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Medicare's 21% Pay Cut In Effect Today; Congress Unlikely To Abandon SGR

By Paul Goldberg

Barring a last-minute reprieve from Congress, on Friday, June 18, all doctors—oncologists among them—will be subjected to a 21.3 percent pay cut from Medicare.

This drop in reimbursement will continue until Congress alters the Sustained Growth Rate schedule that was enacted in 1997 to control health care costs, but never produced any sustained cuts.

While doctors were spared actual cuts year-to-year, the impact of SGR has accumulated, creating a $247 billion budgetary illusion, which Congress seems to have no political will to abandon.

Now, oncologists say that these SGR meltdowns could cause them to

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In the Cancer Centers:

Ohio State Breaks Ground For $1 Billion Expansion Of Medical Center, Cancer Hospital

OHIO STATE UNIVERSITY breaks ground June 18 for ProjectONE, a $1 billion Medical Center expansion that represents one of the largest job-generating initiatives in Ohio's history and will result in the creation of 10,000 full-time jobs.

Ohio Gov. **Ted Strickland**, Columbus Mayor **Michael Coleman** and NCI Director **John Niederhuber**, an Ohio State University College of Medicine alumnus, are among those participating in the groundbreaking ceremony.

Of the full-time jobs created over the course of the project, 6,000 will be at the Ohio State Medical Center. More than 4,000 indirect, full-time jobs will be generated throughout the region from spending by Ohio State, its faculty, staff and visitors. An additional 5,000 construction jobs also will be created. By 2015, ProjectONE will infuse $4.1 billion annually into the Ohio economy.

Once completed, ProjectONE will include a centralized single tower that will house a new Arthur G. James Cancer Hospital and Richard J. Solove Research Institute along with a new critical care building, integrated spaces for research, education and patient care, and upgrades to existing facilities.

The new facilities will feature private rooms with abundant natural light and visual and physical access to green space. Patient rooms on the critical

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Study: Medicare Cut Caused Doctors To Give Costlier Drugs

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transfer their Medicare patients to hospitals—if hospitals agree to take them.

"We do some financial vetting of each patient because of the decreased Medicare reimbursement of the past few years, so I think it would just accelerate that process," said Leonard Kalman, chairman of US Oncology's Public Policy Steering Committee and a Miami oncologist. "If we do an evaluation and it's so unacceptable because of these cuts, then we have to call the hospital and let them know that a certain set of patients would be coming to the hospital, and they would have to decide whether they would find that acceptable. That would be an era we've never entered before."

Allen Lichter, CEO of the American Society of Clinical Oncology, said the government's inability to resolve the SGR problem is undermining Medicare.

"Eventually, as we keep bouncing from patch to patch, physicians will begin to withdraw from Medicare in increasing numbers, and that threatens the viability of the Medicare program," Lichter said.

This is not the first time oncologists voiced such warnings. Over the past decade, as Congress limited their ability to earn a return on selling infusional drugs in the outpatient setting, oncologists predicted that the system would become unstable and Medicare patients would not be able to obtain care.

However, policymakers and some health systems researchers point out that, warnings notwithstanding, the cancer care system in the U.S. continues to function. On June 17, as CMS stood poised to apply the new cuts, the journal Health Affairs published a paper that argued that earlier changes in Medicare reimbursement in oncology have not resulted in a decrease in access to services.

Based on Medicare claims data on lung cancer, the paper argues that the likelihood that patients would receive chemotherapy has, in fact, increased since Congress limited the doctors' ability to profit from drugs.

Also, patients are now more likely to receive the more expensive drug docetaxel and less likely to receive lower-cost drugs carboplatin and paclitaxel.

ASCO as well as some health sciences researchers debate the paper's methodology and validity of its conclusions. Overall, the fact that the oncology system has not yet collapsed is a lousy predictor of its continuing viability, insiders say.

Consider the SGR debacle. Washington insiders say that it's unthinkable that the current 21.3 percent cut would stay in effect long. However, it's equally unthinkable that legislators would gather the resolve to fix the problem permanently by abandoning the fiction of SGR.

"This is the shape of things to come," Lichter said. "This becomes a surrogate for talking about the budget deficit, and who is fiscally responsible. We are debating healthcare reform and everything else under the sun. It becomes a tool to use to score political points.

"If we keep limping along with patches for another two or three years, the $247 billion accounting cost for this will start to get to $350 or $400 billion. There will be a point where we will cross a threshold where this can never be fixed. And then physician fees become political football forever."

As Medicare starts to make cuts, the money would probably be refunded after Congress slaps another patch on the system, Washington insiders say. However, many practices may run into the red.

"Think about running a medical oncology office, where you are paying a substantial number of staff," Lichter said. "And you are purchasing the pharmaceutical agents that you use to treat your patients with. And the distributors of those drugs want payment, and your staff wants salary, and people you rent your office space from want the rent. And there is no money. Medicare is holding all the bills. They thought it was going to be patched. If they actually do the cut, they will start processing the bills that were submitted on June 1."

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Medicare cannot process bills sooner than two weeks after they are submitted.

"If the cut goes in place, and they make the cuts and then fix it, to get the extra 21 percent, you have to re-bill, and the cost of submitting another bill makes this thing a travesty," Lichter said.

Though ASCO and other medical groups would prefer to see SGR repealed, as a practical matter, most groups support a Congressional action that would provide a 19-month SGR patch (H.R. 4213). The measure, which has been bouncing between the House and Senate, would give a 2.2 percent increase to payments for June through December 2010, and an increase of one percent for 2011.

The SGR cut went in effect in June 1. However, CMS is precluded by statute from paying claims earlier than 14 days after they are submitted, which in this case gave the agency as 14-day delay. On June 14, the agency instructed its contractors to hold off on processing the claims through June 17, in anticipation of Congressional action. In the absence of such action, the processing of claims at a reduced rate was scheduled to begin on June 18.

The American College of Physicians was similarly outraged by the situation. "ACP realizes that even a temporary reduction in payments creates havoc for practices and the fact that Congress has already enacted three short-term patches to delay payment cuts compounds the problem," ACP said in a statement. "The situation is unacceptable and the frustration and anger is understandable. The College continues to apply maximum pressure on Congress to immediately halt the cut by enacting legislation that provides stable and predictable payments—with the goal of a permanent fix."

Have Medicare Cuts Changed Cancer Care?

The Health Affairs paper by Mireille Jacobson *et al.* is intriguing, because it suggests that in order to make up for cuts enacted in 2003—when Medicare switched from a formula based on Average Wholesale Price to one based on Average Sales Price—doctors started treating more patients with more expensive drugs.

The text of the abstract follows:

"The Medicare Prescription Drug, Improvement, and Modernization Act, enacted in 2003, substantially reduced payment rates for chemotherapy drugs administered on an outpatient basis starting in January 2005. We assessed how these reductions affected the likelihood and setting of chemotherapy treatment for Medicare beneficiaries with newly diagnosed lung cancer, as well as the types of agents they received. Contrary to concerns about access, we found that the changes actually increased the likelihood that lung cancer patients received chemotherapy. The type of chemotherapy agents administered also changed. Physicians switched from dispensing the drugs that experienced the largest cuts in profitability, carboplatin and paclitaxel, to other high-margin drugs, like docetaxel. We do not know what the effect was on cancer patients, but these changes may have offset some of the savings projected from passage of the legislation. The ultimate message is that payment reforms have real consequences and should be undertaken with caution."

The data showed that prior to January 2005, 16.5 percent of patients received chemotherapy within one month of diagnosis. After implementation of the new payment system, chemotherapy treatment within one month increased 2.4 percentage points ($p<0.001$) to 18.9 percent.

By analyzing claims related to 222,478 Medicare beneficiaries with a confirmed lung cancer diagnosis between 2003 and 2005, the paper found the following shift in the use of drugs:

"Among those treated with chemotherapy, the percentage receiving carboplatin declined from almost 56 percent to 54 percent, and the percentage receiving paclitaxel declined from 30 percent to 26 percent, consistent with the large decline in payment rates for these agents. In other words, physicians were prescribing these drugs to a smaller share of chemotherapy-treated patients than before because there was far less financial inducement to use them.

"Because carboplatin and paclitaxel are often given in combination, and because carboplatin probably retained a margin above 6 percent of average sales price for a few quarters because of the lag in prices used to determine average sales price, some of carboplatin's decline may have been driven by the sharp reduction in paclitaxel's profitability. By contrast, trends in use of docetaxel and etoposide were comparatively flat."

The findings are likely to be influential in Washington, said Peter Bach, a cancer policy researcher at Memorial Sloan-Kettering Cancer Center and a former advisor to Medicare.

"The article confirms at a disease-specific level what a couple of more macro level analyses have already shown: the payment cuts did not lead to a loss of access," Bach said.

"So, policymakers are going to see this as more evidence that oncologists were crying wolf, which will embolden even deeper cuts. But the real challenge

here is that the analysis, just like the Dartmouth atlas way of viewing Medicare, focuses only on spending and views spending unfavorably. Nowhere in here can we figure out if care is higher quality, or patients more comfortable. I'm not saying definitively that patients were better or worse off—just that it is important to not lose sight of that issue, and to some extent we have in these sorts of Medicare analyses.

"After all, the paper at some level shows that more Medicare patients are getting treatments that are supported with Level 1 evidence after the payment change. I have a hard time just seeing that as a negative."

US Oncology's Kalman concurs with the paper's contention that reimbursement can influence the choices of therapy.

"They created a system that would incentivize the use of more expensive drugs," Kalman said. "I believe oncologists always choose efficacy first. Next is toxicity. There are many cases where efficiacy and toxicity are identical. On the third level, is efficacy is the same and toxicity is the same?

"I don't believe that oncologists would use expensive drugs to the detriment of the patient. But there are many many examples where drugs are equally efficiacious and equally toxic, where the CMS system incentivises the use of the more expensive drug, much to their detriment. Shame on them for creating such a silly system."

Kalman said a more rational system would reward oncologists for limiting the cost of care.

However, Kalman said he hasn't seen any evidence of overtreatment among elderly lung cancer patients. "The decision to treat is not based on payment system," he said. "If a patient needs treatment, he needs treatment."

ASCO's Lichter said that access may not have been affected in part because CMS had placed additional funds into the system by enacting a "demonstration project" that paid doctors substantial sums to use Medicare claims to collect information on toxicity. The project's objective was, in part, to soften the impact of the cuts.

"It's not surprising that access was not affected in 2005," Lichter said.

Also, it's overly simplistic to argue that a practice earns a higher return on a more expensive drug, Lichter said.

The more relavant question is whether a drug can be obtained for less than the Medicare reimbursement rate. "Sometimes a drug that is expensive is no longer useful to your practice because you can't purchase it for what the reimbursement is," Lichter said. "Similarly, a drug that is less expensive sometimes is economically viable, because at least you can recoup your costs."

The claim that the changes led to greater utilization of chemotherapy is not persuasive, either, Lichter said.

"You look at the numbers, and basically 16 percent of these elderly lung cancer patients were treated under under AWP, and that went to 18 under ASP," Lichter said. "It's like we are sitting around, and we are saying, `Guys, over the next six months, we are going to see 50 Medicare lung cancer patients, and traditionally we would treat eight of them with chemotherapy. But because of this huge seachange in the way we are reimbursed, I think we should treat nine instead of eight.' If that's now the field responded, it's a prety meek response."

Also, these findings don't seem to be reflected in the aggregate sales data for chemotherapy drugs. Total Medicare drug reimbursement payments flattened out between from 2004 and 2006, after growing at 15 percent per year prior to that. In 2009 and early this year, total revenues coming into medical oncology practices has been declining, Lichter said.

ASCO has collected anecdotal accounts of physicians closing practices and moving into hospitals. "We are trying to gather data," Lichter said. "It's not the easiest thing to do, but we have enough anecdotal examples to know that this is a meaningful trend."

Finally, the quality of care issue shouldn't be ignored, Lichter said. "At the plenary session of ASCO, a paper was presented about elderly patients with lung cancer," he said. "We recognize today that elderly patients should receive more intensive chemotherapy than they have been getting in the past, and their survival increases. There is a sense when you see the Health Affairs article that 16 percent is the right number and 18 percent is something wrong. But as we look at this, more therapy was probably the correct direction to go into, and probably is the direction that should continue."

The Health Affairs paper is posted at http://www.healthaffairs.org.

FDA Approvals

FDA Approves New Indication For Tasigna In Leukemia

The U.S. Food and Drug Administration approved a new indication for Tasigna (nilotinib) for the treatment of Philadelphia chromosome positive chronic phase chronic myeloid leukemia (Ph+ CP-CML).

Tasigna is believed to work by blocking a signal that leads to leukemic cell development. The new indication expands the use of Tasigna to adult patients in earlier stages of the disease. The FDA originally approved Tasigna in October 2007 for the treatment of Ph+CP-CML in adult patients whose disease had progressed or who could not tolerate other therapies, including Gleevec (imatinib).

When Tasigna was originally approved in 2007, the FDA identified that the therapy placed patients at risk of an abnormal heart rhythm called QT prolongation. In March 2010, the FDA approved a Risk Evaluation and Mitigation Strategy (REMS) for Tasigna to help patients and health care professionals to better understand this risk. The REMS includes an updated Medication Guide and a communication plan to help reduce medication errors involving drug-food interactions and incorrect dosing intervals.

"It's important for companies to continue developing oncology drugs for earlier stages of the disease once they have demonstrated clinical effectiveness in resistant forms of cancer," said Richard Pazdur, director of the Office of Oncology Drug Products, part of the FDA's Center for Drug Evaluation and Research. "This approach has the potential to increase the availability of an effective treatment to more patients."

In CML, too many blood stem cells develop into a type of white blood cell called granulocytes. These granulocytes are abnormal and do not become healthy white blood cells. These cells can build up in the blood and bone marrow so there is less room for healthy white blood cells, red blood cells, and platelets. When this happens, infection, anemia, or unexpected bleeding may occur.

The FDA granted Tasigna a priority review for Ph+ CP-CML. The agency completed the review in six months. The new indication for Tasigna was approved under the FDA's accelerated approval program, which allows FDA to approve a drug to treat serious diseases with an unmet medical need based on an endpoint thought to reasonably predict clinical benefit. The company is required to collect additional long term efficacy and safety information data confirming the drug's benefit. The accelerated approval program provides earlier patient access to promising new drugs while the confirmatory clinical trials are being conducted.

The safety and effectiveness of Tasigna were evaluated in a single clinical trial enrolling 846 patients with newly diagnosed Ph+ CP-CML. Patients received either Tasigna or Gleevec until the disease worsened, or until unacceptable side effects developed. The study was designed to measure a significant reduction in the surrogate endpoint of the number of CML cancer cells in the blood stream (i.e., major molecular response) at 12 months. About 44 percent of patients who received Tasigna experienced a major molecular response, compared with 22 percent of patients receiving Gleevec.

In patients with newly diagnosed CP-CML, the most commonly reported non-blood-related adverse drug reactions were rash, itching (pruritus), headache, nausea, fatigue, and muscle pain (myalgia). Serious blood-related drug reactions included decrease in bone marrow activity (myelosuppression), low level of platelets in the blood (thrombocytopenia), decrease in infection-fighting white blood cells (neutropenia), and anemia.

Other FDA-approved drugs to treat CML include Gleevec in May 2001 and Sprycel (dasatinib) in June 2006. Tasigna and Gleevec are marketed by East Hanover, N.J.-based Novartis Pharmaceuticals. Sprycel is marketed by New York City-based Bristol-Myers Squibb.

Jevtana Approved To Treat Advanced Prostate Cancer

FDA approved Jevtana (cabazitaxel), a chemotherapy drug used in combination with the steroid prednisone to treat men with prostate cancer.

Jevtana is the first treatment for advanced, hormone-refractory, prostate cancer that has worsened during or after treatment with docetaxel.

Jevtana was reviewed under the FDA's priority review program, which provides for an expedited six-month review for drugs that may offer major advances in treatment, or provide a treatment when no adequate therapy exists.

"Patients have few therapeutic options in this disease setting," said FDA's Pazdur. "FDA was able to review and approve the application for Jevtana in 11 weeks, expediting the availability of this drug to men with prostate cancer."

Jevtana's safety and effectiveness was established in a single, 755-patient study. All study participants had previously received docetaxel. The study was designed to measure overall survival (the length of time before death) in men who received Jevtana in combination with prednisone compared with those who received the chemotherapy drug, mitoxantrone, in combination with prednisone. The median overall survival for patients receiving the Jevtana regimen was 15.1 months compared with 12.7 months for those who received the mitoxantrone regimen.

Side effects in those treated with Jevtana included decrease in infection-fighting white blood cells (neutropenia), anemia, decrease in the number of white blood cells (leukopenia), low level of platelets in the blood (thrombocytopenia), diarrhea, fatigue, nausea, vomiting, constipation, weakness (asthenia), and renal failure.

Jevtana is marketed by Bridgewater, N.J.-based Sanofi-Aventis.

Philanthropy:

Foundation for NIH Program Funds Outcomes Research

Observational Medical Outcomes Partnership announced the winners of its OMOP Cup methods competition, which featured two separate challenges designed to help predict associations between therapeutic drugs and medical outcomes (or adverse events).

It encouraged participation from researchers of many fields and entities—both public and private. OMOP is a public-private partnership created to determine whether existing health care data—such as electronic health records or insurance claims—can be employed to identify potential drug risks.

The ability to use large health care data sources and efficient and effective statistical tools to analyze them to solve drug safety concerns has been lacking. The OMOP Cup sought to fill that gap.

OMOP is a two-year project funded through, and managed by, the Foundation for the National Institutes of Health. OMOP draws on the expertise and resources of the pharmaceutical industry, FDA, other federal agencies, academic institutions and non-profit organizations to improve the monitoring of drugs for safety and benefits.

For the competition, OMOP provided a data set of hypothetical records for competitors to use in creating their analysis methods.

The first challenge rewarded best overall performance, while the second looked at performance over time, as data accumulated. Entries were scored on how accurately they distinguished between "true" drug-event relationships and "negative" controls.

Although only U.S. competitors were eligible for prizes, individuals and teams from around the world—69 in all—participated in the challenges. Twenty-one beat OMOP's own internal benchmarks.

The $10,000 prize for Challenge 1 went to David Vogel of Data Mining Solutions. The top-performing method for Challenge 1 was developed by Martijn Schuemie of Erasmus University in the Netherlands.

A University of Iowa health informatics team comprising Lian Duan, Mohammad Khoshneshin, Si-Chi Chin and Nick Street won the $5,000 prize for Challenge 2. The top-performing method for Challenge 2 was developed by Vladimir Nikulin of University of Queensland, Australia.

"The competitors applied an extraordinarily diverse set of technical approaches, and many of their novel ideas may well represent important new directions for methods research in this area," said David Madigan, professor of statistics at Columbia University and an OMOP investigator.

The competition opened last September and closed March 31. To maintain momentum for the complex work, OMOP also awarded prizes for early progress. Those whose results were promising will be invited to participate on the OMOP methods development team to implement and test their methods.

Much of the OMOP work product is already in the public domain, and eventually all OMOP results will be made public in accordance with the public health mission of the partnership. These will include comprehensive reports on scientific and technical findings, lessons learned, and peer-reviewed articles on specific experimental findings by sponsored investigators.

Further information is available at http://omop.fnih.org/

In the Cancer Centers:

Kimmel Center Given $20 Mil. For Pancreas Cancer Research

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care floors will have an apartment setting designed for families that travel to the OSU Medical Center from a distance.

Located at Cannon Drive and 12th Avenue,

the tower will include 276 beds in the new James Cancer Hospital and 144 beds in the new critical care building, and is designed to address capacity issues in the Medical Center's current facilities. It's anticipated that ProjectONE will allow the Medical Center to serve 310,000 additional patients annually.

ProjectONE will be certified under the Leadership in Energy and Environmental Design Green Building Rating System for its use of sustainable materials, technology and building practices. The university Board of Trustees approved the project's architecture and construction plans in September 2009.

JOHNS HOPKINS KIMMEL CANCER CENTER was awarded the largest gift for pancreas cancer research in its history, $20 million from Albert "Skip" Viragh Jr., a pancreas cancer patient treated at Johns Hopkins. He died of the disease at age 62.

The funds formally establish the Skip Viragh Center for Pancreas Cancer Clinical Research and Patient Care. The center brings together the pancreas cancer laboratory and clinical expertise already in place at Johns Hopkins and cutting-edge research discoveries to improve patient care. The center also allows for the expansion of current internationally recognized clinical programs and the development of promising new ideas in pancreas cancer as well as support promising new research by young investigators.

The new center's namesake was considered to be one of the region's most influential mutual fund investment authorities. He founded Rydex Investments, based in Rockville, Md.

Co-directors of the center are **Elizabeth Jaffee**, the Dana and Albert "Cubby" Broccoli Professor in Oncology at the Johns Hopkins Kimmel Cancer Center, and **Daniel Laheru**, the Ian T. MacMillian Professor in Clinical Pancreatic Cancer Research.

"The Viragh gift builds on the already strong foundation of discovery and innovation at Johns Hopkins, including the first mapping of the pancreas cancer genome, a therapeutic vaccine, perfecting the Whipple surgical procedure and expertise in diagnosis and staging," said **William Nelson**, director of the Johns Hopkins Kimmel Cancer Center.

KIMMEL CANCER CENTER at Thomas Jefferson University said **Mark Weiss** has joined the Department of Medical Oncology as director of hematologic malignancies and professor of medical oncology. He comes to the center following a 19-year career at Memorial Sloan-Kettering Cancer Center. He is an associate attending pttending physician in the Division of Hematologic Oncology and associate professor of medicine at Weill Cornell Medical College of Cornell University Department of Medicine at New York Presbyterian Hospital.

UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER said **Margaret Fields**, an advanced practice nurse in center's Department of Gynecologic Oncology, is the recipient of the 2010 Ethel Fleming Arceneaux Outstanding Nurse-Oncologist Award, the institution's highest nursing honor, made possible by The Brown Foundation Inc. Fields will receive a cash award of $15,000, a crystal plaque and a commemorative pin.

Fields plays an integral role at MD Anderson's gynecologic oncology outreach site at Harris County Hospital District's Lyndon B. Johnson General Hospital. Fields works closely with **Lois Ramondetta**, associate professor in the Department of Gynecologic Oncology and chief of the Division of Gynecologic Oncology at LBJ, as part of a gynecologic oncology team to provide underserved patient populations access to clinical trials of potential new therapies, state-of-the-art patient care and psychosocial support.

Professional Societies:

SGO Studies Barriers To HPV Vaccination In High-Risk Groups

The Society of Gynecologic Oncologists has published its third in a series of four papers on a variety of cervical cancer issues and topics featured at "The Future Strategies for Cervical Cancer Prevention: What Do We Need to Do Now to Prepare" Forum.

The paper, entitled "Can the Barriers to HPV Vaccination in High-Risk Populations be Overcome?" appears in the June issue of Gynecologic Oncology Journal. The paper identifies populations of women in the U.S. at high-risk for cervical cancer and evaluates the known reasons for existing outcome disparities. The paper also advocates potential strategies to reduce barriers to HPV vaccination and current strategies for cervical cancer prevention.

Levi Downs, the paper's lead author, states that "while epidemiological data is useful and necessary to identify populations at high risk for cervical cancer, an understanding of the knowledge and attitudes regarding HPV and cervical cancer prevention of those racial/ethnic groups are critical for the implementation of effective, targeted educational efforts. Inequities in

cervical cancer screening, diagnosis and treatment and HPV vaccination may arise from a number of barriers including access to healthcare, cultural beliefs, and limited awareness."

"To address the issue of limited vaccine uptake, it may be beneficial to establish national/state guidelines, as well as culturally-relevant interventions at the individual and community levels," said Downs, an assistant professor at the University of Minnesota. "That, coupled with an increased educational program regarding HPV related cervical disease, transmission and risk as well as vaccination as a preventative measure may help to diminish existing disparities in cervical cancer incidence and mortality."

Funding Opportunities:

Program Announcements

Development of Assays for High-Throughput screening for use in Probe and Pre-therapeutic Discovery (R01) (PA-10-213) http://grants.nih.gov/grants/guide/pa-files/PA-10-213.html

High-Throughput-Enabled Structural Biology Research (U01) (PAR-10-214) http://grants.nih.gov/grants/guide/pa-files/PAR-10-214.html

NIH News:

NIH CSR Posts Free Videos On Peer Review Process

And now, something to put on the list of summer movies to watch: The latest hit from Bethesda, "NIH Peer Review Revealed."

The NIH Center for Scientific Review released a video to show new applicants and others how NIH assesses over 80,000 grant applications each year to help find those with the most merit and distribute the majority of the institutes' $31 billion budget.

"The video provides an inside look at the dynamic way reviewers evaluate NIH grant applications," said CSR Director Toni Scarpa. "You'll see the rigor and integrity of their efforts, which have enabled NIH to identify ground-breaking research year after year."

"NIH Peer Review Revealed" can be viewed and downloaded at http://www.csr.nih.gov/video/video.asp.

CSR also has released a companion video: "NIH Tips for Applicants." In this video, the reviewers and NIH staff members featured in the "NIH Peer Review Revealed" video provide advice to new applicants.

Both videos incorporate many of the recent changes to NIH peer review and grants systems.

Advocacy:

One Voice Against Cancer Lobbies For $5.8B NCI Budget

Cancer patient advocates from nearly 20 organizations descended on Washington, DC, this week to urge lawmakers to increase funding for cancer research and prevention programs at NIH, NCI, Centers for Disease Control and Prevention and other federal agencies.

The effort was part of the One Voice Against Cancer lobby day. The groups had more than 150 scheduled meetings with members of Congress and their staff.

The agenda included the following priorities:

• Sustain the current level of support for medical research and provide the NIH with $35.2 billion in FY 2011, including $5.8 billion for NCI and $240 million for the National Center on Minority Health and Health Disparities.

• Support a funding level of $601 million for key CDC cancer prevention and early detection programs.

• Provide the Health Resources and Services Administration with $267.3 million in FY 2011 to support Title VIII Nursing Programs, along with an additional $18.6 million to support the Patient Navigator Program.

• Fully fund the Caroline Pryce Walker Conquer Childhood Cancer Act by providing $30 million in FY 2011 for this program. This funding would support the pediatric cancer programs at NCI, CDC, and the Department of Health and Human Services.

• Support an increase of $495 million for FDA in the FY 2011 Agriculture-FDA appropriations bill.

The organizations taking part included:

The American Cancer Society's Cancer Action Network, American Academy of Dermatology Association, American Association for Cancer Research, Asian & Pacific Islander American Health Forum, C3: Colorectal Cancer Coalition, Colon Cancer Alliance, ICCCaucus, International Myeloma Foundation, Lance Armstrong Foundation, Leukemia & Lymphoma Society, Men's Health Network, National Coalition for Cancer Research, National Patient Advocate Foundation, Nevada Cancer Institute, Ovarian Cancer National Alliance, Pancreatic Cancer Action Network – PanCAN, Susan G Komen for the Cure Advocacy Alliance, and Us Too International Prostate Cancer Education and Support Network.

One Voice Against Cancer is a coalition of more than 40 national and community-based organizations.