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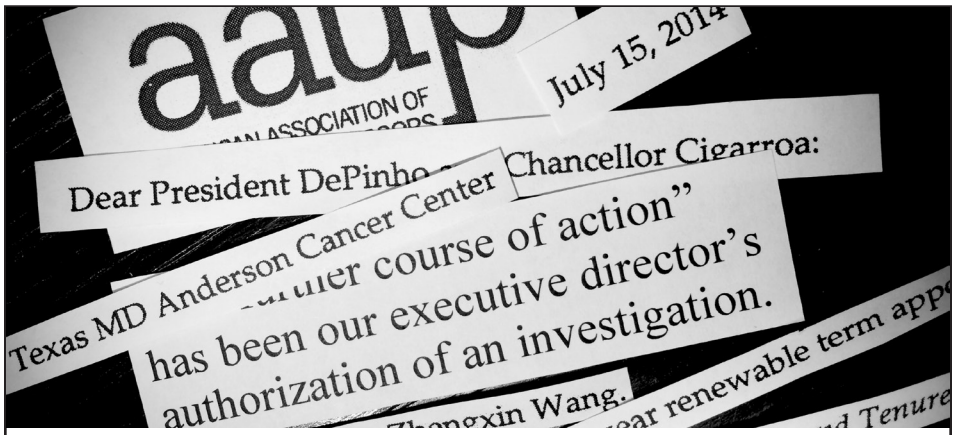

DePinho's Handling of Tenure Dispute Triggers Formal Investigation by AAUP

By Matthew Bin Han Ong

The American Association of University Professors authorized a formal investigation of MD Anderson Cancer Center, a move that could result in censure.

The investigation was triggered by refusal on the part of MD Anderson's administration to provide justification for denying tenure renewals to two faculty members.

The faculty members in question—Kapil Mehta and Zhengxin Wang—received unanimous votes in favor of renewal from the Faculty Senate

(Continued to page 2)

Memorial Sloan Kettering Seizes Top Cancer Hospital Prize from MD Anderson in U.S. News & World Report Ranking

By Paul Goldberg

MD Anderson Cancer Center's uninterrupted seven-year stretch as the top cancer hospital in the U.S. News & World Report rankings has come to an end.

Memorial Sloan Kettering Cancer Center has broken the spell of being the perpetual runner-up and moved to the lead.

The result is as close as cancer care can come to a photo finish:

- MSKCC: 100 percent.
- MD Anderson: 99.9 percent.

(Continued to page 6)

In Brief

Pietenpol Named to National Cancer Forum

JENNIFER PIETENPOL was named an at-large member of the **National Cancer Policy Forum**, an advisory group of the Institute of Medicine. She will serve a three-year term.

(Continued to page 10)

AAUP Seeks Meeting with DePinho, Chancellor Cigarroa

(Continued from page 1)

Promotions & Tenure Committee, but the institution's president, Ronald DePinho, ultimately decided not to extend their tenure (The Cancer Letter, April 25).

"Regrettably, our primary concerns remain largely unresolved, in particular, our concern about inadequate protections for academic freedom at the MD Anderson Cancer Center under its current policies," wrote Gregory Scholtz, AAUP associate secretary and director of the Department of Academic Freedom, Tenure, and Governance, in the July 15 letter to DePinho and University of Texas System Chancellor Francisco Cigarroa.

A formal investigation is authorized only when all other methods of mediation by the AAUP staff have proved inadequate.

In an earlier letter to DePinho, Scholtz urged the MD Anderson president to immediately reinstate Mehta and Wang to their full-time appointments.

"Our further course of action in these cases will depend upon how you will act now," Scholtz wrote (The Cancer Letter, May 16).

DePinho didn't. In his reply May 13, he said that Mehta had received a non-renewal recommendation from his former department chair. He also said that Wang did not exhaust all appeal processes (The Cancer Letter, May 30).

The administration also declined to follow recommendations made by the Faculty Senate PTC Issues Committee regarding tenure renewal, according to a letter addressed to the AAUP from MD Anderson professor Douglas Boyd, a Faculty Senate executive member. These recommendations are posted here.

"As of yet no credible reason(s) has/have been advanced by the Administration towards non-renewal of tenure for these two faculty members," Boyd wrote July 10. "This decision by the Administration runs counter to the principle of shared governance as described in the 'Statement on Government of Colleges and Universities' adopted by several organizations which MD Anderson Cancer Center is a member of."

The AAUP said it had three reasons to take the next step: (1) DePinho's rejection of the Faculty Senate's recommendations, (2) the administration's lack of justification for their decision to deny tenure renewal to the affected faculty, and (3) MD Anderson's lack of an indefinite tenure program.

"Academic freedom is necessary for all kinds of teaching and research that serve the common good, and we believe that tenure is necessary to protect academic freedom," AAUP's Scholtz said to The Cancer Letter.

"These two long-serving faculty members and researchers whose appointments were suddenly terminated—under our standards, they should have been afforded a hearing before a body of faculty peers in which the administration demonstrated adequate cause for dismissal. They have gone long beyond any reasonable period of probation."

The investigation will be conducted by an ad hoc committee, which will prepare a report for the consideration of the AAUP's Committee A on Academic Freedom and Tenure.

MD Anderson's case is reminiscent of another recent investigation of the UT Medical Branch at Galveston, which resulted in imposition of censure, AAUP officials said. That process involved Cigarroa; Kenneth Shine, then-executive vice chancellor for health affairs; and Barry Burgdorf, then-vice chancellor and general counsel.

"[The MD Anderson investigation] will be undertaken under the unique circumstance of another medical school in the University of Texas system… having been investigated in 2009 (with AAUP censure imposed since 2010) and of the adequacy of official system policies on faculty appointments having been an issue in both investigations," Scholtz wrote.

Cigarroa, current Vice Chancellors Raymond Greenberg and Daniel Sharphorn, and Paul Foster, chair of the UT System Board of Regents, have been notified of the AAUP investigation.

"We shall welcome your advice on whether our

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MD Anderson committee should plan to visit both Austin and Houston or whether a Houston visit will suffice," Scholtz wrote.

"A Predetermined Outcome"

MD Anderson officials challenged the fairness of the AAUP investigation, further asserting that its outcome has been predetermined.

"We do have some serious and legitimate concerns about the American Association of University Professors' proposed investigation," MD Anderson officials said in a statement to The Cancer Letter. "In response to the recent correspondence from the AAUP, we have gathered information concerning previous AAUP reviews of completely appropriate personnel procedures at other American universities and questionable positions taken by the AAUP about those matters.

"We are committed to academic freedom principles and believe there are many ways these principles can be safeguarded, not just one single way. Our questions concern the objectivity of the proposed investigation, including the process, the staff involved and potential outcomes.

"We would hope that all reasonable people would agree that any proposed investigation that has a predetermined outcome is not really an investigation at all.

"We plan to transmit our questions to the AAUP within a few days. We're hopeful the AAUP's answers will address our reasonable concerns. We will determine our next steps based on the responses to those questions."

The MD Anderson administration has the right to clarify its reservations, said Matthew Finkin, director of the Program in Comparative Labor and Employment Law & Policy and the Albert J. Harno and Edward W. Cleary Chair in Law at the University of Illinois.

"The investigation does not have a predetermined outcome, and MD Anderson is under no obligation to cooperate," said Finkin, who has participated in four AAUP investigations and chaired two. "Yes, the bureaucracy of the AAUP is that the general secretary has determined that it has reason to believe that there has been a violation of the AAUP principles.

"But the committee is not told, 'Go confirm what we found.' The committee is an independent body and it's free to make its own determinations. If it concludes that there's no violation, that will be the nature of its report.

"The investigation committee will interview all the principals in the case. If the administration is willing to participate—they usually would, with thanks, and most of them do—they'll interview the president, the key administrators, the faculty members, and the faculty senate people. They'll usually set some time aside to meet with anybody."

Finkin is the author of two definitive books on tenure in the U.S.—The Case for Tenure, and For the Common Good: Principles of American Academic Freedom. He is also an author of Labor Law, a leading casebook in American legal education.

"The AAUP has been in the business of doing this since 1915, when a professor at the University of Utah was discharged, upon which many of his colleagues resigned. The AAUP put a committee together, they wrote a report, which, by the way, found that there was no violation of academic freedom. It was, rather, an intramural governance dispute. That's how it happened, quite by accident, and the AAUP started getting all these complaints.

"The investigations were never a part of the initial designs of the creation of the organization at all, but it became a mainstay of the organization's portfolio. The AAUP has been doing it for just about 100 years.

"I doubt that MD Anderson's going to find some fault in the process that has not been discerned over the previous century. The process bends over backwards, and has, from the very beginning, to ensure accuracy."

Censure = "A Black Eye"

The investigation of MD Anderson will be conducted by a committee of academics who have no involvement in the case, Finkin said.

"The important point is the committee is a neutral committee, chosen for their neutrality and expertise," Finkin said. "It's given a charge to investigate; it's not told what to find.

"The committee's report will be submitted for authorization of publication. The institution is given a full opportunity to reply, to respond, or to correct the draft before it is released.

"Authorization to publish is in the hands of the AAUP's Committee A on Academic Freedom and Tenure—it may or may not choose to authorize publication. But if it does publish, then there is a complete veneration before the academic community. The veneration of the facts and the conclusion is drawn by an impartial and expert panel.

"In terms of the possibility of sanctions, the report itself is a kind of sanction, in the sense that, everybody now knows what really happened, and the reasons and the conclusions of this committee. On the basis of published reports, the Committee A on Academic Freedom and Tenure will make a recommendation to the

organization's annual meeting and that recommendation may be to take no action, or to holdover depending on developments, or to impose censure, which goes back to the 1930s."

Imposition of censure means that MD Anderson would be listed in the AAUP's list of censured administrations, Finkin said. http://www.aaup.org/our-programs/academic-freedom/censure-list

"This means that the academic community is on notice that conditions of academic freedom and tenure are not secure in the institution," he said. "Cooperating disciplinary associations will publish the list, and some will not accept job postings from institutions that are on the censure list.

"All of this derives from the 1940 Statement [of Principles on Academic Freedom and Tenure]. There are over 200 endorsees—educational organizations and disciplinary societies.

"As to how these associations will respond to the findings, each has their own way of dealing with conclusions drawn by the AAUP. Some will not allow chapters to be opened at censured institutions, others will accept job postings from censured institutions, but will inform the readership or the membership—by the way of footnotes or the like—that the institution is censured.

"So it's a black eye. It's not something that any reputable institution would want to have."

Zwelling to AAUP: Mind Your Own Business

Several critics say that the central question should be whether faculty members whose performance was equal to or less stellar than Mehta's and Wang's were offered renewal.

Len Zwelling, a former professor at MD Anderson, criticized the AAUP's move on his blog, saying the faculty knew that they were not signing on to an indefinite tenure program.

"MD Anderson has had 7-year term tenure system throughout its existence as far as I am aware," wrote Zwelling. "When I came to Anderson 30 years ago this month, I was quite cognizant that lifetime tenure was not a benefit of a productive and protracted period of research years.

"I hope the AAUP does not seek to address the fairness of this system for frankly, it really is none of its business.

"The real question is whether or not the system is being implemented fairly and uniformly. Are all candidates nominated for promotion and tenure renewal by their department and Division leadership given equal consideration by the Promotions and Tenure Committee and then by the president who has final say? Do some less than stellar individuals make it through the process successfully due to pressure being asserted on the system by executive leadership?"

"Every single faculty member who ever signed a contract at Anderson, whether originally term-tenured or not, knew the rules. If obtaining lifetime tenure was a critical professional goal of the individual, MD Anderson should not be the locale of that individual's career in biomedicine.

Finkin said that the point of the AAUP involvement is not to debate whether academic freedom is a waivable individual right, but rather to endorse standards normative to the academic community.

"That criticism has a beard—nothing new under the sun," Finkin said. "It's an old argument, it's shop-worn, and it has no merit.

"The AAUP's position is that its standards—signed on by 200 disciplinary associations and educational organizations—are normative in the academic community," he said. "We expect the academic community expects institutions to abide by them. They're not waivable by the individual.

"Let's assume an institution says, 'We have no academic freedom, and whatever you publish has to be approved by your dean or the president beforehand,' and the faculty members governed by that system profess themselves to be entirely delighted with it, quite ecstatic to function in that regime.

"Well, who cares?" Finkin said. "The academic community says that's not a regime that should parade under the banner of being an authentic institution of higher education. It's not the individual. Academic freedom is not waivable by the individual. It allures to the benefit of the institution as a whole and, indeed, to the larger community. It's not dispensable by private disposition.

"From the very beginning, we've had institutions say, 'Well, look, he agreed to this, he signed or she signed on to this, you're an officious intermeddler, it's none of your business, this is a system we devised, and everybody's happy with it.'

"And the AAUP's position is, 'My God, this goes back decades and decades, and that's not our interest.' We're not defending the individual, we're defending the principle, and it's the question of whether the institution is abiding by acceptable principles and norms of behavior."

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A Second Letter Surfaces

In a reply to AAUP's initial letter, DePinho wrote that Mehta, one of the affected faculty members, did not receive term renewal because of a negative recommendation from his former department chair, Garth Powis (The Cancer Letter, May 30).

The documents—an email correspondence and a letter—authored by Powis, were released after the AAUP started its inquiry. Mehta said the information was not included in his case docket, and that he was not informed of the documents until they were provided to the AAUP.

The email correspondence and letter are available on The Cancer Letter website.

Powis declined to comment on the documents, which were submitted to the administration after the Faculty Senate Promotions and Tenure Committee had unanimously voted Nov. 4, 2011 to recommend Mehta for renewal.

Powis had initially written a positive letter, dated Sept. 8, 2011, recommending Mehta for renewal.

"Dr. Mehta's numerous contributions to the department and to the institution over the course of his last term of tenure certainly warrant his request for a renewal of term tenure," Powis wrote.

In a Nov. 9 email to DePinho, Powis said that Mehta at that time did not meet the required 40 percent salary support on grants, and would need more funds to support his laboratory past Dec. 31, 2011.

"The grants were listed by Dr. Mehta in his letter to the PTC but both were in a no-cost extension year with no funds," Powis wrote. "It was an oversight on the part of the department not to note to the [PTC] committee that these grants were in their no cost extension year."

Powis proceeded to recommend that the final decision by DePinho be postponed for one year—a chance for Mehta to turn his funding situation around.

It is unclear what events transpired between the email and the final letter from Powis, dated June 11, 2012, which said:

"I recommend that Dr. Mehta receive a non-renewal of appointment notification in June 2012, informing that his appointment as professor with term tenure will not be renewed beyond August 31, 2013."

Douglas Boyd, the MD Anderson professor who requested an investigation by the AAUP, wrote that other faculty members that did not meet the 40 percent requirement received renewal.

"In the case of Dr. Mehta, insufficient funding was cited as a reason, yet two faculty members with less funding and contributing less to their salary that Dr. Mehta was renewed for tenure in the corresponding cycle," Boyd wrote in a July 10 letter to the AAUP.

No credible reasons have been provided by the administration in Mehta's and Wang's case, Boyd wrote.

AAUP officials said they took Powis's letters into consideration prior to authorizing the investigation.

The text of the AAUP letter to DePinho and Cigarroa follows:

Dear President DePinho and Chancellor Cigarroa:

Thank you, President DePinho, for your candid and informative letter of May 23, responding to mine of May 13 (both are attached), regarding the cases of Professor Kapil Mehta and Professor Zhengxin Wang.

Regrettably, our primary concerns remain largely unresolved, in particular, our concern about inadequate protections for academic freedom at the MD Anderson Cancer Center under its current policies.

As I noted in my letter, the Association's foundational position, set forth in the widely endorsed 1940 *Statement of Principles on Academic Freedom and Tenure,* is that academic freedom, "the free search for truth and its free exposition," is best protected by a system of "permanent or continuous tenure," in which, after a limited period of apprenticeship, "teachers and investigators" will have their "service ... terminated only for adequate cause, except in the case of retirement for age or under extraordinary circumstances because of financial exigencies."

Seven-year renewable term appointments ("term tenure"), though perhaps more protective than one- or two-year term appointments, cannot provide the safeguards of indefinite tenure, as these two cases demonstrate.

Because of the gravity of the Association's concerns, my letter urged you to rescind the notices of nonreappointment issued to Professors Mehta and Wang and to "immediately reinstate them to their full-time appointments." In closing, I wrote that "our further course of action ... will depend on how you will act now."

Our "further course of action" has been our executive director's authorization of an investigation.

It will be undertaken under the unique circumstance of another medical school in the University of Texas system, the University of Texas Medical Branch at Galveston, having been investigated in 2009 (with AAUP censure imposed since 2010) and of the adequacy of official system policies on faculty appointments having been an issue in both investigations.

The investigating committee being selected for the MD Anderson Center will include two members

who served on the UTMB investigating committee. It will be provided with relevant available information for its examination, and it will arrange to visit Texas, most likely in September, in order to consult fully with both of you and with such members of the faculty and the administration as may be designated, thus to ensure that MD Anderson will have a more-than-adequate opportunity to present its position.

As to the locations of the visit, in the Medical Branch case, Chancellor Cigarroa had designated Executive Vice Chancellor for Health Affairs Shine and Vice Chancellor and General Counsel Burgdorf to write in his behalf following the receipt of the AAUP's initial letter, and our committee accordingly went first to Austin for meetings with those three.

It next went to Galveston for meetings with President David Callender, Provost Garland Anderson, a number of professors who had been notified of layoff, and another professor who had not. We shall welcome your advice on whether our MD Anderson committee should plan to visit both Austin and Houston or whether a Houston visit will suffice.

The ad hoc committee will prepare a report for the consideration of the Association's standing Committee A on Academic Freedom and Tenure, which may authorize its publication.

Under Association procedures, prior to any publication a draft text is submitted on a confidential basis to the institution's chief administrative officers and to others principally concerned in the report, with an invitation to them to offer corrections of any factual errors and whatever other comments they deem suitable.

We shall be writing again soon with the names of the members of the investigating committee and about potential dates for the committee's visit. We should like at this time to emphasize the Association's receptivity in this case, as in all others, to resolutions of our concerns that would preclude the necessity for the investigation now authorized.

Sincerely,
Gregory F. Scholtz

MSKCC Tops MD Anderson In U.S. News & World Report Cancer Center Rankings

(Continued from page 1)

The contest between MD Anderson and MSKCC provides the consumers and researchers alike with the opportunity to examine what the U.S. News hospital rankings measure—and, just as importantly, what they don't measure.

While many health services researchers dismiss the magazine's ranking system as non-scientific, their own institutions aren't reticent to use these rankings aggressively in marketing. MD Anderson has been heralding its primacy on billboards at airports, in ads that pop up on computer screens and news publications, and in outgoing messages on the cancer center's phone system.

The top spot in the U.S. News rankings of cancer hospitals represents the ultimate bragging rights in oncology. High grades from U.S. News can help compete for patients and enhance ability to raise funds.

The change at the pinnacle of the rankings appears to have occurred because the magazine changed the methodology it uses to calculate scores. The scoring system this year changed in two ways, both of which likely influence rankings, especially in the case of MD Anderson vs. MSKCC.

• The safety score was expanded to include two new metrics and given a greater weight in the overall composite score. MSKCC gets significantly higher marks in safety than MD Anderson. In 2013, safety score accounted for 5 percent of the grade. In 2014, it accounts for 10 percent.

• The "reputational" score, in which MD Anderson consistently does better than MSKCC, became a less important component in calculation of the overall grade. Last year, the reputational score accounted for 32.5 percent of the grade. Now, it accounts for 27.5 percent.

The manner in which institutions use the U.S. News rankings is symptomatic of the intense thirst for metrics that could enable consumers to compare institutions—and even categories of institutions, such as academic centers vs. community care.

Full ranking of cancer centers, released today, is posted on the U.S. News website.

What does the 0.1 percent gap really mean?

"Not much," said Rena Conti, an economist at the University of Chicago and co-author, with this reporter, of a recent paper on metrics of quality of care published in the Journal of Oncology Practice. "The differences

in the rankings are to health services research what astrology is to astrophysics. In this contest over top bragging rights, the joy of victory is as irrelevant as the agony of defeat."

Avery Comarow, health rankings editor at U.S. News, said the overall 0.1 difference in rankings is probably meaningless, but the difference in safety scores likely conveys meaning.

"I would hate for any family or patient to make a decision based on five points or ten points, let alone one-tenth of a point," Comarow said to The Cancer Letter. "Cancer is one of those broad specialties where a patient's own cancer and a particular cancer center's experience and expertise in dealing with that cancer is far more important than a few points difference in score between a couple of centers."

Patient safety—where MSKCC scored in the excellent range and MD Anderson in the mediocre range—is another matter.

"[The safety metric] matters enough to make it an important part of the score," Comarow said. "Whether patients should be making that the basis of a decision is an individual choice. I would look at something like that fairly carefully myself.

"I would look at something like pressure ulcers. And it would probably alert me to the necessity of having someone with me. If I am an inpatient following surgery, I can't advocate for myself. That person would make sure that I am turned regularly and I am clean, and I am on one of those special mattresses that alternate pressure on different parts of the body. I would want someone watching after me, paying attention to some of these potential deficiencies or problems that the patient safety score might reflect. It would probably not determine my final choice."

In safety overall, MSKCC got the score of five—the highest. MD Anderson scored two. The same difference in scores was observed in the metric of preventing pressure ulcers, or skin breakdown from prolonged bed rest, weight, dressing and other factors.

"In cancer, more than anything else, I would want to know how patients have done at that center," Comarow said.

The U.S. News index measures 30-day survival, and both centers received the same top score of 10. "I wish like crazy that five-year survival were available, but it's not," Comarow said. "Since five-year survival isn't available, then a short-term proxy is what we use. And here you can see that most of the centers at the top of the rankings do very, very well."

The Problem of Reliable Metrics

Survival is indeed recognized the gold standard in drug trials, but it's not viewed as a reliable measurement of quality of care, especially in comparison of outcomes at different institutions.

Different hospitals get different mixes of patients. For example, a patient at a top-level academic cancer center may be there because of severity of her disease. On the other hand, that same patient could be better educated, more motivated, better insured, healthier and able to travel.

There is no known way to adjust for such differences in patient populations (The Cancer Letter, March 18, 2011).

The reputational score—still a dominant component of the U.S. News index—seems not to have reflected what insiders, particularly faculty, describe as morale problems at MD Anderson (The Cancer Letter, May 23).

Many insiders attribute these problems to top leadership, particularly the institution's president, Ronald DePinho. Some of these insiders say morale problems have affected the quality of care (The Cancer Letter, Sept. 20, 2013).

The U.S. News index isn't calibrated to measure such changes inside institutions, and in fact seeks to avoid gauging sudden changes by averaging out some metrics over three years.

According to a document describing the methodology in the index:

"The process component of the IHQ score is represented by a hospital's reputation. For these rankings, the concept of reputation speaks to an institutional ability to develop and sustain a system that delivers high-quality care to especially challenging patients. It can be seen as a form of peer review. A hospital's reputational score is based on the average of responses from the three most recent annual surveys of board-certified physicians conducted for the Best Hospitals rankings, which for the 2014-15 rankings were conducted in 2012, 2013 and 2014.

"A random sample of 200 board-certified physicians is selected in each specialty from the American Medical Association (AMA) Physician Masterfile, a database of more than 850,000 physicians. The physician sample is stratified by census region—West, Northeast, South and Midwest—and by specialty to ensure appropriate representation. The final aggregated sample includes both federal and nonfederal medical and osteopathic physicians in all 50 states and the District of Columbia.

"The surveyed physicians were asked to nominate the hospitals in their specific field of care, irrespective

of expense or location, they consider best for patients with serious or difficult conditions. Up to five hospitals could be listed. For the 2014-15 rankings, a new initiative was added to address declining response rates by the survey sample drawn from the AMA database and to evaluate a broader set of physician responses. An additional survey was conducted with the Doximity online panel of physicians. The results were analyzed separately and incorporated as a small percentage of the reputation score for 2014."

The methodology paper shows that 31.3 percent of the 200 cancer specialists randomly selected to set the score responded to the survey. After that, the score is combined with another survey and averaged over three years. Last year, MD Anderson's reputational score was 67.7 percent. This year, it's 67.5. MSKCC scored 62 percent last year and 64.7 percent this year.

Of course, the weight given to the score has been reduced, a change that favors MSKCC.

Past Irregularities with Data Submitted by MD Anderson

Last year, this publication reported that systematic misclassification of emergency patients at MD Anderson Cancer Center has enhanced that institution's rating by U.S. News over the past seven years.

The miscounting led to exclusion of nearly 40 percent of admissions, was discovered and corrected in mid-2009, but no reliable way could be found to adjust the results to reflect the missing data, officials at U.S. News and MD Anderson confirmed.

Since U.S. News averages data over three years, the results of the MD Anderson top rating by the magazine released last year were still partially based on tainted data.

Insiders say that MD Anderson had been submitting incorrect data submitted to Centers for Medicare and Medicaid Services. U.S. News doesn't ask hospitals to provide data directly, relying instead on government databases, which are less prone to tampering.

The problem was caused by an error, MD Anderson officials said. The error was discovered by MSKCC officials and acknowledged by their counterparts at MD Anderson, but U.S. News editors said a recount would be impossible, because of the volume of missing data. Just as importantly, the methodological pillar of the index—not accepting data from institutions directly—was at stake.

Insiders, including Comarow, say that had data been submitted, the top spot would have been likely to have been traded by MD Anderson and MSKCC (The Cancer Letter, July 19, 2013).

The data are averaged over three years, and the last of the tainted data were used in the U.S. News 2013 rankings.

"The statistics based on volume now reflect reality at MD Anderson," Comarow said of the current year's results. "These three years should be clean."

MSKCC is "proud and honored" to be named the number one hospital for cancer care in the nation, officials said.

"We are delighted and honored to once again be a top hospital for cancer," said MSKCC President and CEO Craig Thompson in a statement. "But this recognition is really a reflection of an entire community of exceptional people—our dedicated staff of almost 13,000 and our patients, who have placed their trust in our care. We may be number one in the national rankings for this year, but our patients are number one to us every day.

"While competition among medical institutions in the New York metro area is high (MSK ranked number seven of all hospitals in New York City), MSK's singular focus on cancer means the hospital far outranks its neighbors for cancer care."

Ranking second this year is a sign of success, MD Anderson officials said in a statement.

"MD Anderson has been ranked either first or second for the 25 years that the U.S. News & World Report 'Best Hospitals' survey has been conducted. We're honored by the designation and thank U.S. News & World Report for providing this important service to readers.

"Ranking No. 2 this year among all of the other superb cancer hospitals reflects our success in recruiting and retaining world recognized faculty and staff, extending our reach globally for the benefit of cancer patients, increasing our philanthropic support and securing our financial future.

"We continue to be recognized as one of the best cancer hospitals and take great pride in this year's ranking as in other years. We also congratulate Memorial Sloan Kettering Cancer Center on their No. 1 ranking this year, as well as all of the superb cancer hospitals that received recognition."

The U.S. News index was never intended to provide bragging rights—and marketing advantage—based on minute differences in scores, Comarow said.

"It's never been something that we've especially cared for," he said. "The differences between No. 1 and No. 2 and No. 3 and No. 4 is so small that there are very few specialties where these differences between

the very top hospitals amount to a hill of beans.

"It's just human to think of horse races, and if you are a marketing person, it's part of your DNA."

Matthew Bin Han Ong contributed to this story.

Capitol Hill

Advocates Lobby Congress To Close Medicare Loophole For Colonoscopy Coverage

By Tessa Vellek

A coalition of advocacy groups focused on colorectal cancer asked Congress to fix the loophole in Medicare coverage of colonoscopies.

The group, organized by Fight CRC and the American Cancer Society Cancer Action Network, met July 16 to lobby for proposed legislation that would ensure cost is not a barrier to colon cancer screenings.

Under Medicare rules, routine colonoscopies are classified as a free preventative service, but there is a loophole when polyps are removed. The removal of these polyps requires a co-pay. On the other hand, private insurance is required by the Affordable Care Act to cover the entire screening procedure, regardless of whether polyps are removed.

The 'Removing Barriers to Colorectal Cancer Screening Act,' (H.R. 1070 & S. 2348) sponsored by Rep. Charlie Dent (R-Penn.) and Sen. Sherrod Brown (D-Ohio), would eliminate cost sharing for Medicare beneficiaries.

"Colonoscopies are proven to prevent colon cancer and save lives, but any cost-sharing can be a deterrent from getting the screening," Chris Hansen, president of the American Cancer Society Cancer Action Network, said in a statement. "This important bill would help ensure that seniors would have access to lifesaving cancer screenings, regardless of their ability to pay."

The lobbying day began with a breakfast meeting with stakeholders—patients, survivors, advocates, and health care providers—led by Dent, Rep. Donald Payne, Jr. (D-N.J.), and Rep. Leonard Lance (R-N.J.). Advocates then held more than 60 meetings with lawmakers to ask for their support of the proposed legislation to remove barriers for colon cancer screening.

Payne's father died of colon cancer two years ago.

On May 30, Payne and Brown, along with Reps. Joe Courtney (D-Conn.), Henry Waxman (D-Calif.), Sander Levin (D-Mich.), Frank Pallone (D-N.J.), and Jim McDermott (D-Wash.), wrote a letter to President Barack Obama requesting a closing of the loophole in Medicare coverage of polyp removal during a colonoscopy screening.

The text of the letter follows:

Dear Mr. President:

Colorectal cancer is the third leading cause of cancer deaths in the United States. This year, approximately 140,000 adults (two-thirds of whom are age 65 and older) will be diagnosed with colorectal cancer and more than 50,000 will die from the disease. These statistics are disturbing because colorectal cancer is one of the most preventable cancers thanks to highly-effective screening tools, including colonoscopy. Regular colonoscopy screenings can be the difference between life and death. Yet, about one in three adults between the ages of 50 and 75—about 23 million people—are not getting screened as recommended.

The Administration's interim, final regulations (OCIIO-9992-IFC) recognize the important role that preventive screenings can play in preventing colorectal cancer. The interim rule with the clarifying guidance provides that a plan or issuer cannot impose cost-sharing for polyp removals that occur during a colonoscopy performed as a screening procedure. We support this rule but are troubled by the fact that Medicare's policy of requiring coinsurance for polyps removed during a screening is contrary to this rule.

Specifically, under current law, Medicare beneficiaries are not liable for cost-sharing (coinsurance or deductible) for services that have an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF). Colorectal cancer screening is a preventive service that has an "A" rating from the USPSTF. According to the USPSTF, "screening for colorectal cancer reduces mortality through detection and treatment of early-stage cancer and detection and removal of adenomatous polyps." Yet the removal of precancerous polyps—which occurs during the screening—still requires that Medicare beneficiaries pay a coinsurance fee.

The Administration has promoted screening colonoscopies to Medicare beneficiaries as a preventive service not requiring cost sharing. However, more than three years after implementation of the preventive benefits provisions of the Affordable Care Act, Medicare beneficiaries remain liable for coinsurance if a polyp is removed during a screening colonoscopy.

We believe that this Medicare policy is counterproductive, inconsistent, and unfair to

Medicare beneficiaries who have no way of knowing whether or not this preventive measure will result in a coinsurance payment.

Polyp removal is the preventive component of colorectal cancer screening colonoscopy. That is why we urge the Administration to treat screening colonoscopies with polyp removal consistently for both those who utilize private insurance and those insured under Medicare.

We ask that you work with us to explore every administrative avenue to ensure beneficiaries have access to this life-saving preventive service. We look forward to hearing from you regarding this important issue.

In Brief

Pietenpol Named to IOM National Cancer Policy Forum

(Continued from page 1)

Pietenpol is the B.F. Byrd Jr. Professor of Oncology and director of Vanderbilt-Ingram Cancer Center. She is currently serving the last year of a six-year term on the National Cancer Advisory Board.

The IOM established the National Cancer Policy Forum to serve as a venue for national leaders from multiple sectors to work cooperatively to address high-priority policy issues in the nation's effort to combat cancer.

Panel participants include clinicians, patients, researchers, professional and advocacy organizations, pharmaceutical manufacturers and policymakers. During the most recent meeting, members examined the issue of escalating treatment costs, as well as shortages of some cancer drugs and the impact of these issues on cancer patients and their families.

THE UNIVERSITY OF ARIZONA HEALTH NETWORK executed a principles-of-agreement document with **Banner Health** to create a statewide health care organization and a comprehensive new model for academic medicine. This agreement is intended to lead to final agreements in September.

The anticipated transition of 6,300 employees from the university health network's two hospitals, the health plan and the medical group to Banner Health will create Arizona's largest private employer, with more than 37,000 employees.

The final agreements must also be approved by the Arizona Board of Regents and the boards of directors of the two parties.

The key elements of the proposed transition include: creating an Arizona-based, statewide health system; expanding the University of Arizona Medical Center capabilities for academic/clinical programs such as transplantations, neurosciences, genomics-driven precision health, geriatrics, and pediatrics; eliminating the debt burdening the university health network, currently projected to be $146 million; improving hospital infrastructure, including the $21 million purchase of land currently leased to UAMC and $500 million within five years to expand and renovate the medical center; and creating a $300 million endowment.

ROSWELL PARK CANCER INSTITUTE was granted approval to begin genomic testing of cancer patients by the **New York State Department of Health**.

The OmniSeq Target advanced molecular diagnostic laboratory test was approved through the department's Clinical Laboratory Evaluation Program.

OmniSeq Target is one of only three tests approved for use in New York State that use next-generation sequencing, and is the only assay to exclusively target actionable mutations. The test is part of an approach developed by the RPCI Center for Personalized Medicine for profiling and interpreting genetic information contained in tumor tissue.

The test analyzes 23 different cancer-associated genes, detecting gene mutations, translocations and copy-number changes, and looks for specific alterations and aberrations that indicate particular forms or targetable molecular characteristics of cancer. The test employs a dual sequencing platform for mutation testing, simultaneously using the Ion Torrent and Illumina sequencing platforms.

THE MEDICAL COLLEGE OF WISCONSIN received a five-year, $2.6 million grant from **NCI** to study new therapeutic approaches for pancreatic cancer.

Michael Dwinell, associate professor of microbiology and molecular genetics; and **Balaraman Kalyanaraman**, the Harry R. & Angeline E. Quadracci Professor in Parkinson's Research and professor and chairman of biophysics, are co-principal investigators of the grant.

Researchers will investigate a combination of energy metabolism inhibitors with relatively nontoxic mitochondria-targeting drugs. The results will advance researchers' understanding of the roles of metabolism and energy in pancreatic cancer malignancy.

This project will also be conducted with NCI intramural researchers Murali Krishna Cherukuri, head of the biophysical spectroscopy section of the Radiation Biology Branch; and Peter Choyke, chief of the molecular imaging program in the Center for Cancer Research, who will consult on the project.

DANA-FARBER CANCER INSTITUTE formed a three-year immuno-oncology lung cancer research collaboration with **Johnson & Johnson Innovation** and **Janssen Biotech Inc**.

Janssen scientists will work with the research team at Dana-Farber's Belfer Institute for Applied Cancer Science to determine the clinical setting for certain immuno-oncology agents in Janssen's lung cancer pipeline.

Researchers will also seek to identify rational immuno-oncology drug combination strategies and biomarkers, and to characterize mechanisms of resistance. The collaboration will also identify and validate novel targets for lung cancers.

ELI LILLY AND COMPANY and **Immunocore Limited** entered into a co-discovery and co-development collaboration to research and develop novel T cell-based cancer therapies.

Immunocore will receive an upfront fee of $15 million per program for the discovery of novel monoclonal T-cell receptors against jointly-selected cancer targets in order to generate preclinical candidate packages.

If Lilly accepts a preclinical candidate package to develop and potentially commercialize, Immunocore will receive an opt-in fee of $10 million and will have an option to continue co-development with Lilly on a cost-sharing and profit-sharing basis. If Immunocore does not exercise its option, it will be entitled to potential future significant milestone and royalty payments.

THE OHIO STATE UNIVERSITY and the **UNIVERSITY OF MICHIGAN** have signed an agreement with Ohio-based **Venture Therapeutics Inc.** to form a new company to develop and commercialize a pharmaceutical technology targeted for the treatment of precancerous oral lesions.

The technology developed by researchers at The Ohio State University College of Dentistry with secondary appointments at the OSU Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute and the University of Michigan addresses a significant unmet need related to the prevention of oral cancer. Precancerous oral lesions can be seen and touched by patients, so this easy access to the lesion allows the use of local delivery formulations in an oral patch to directly treat the disease without causing adverse side effects.

Susan Mallery, professor and interim chair of the division of oral pathology and radiology at the Ohio State College of Dentistry and member of the OSUCCC–James Molecular Carcinogenesis/Chemoprevention Research Program, worked alongside researcher Steve Schwendeman, from the University of Michigan College of Pharmacy and the Biointerfaces Institute to invent this breakthrough technology. Kashappa Goud Desai also worked with Schwendeman on the patch design and development during his post-doctoral studies at the University of Michigan.