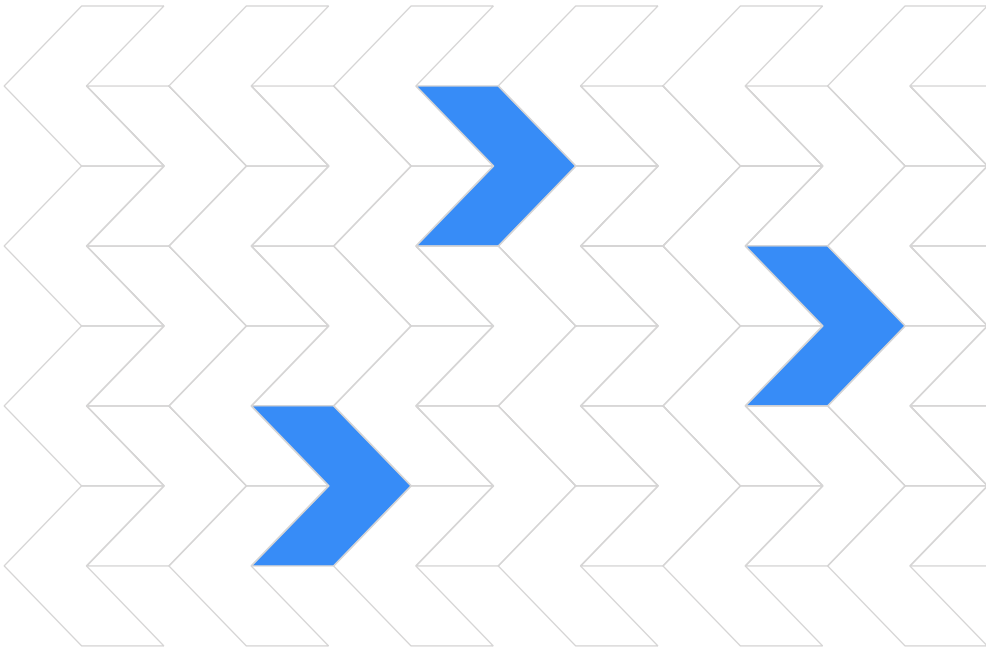


The Next Generation of NCI-Community Cancer Center Partership Is Here

Part of the Chartis “Future of Cancer” Series

CHARTIS

In an April 2023 report, we explored the forces that are shaping the future of cancer care and the implications for providers. A key theme in the report was the convergence of academic and community cancer center roles, driven by the scale achieved through community hospital mergers (and cancer scale unlocked therein) and the decentralization of National Cancer Institute (NCI)-designated cancer centers as they add care environments closer to where patients live. We posited that the effects of convergence would upend traditional roles occupied by community and academic providers and redefine the ways in which the two compete and collaborate in the delivery of cancer care.

In this briefing, we take a closer look at the pattern of industry change we believe will remake NCI-community affiliation relationships over the next 5 years. In their place, we expect a new class of partnerships to emerge—characterized by higher-fidelity clinical integration, deeper strategic and financial alignment, and a research-first orientation. Designing and participating within these "next-generation" partnership models will require a wholesale change in the way NCI centers manage and resource external affiliations and a resetting of the expectations with their community partners. When implemented in their purest form, we predict these models will create seamless, multi-site care ecosystems, with community programs as natural and indistinguishable extensions of the NCI center and a shared standard of excellence that brings immense value to the cancer patient.

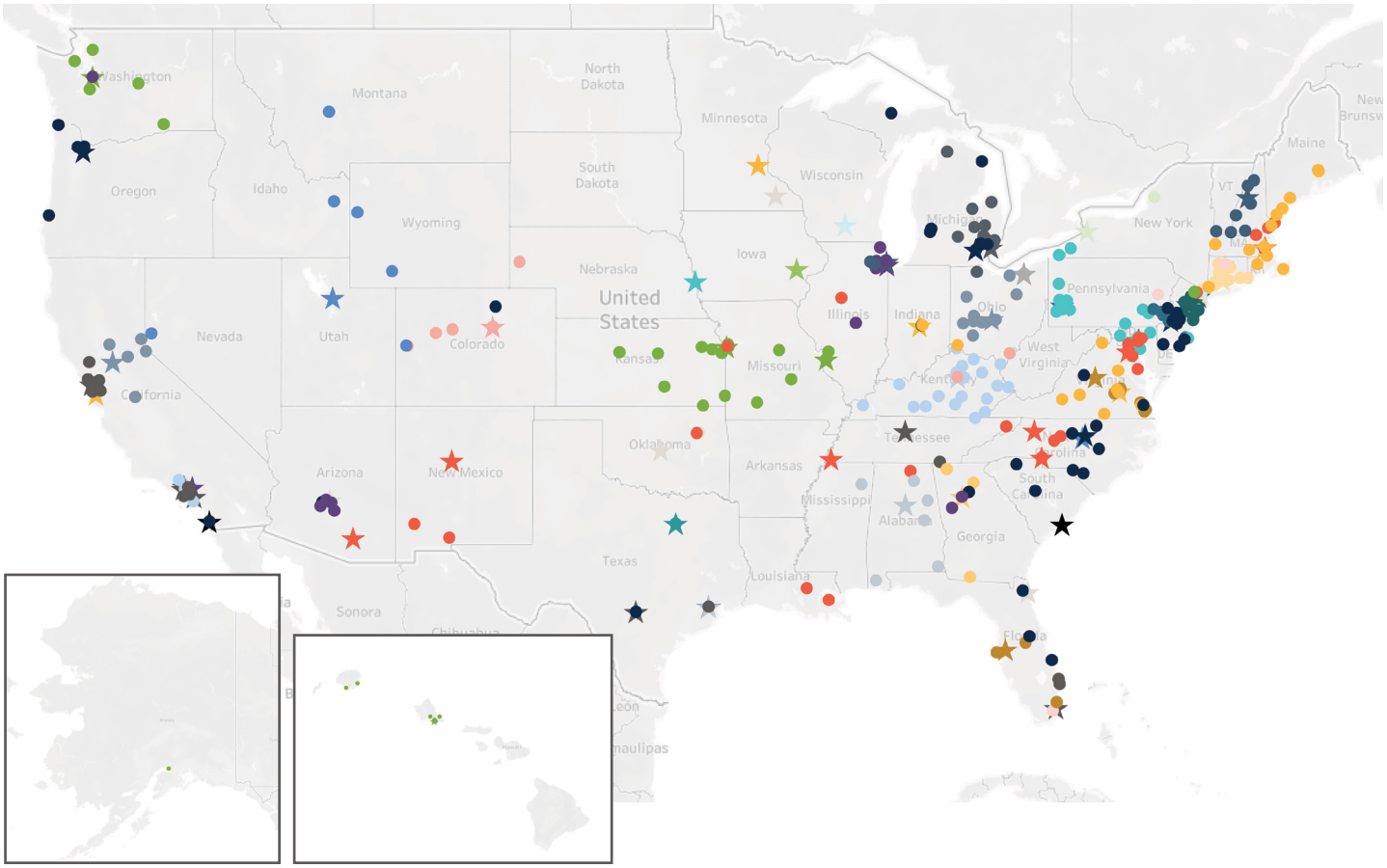
The Community "Affiliate" Model Has Been Adopted Widely by NCI-Designated Centers

There are currently 65 NCI-designated cancer centers in the United States with a clinical or comprehensive designation. Each has a unique geographic area (or catchment) in which they have made a commitment to the NCI to advance clinical research, prevention, and community outreach.[1] Over the past decade, NCI centers have worked to achieve these goals through "affiliate" relationships—generally organized around small networks of community programs. Of the 65 NCI centers, 77% (50) have networks, with an average of 4.5 affiliates. Their networks include 400 total members, spanning multiple organizational types, including community hospitals (60%), other academic medical centers (37%), and physician practices (3%). The networks are heterogenous, with 6 that span nationally, 11 that span regionally, and 33 that are exclusively local.

Figure 1 below shows the network for the NCI centers, with additional detail available through our interactive dashboard.*

**Note: This shows the continental United States, so does not show University of Hawaii Caner Center.*

Figure 1: NCI-Designated Cancer Centers and Partnership Networks



Industry Disruption Is Challenging First-Generation Affiliation Models

In recent years, several industry forces have begun to challenge traditional forms of NCI-community affiliation. These include capability and market overlap—introducing new forms of competition between community and academic providers; narrowing clinical trial eligibility and a corresponding need for NCI centers to reach larger partners with more research-forward offerings; and a growing imperative for NCI centers to migrate from regional affiliates to national partnership networks as they seek to build national brand. Each of these dynamics is slowly eroding the rationale for the "first generation" of affiliation models.

BLURRING "ROLES" AND GEOGRAPHIC OVERLAP HAVE CREATED NEW COMPETITIVE PRESSURES

The most powerful force affecting traditional affiliate relationships is the convergence of academic and community roles. Over the past decade, 70% of hospitals joined health systems, and more than 1,000 oncology practices were acquired.[2,3] The resulting scale has created community-based cancer programs with patient volumes that often exceed NCI environments, unlocking an ability to support tertiary and quaternary clinical and research offerings.

At the same time, traditional geographic demarcations have begun to break down as NCI centers regionalize their delivery networks, frequently into communities served by affiliates or would-be partners. For example, organizations like Memorial Sloan Kettering Cancer Center (MSKCC) report 60%–70% of infusion and radiotherapy volumes being delivered at regional sites, rather than at the Manhattan hub.[4]

The combination of blurring capability and market overlap is gradually producing a cancer product that is less distinguishable to the consumer and creating new competitive pressure in geographies where NCI centers and their affiliates compete for similar patient segments—eroding the premise for affiliation.

AS RESEARCH BECOMES MORE TARGETED, NCI CENTERS NEED NETWORKS THAT MEANINGFULLY EXTEND THEIR REACH

The arc of oncology clinical research is toward narrowing patient populations, defined by unique "omic" signatures that determine whether a patient is eligible for a targeted therapy. This trend is requiring NCI centers to think differently about how they access patients for research, with many concluding that the population accessible on their campus or through small local affiliations will be insufficient to sustain the requirements of contemporary clinical trials. The challenge is compounded by the U.S. Food and Drug Administration and NCI's renewed diversity goals requiring NCI centers to target segments not always reflected in their patient mix.

These trends require NCI centers to cast a wider net for their narrowing—and diversifying—research populations. Most first-generation affiliate models are ill-equipped to meet this need, either because the partnerships are sub-scale for research or because the infrastructure required to support multi-site clinical trials was never core to the network offering.

CANCER PLATFORMS ARE INCREASINGLY NATIONAL IN SCALE, PRESSURING THE TRADITIONAL LOCAL AFFILIATE MODEL

Each year, NCI centers receive a highly watched ranking by the U.S. News & World Report, of which peer-based feedback is a critical determination. In conversations with top NCI centers, national presence is frequently mentioned as an element in influencing peer perception and top-of-mind awareness. While it remains to be seen how impactful affiliate networks are for rankings, many NCI centers are investing in national expansion, as seen in the MSKCC Alliance (3 states), MD Anderson Cancer Network (6 states), Dana-Farber Cancer Care Collaborative (6 states), and City of Hope's acquisition of Cancer Treatment Centers of America (3 states).

A Next-Generation Partnership Model Is Emerging

The forces described above are leading to gradual obsolescence of the first-generation affiliate model. In its place, we are witnessing the emergence of next-generation partnerships predicated on higher-fidelity clinical and strategic integration. The features of this new model are morphing along every dimension (Figure 2), including how the network is constructed and managed, its geographic scale and reach, the depth of its clinical and financial integration, and its research-first orientation.

Figure 2: The Emerging Next-Generation Model

FEATURES/MODEL	FIRST GENERATION	NEXT GENERATION
Network Design/ Management	• Opportunistic alignment: No master go-to market plan • Nonstandard product: Negotiated individually from "menu" • Managed off the side of the desk/no dedicated business unit	• Organized strategically: Top institutional priority • Standard product: Tiered for any affiliate hierarchy, single contracts • Executives and teams (clinical and nonclinical) dedicated to the work
Geographic Reach/Scale	• Primarily local: Focused in-state and in-market • Focused on small hospitals and independent oncologists	• Super regional/national: Not geographically bound • Focused on IDNs, peer academics, nontraditional providers
Clinical Integration	• Periodic/self-reported quality metrics • Limited alignment with community physicians and NCI faculty	• Dynamic clinical integration: Integrated electronic health records, real-time QA • Integrated more fully with NCI enterprise
Financial Alignment	• Funded through service agreements and royalties • Monetized through "selling the brand"	• Funded through shared risk: joint ventures and other financial integration • "Earn the brand" orientation
Research Focus	• Oriented toward research through CTO services/trial screening (i.e., limited disruption)	• Purpose-built for research: Research as a primary aim, building systems/processes to support expert multi-site trials

AS THEIR VALUE IS UNDERSTOOD, NCI NETWORKS ARE BEING DESIGNED AND MANAGED DIFFERENTLY

The first generation of NCI-community affiliations were built opportunistically—often featuring one-off negotiations, broad "menus" of offerings, and only tangential alignment with broader cancer center strategic aims. As community partnerships have gained institutional traction in NCI centers, internal demands have emerged for building models that are more scalable, better aligned with broader organizational strategy, appropriately resourced, and professionally managed. For example, the MD Anderson Cancer Network, which has partnerships with 6 large cancer centers across the country, is organized through a dedicated subsidiary company, with its own dedicated management team, Board of Directors, and budget. City of Hope is organizing its national footprint similarly, both through a direct-to-employer subsidiary, AccessHope, and its new division created to integrate Cancer Treatment Centers of America

As next-generation NCI models reach maturity, we expect to see more NCI networks organized as discrete business units, enabling a more standardized offering, tiered as needed to support partners of different scale, single legal contracts that facilitate scaling, and dedicated corporate functions organized around the unique needs of NCI and community partnership.

NCI NETWORKS ARE BEING ACCELERATED THROUGH EXPANSION AT THE STATE AND NATIONAL LEVEL

The next generation of NCI and community partnerships are also taking on new scale and reach dimensions. Whereas the old model largely relied on in-state collaboration (primarily to drive referrals for complex disease), newer initiatives are increasingly borderless and targeting new segments of partnership. The most direct form of scale has been national expansion, including the aforementioned organizations like MD Anderson Cancer Center and MSKCC, and newer national players like the Dana-Farber Brigham Cancer Care Collaborative, whose recently announced partner, The Christ Hospital Health Network, is the first member outside of the Northeast.[6]

NCI centers are also pursuing scale via integrated delivery network (IDN)-wide affiliation, migrating away from hospital-specific deals and seeking strategic partnerships that span states and regions. The Ohio State University and its James Cancer Network are a prime example—recently advancing formal alignment with Mercy Health across multiple markets in the state of Ohio as part of the Healthy State Alliance.[7] We expect network models to more frequently follow this path, rapidly scaling across geographies when NCI centers and large IDNs come together on common priorities.

NEW MODELS ARE MIGRATING FROM "OVERSIGHT" TO AUTHENTIC CLINICAL INTEGRATION

A principal aim of the first generation of NCI-community affiliation was clinical integration, but it manifested in limited ways (e.g., shared clinical guidelines, retrospective quality data, and invitation to collaborate through peer review and joint tumor boards). The next-generation models are correcting for this deficiency, with deep and meaningful clinical integration as a design requirement. These integrations include extended quality evaluation during partner intake (e.g., Cleveland Clinic's on-site program assessments[8]); provider cross-coverage in community settings (e.g., Duke Cancer Network at Johnston Health and Scotland Memorial[9]); shared clinical pathways software (e.g., Dana-Farber's Philips product extended to affiliates[10]); co-located and collaborative clinical services (e.g., University of Colorado and US Oncology in Denver[11]); and joint appointments for community-based faculty (e.g., UCSF and John Muir in the East Bay Cancer Collaborative).[12]

While no prototype will apply across all markets, we expect most next-generation NCI models to feature these clinical integration elements. What results will be a relationship that is less about oversight and more about authentic collaboration and harmonization of clinical outcomes that will continue to evolve with the advent of new technology and treatment approaches. Establishing a truly integrated clinical environment is arguably the most important step in extending the NCI center's capabilities to a partner organization, providing a merited reputational lift for both organizations that improves quality, enhances the patient experience, and drives growth.

FINANCIAL ALIGNMENT WILL UNLOCK GROWTH AND RELATIONSHIP LONGEVITY IN THE NEXT GENERATION OF PARTNERSHIPS

One of the fundamental challenges in first-generation affiliate models was a lack of incentive alignment. Most NCI partnership models were constructed around service agreements and brand royalties, with a minimal (or non-existent) line drawn between the relationship and its ability to drive growth to the partners.

A paradigm shift is underway in more contemporary partnership models—many of which feature performance-based fees like that constructed between Moffitt Cancer Center and Memorial Healthcare System in their joint malignant hematology and stem cell transplant program in Broward County.[13] Others include modality-specific joint ventures, like the radiotherapy partnership between Johns Hopkins Medicine and the University of Maryland Medical Center.[14] The most integrated models include "service line mergers" that create site-agnostic, multi-site models of cancer care, like those developed between Stanford Medicine and Sutter Health in Oakland, and UCSF and John Muir in Berkley and Walnut Creek.[15,16]

In coming years, we expect shared risk to be a common feature in NCI and community cancer center models, helping to resolve the issue of overlapping service areas and allowing for site-agnostic care optimization. Sustaining alternative sources of margin in the face of mounting pressure on traditional profit centers will require organizations to have "skin in the game." Without a model of shared risk and investment, the durability of the partnership will be tested at the first sign of stress.

INTEGRATED CLINICAL RESEARCH WILL BECOME THE PRIMARY VALUE PROPOSITION FOR PARTNERSHIP

Integrated clinical research remains a final frontier of sorts for NCI-community affiliate networks. To date, there have been minimal examples of high-performing networks that feature trials exported to community sites from NCI cancer center research portfolios. Historically, the limitation was on the community cancer program side, given a lack of infrastructure, insufficient experience administering complex clinical trials, and/or productivity-based compensation models that did not encourage time spent managing patients on research studies. Many larger community environments are overcoming these challenges now with sophisticated clinical trials offices, active and engaged investigators, and complex, early phase trial portfolios.

As a result, the onus has shifted back to the NCI center to build the systems and processes that enable multi-site clinical trials in their networks. This could look like Yale's Smilow Cancer Hospital Network, with clinical trials across 15 centers in Connecticut and Rhode Island;[17] the University of Hawaii, with clinical trials offered at partner sites throughout the Hawaiian Islands;[18] or the University of Kansas' Masonic Cancer Alliance, with clinical trials, including Investigator Initiated Trials (IITs), offered across 7 community sites in Kansas and Missouri.[19]

In coming years, we expect an urgent focus on making multi-site research capabilities native to affiliate partnership models. We also expect NCI centers to increasingly evaluate their community partners on the basis of research readiness. Those NCI centers that are successful will expand the diversity and reach of their research population, bring value to industry sponsors seeking reliable and efficient accrual to studies, and accelerate the speed of their own innovation as investigator-initiated research expands to new locations.

Leading Practices Are Emerging in the Next Generation of NCI-Community Partnerships

While the implications of the next-generation NCI-community partnership shift are still unfolding, a few early takeaways are emerging from the examples discussed in this paper.

- **NCI centers must reinvent their partnership offering to remain relevant.** A review of the top 25 NCI centers reveals many neglected affiliate models, often attached to NCI centers that have been slipping from top-tier rankings over the past 3 to 5 years. Our conversations with NCI leaders around the country acknowledge that thoughtful partnership strategy is no longer optional and that strong networks will be a critical component of remaining viable as headwinds challenge the academic cancer care model.
- **Community programs can and should expect more from their NCI partnerships.** Community programs have new scale and market leverage, affording them more agency in the design of NCI partnership. They also have access to more alignment options (beyond local players) as new national platforms emerge and the alignment marketplace becomes hypercompetitive. As a result, these programs should be more discerning as they evaluate partnership against next-generation needs.
- **Lines will blur, creating something like an NCI center "without walls."** As NCI affiliates give way to integrated partners, we expect community programs to become natural and indistinguishable extensions of the NCI center. Faculty will move and work seamlessly between the environments, and operators will master the complexities of managing a multi-site, multi-ownership ecosystem. Most importantly, a single standard of care and standard of excellence will be able to emerge across a mixed model, and patients should be the true beneficiaries of these next-generation pairings.
- **Affiliation design and negotiation will become far more complex.** As traditional service models are replaced by economically intertwined business arrangements, the demands of partnership design will become intensive. NCI centers will need dedicated teams with extensive finance and legal expertise embedded in their affiliate network organizations to navigate collaborations.
- **NCI partnership will become a more powerful market device.** Next-generation clinical integration should create the conditions necessary for true shared excellence and quality impact, in turn influencing consumer and referring provider behavior in a manner never fully realized in the first-generation franchising models. We expect integrated partnerships to be rewarded by the market, as cutting-edge expertise and capabilities extend to new geographies and NCI centers and community partners direct patients to the most clinically appropriate and patient-accessible location.

Over the next 5 years, NCI and community cancer center partnerships will be completely remade. Next-generation models will be deliberate and mission-aligned, scaled for maximum impact in care and research, and architected with high-fidelity clinical and business integration. Success will require openness to new thinking and a reframing of traditional NCI and community roles. It will require institutional commitment and resourcing to support deeply integrated relationships and care models. And it will require a willingness to take risks—through new forms of partnership, financial upside and downside, and committing to the big bet that the future of cancer care will belong to ecosystems that seamlessly blend the strengths of community and academic medicine.

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