deduction for people with very high medical bills. It would keep the individual mandate of the Affordable Care Act, but the Senate version would scrap it.

If the final version does away with the individual mandate, healthy individuals would be released from their obligation to carry health insurance. This is expected to increase the concentration of sicker people in health plans and prompt payers to raise their premiums, adding to the expense and instability of the health exchange system established by the Obama administration. "The protection against pre-existing condition limits and exclusions [from coverage] is of critical importance for cancer patients. An insurance system without those protections is an insurance system that typically excludes cancer patients from coverage or places severe limits on their access to coverage," the providers and advocacy groups wrote in the letter. Those signatories included ASCO, the Hematology/Oncology Pharmacy Association, CancerCare, and Susan G. Komen. The group issued the statement under the collective moniker Cancer Leadership Council.

In an analysis of the Republican tax reduction proposal, the CBO stated that the $1.5 trillion in tax cuts would result in an equivalent amount of deficits between 2018 and 2027 that would need to be offset by spending reductions. Those automatic cuts were established by the Pay-As-You-Go Act (PAYGO) of 2010.

The CBO stated that the Office of Management and Budget (OMB), which keeps track of deficits and has the power to impost spending reductions, "would be required to issue a sequestration order within 15 days of the end of the session of Congress to reduce spending in fiscal year 2018 by...$136 billion."

However, the CBO stated that much federal spending is beyond the reach of the OMB, such as low-income programs and Social Security, which are exempt from sequester cuts.

"Given that the required reduction in spending exceeds the estimated amount of available resources in each year over the next 10 years, in the absence of further legislation, OMB would be unable to implement the full extent of outlay reductions required by the PAYGO law," the CBO said.

COA contends that the ongoing closures of independent oncology clinics, which are said to provide the majority of cancer care in the United States, not only affects patient access but drives up the costs of care, including for Medicare, because oncology treatment is more costly in hospital centers than in private clinics.

"Closing community treatment facilities creates access problems, and consolidation into more expensive hospital systems drives up costs for seniors with limited mobility and fixed incomes," COA stated. ■