

# THE CANCER LETTER

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## Lowy: “We Need to Continually Look at the Distribution of Funds That We Allocate to the Areas of Investment”

Douglas Lowy became the NCI acting director April 1. On April 16, Lowy spoke with Paul Goldberg, editor and publisher of The Cancer Letter.

**Paul Goldberg:** *Congratulations, first of all. How is the job treating you?*

**Douglas Lowy:** Well, it is certainly a lot of work, but it’s an incredible opportunity—I have the opportunity of working with terrific people every day. I love it.

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## MD Anderson Execs Get Big Raises In the Midst of Faculty Morale Woes

*By Paul Goldberg*

Two top administrators at MD Anderson Cancer Center, whose job responsibilities include maintaining harmony with the faculty, received substantial pay increases for having “excelled beyond expectation” and “effectively” directing the center’s clinical activities.

According to documents obtained by The Cancer Letter under the Texas Public Information Act, MD Anderson Provost Ethan Dmitrovsky and Physician-in-Chief Thomas Buchholz received \$200,000 each in deferred compensation in 2015.

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### In Brief

## Purdue Renewed as NCI Basic Science Center

PURDUE UNIVERSITY Center for Cancer Research was renewed as an NCI-designated basic science cancer center, and was awarded \$8 million in funding over the next five years. In its review, the institute rated the center as “outstanding.”

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## Drive to Boost Cancer Center Funds to Continue, Lowy Says

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**PG:** *Did you want this job?*

**DL:** I never thought of myself as either becoming acting NCI director or the permanent NCI director, and it was not something I lobbied for.

**PG:** *But as a practical matter, do you see any difference in being acting and being permanent?*

**DL:** My colleagues tell me that I would have a little more authority if I were permanent, rather than acting—but I am certainly going to act as though I am the regular director, because the NCI requires that. I'm going to try to move forward as efficiently as possible.

**PG:** *It's fascinating, because there's probably a certain period of time when change is possible, and then everything else becomes stuck. Is it 100 days; is it 120 days?*

**DL:** For what?

**PG:** *The most important things, that any US President, for example, is able to accomplish is within about 100 days. How many days do you think you have?*

**DL:** I think I will be accomplishing things on the last day that I am acting director, although I think the opportunities may be greater during the first part.

**PG:** *What's the difference between Doug Lowy and Harold Varmus?*

**DL:** I think there are probably more similarities than there are differences. I think that we both share a vision for trying to have an impact on cancer research, from the most fundamental research to the most applied.

I think that the way in which we go about thinking about things, prioritizing, etc., are really quite similar.

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**PG:** *If you were to put it in a nutshell, what is your scientific vision for the institute?*

**DL:** My vision is that we should be trying to have an impact and make progress at various stages of the cancer process.

And, if you will, I am thinking about it going backwards, in the sense that we start with cancer, and try to have an impact on improving the outcomes for patients with cancer. Then we start with efforts in screening, and try to improve screening so there are more benefits and fewer harms.

Then comes prevention, where we try to prevent the development of cancer, and even pre-cancer in some situations.

And then, importantly, research that is basic, as well as research that looks at the etiology of cancer. And they take a long time to have an impact on the cancer process, but it's absolutely critical for long term progress in trying to reduce incidence and mortality from cancer.

**PG:** *Could you walk me through what you outlined to the NCI staff at yesterday's town hall meeting regarding your priorities for the institute?*

**DL:** Sure. The priorities—in terms of trying to do things a little bit differently than we are right now—the first is the precision medicine initiative, which is part of President Obama's proposal for 2016.

The NCI component of that is for precision medicine for patients with cancer. And that initiative has several parts to it. One important part is clinical trials that are targeted and use, as a paradigm, the adult MATCH trial, which we launched a few months ago.

But if there is an infusion of funds as proposed in the president's budget for FY16, that could be expanded more rapidly and the scope could be larger.

The MATCH trial challenges the usual paradigm of how we do clinical trials. Instead of being focused on organ sites, it's focused on the molecular abnormalities in the cancer, relatively independent of the organ site. It brings together an agreement that involves more than 15 different pharmaceutical companies with approved and experimental targeted drugs, for testing them in relatively efficient manner in a single clinical trial.

**PG:** *Isn't it also a shortcut into FDA?*

**DL:** I don't know about a shortcut, but it is a potential path to FDA approval. This would require late-phase trials that are not truly in the scope of the MATCH trial, but the hope would be that if positive findings are obtained with one or more of the drugs, that that certainly would speed the time required for FDA approval if the appropriate clinical trials validate it as beneficial.

**PG:** *Anything else in your scientific vision you'd like to highlight?*

**DL:** I think a critical clinical part is the pediatric MATCH trial, which would be an analogous trial for children with cancer.

The initiative also has a preclinical model component, efforts to try to prevent the development of treatment resistance through combination targeted therapy and also a cancer database and a bioinformatics component.

What I am hoping to articulate is how to make more progress in cancer prevention and screening largely through the application of the principles of precision medicine. There also may simply be some opportunities to improve screening algorithms or something like that. That's the main area.

Another area is cancer health disparities: to focus on several cancers and to try to understand the relative roles of biology, lifestyle, and health care access and utilization, and trying to mitigate them.

And the last area is basic research to try to emphasize that—although we are enthusiastic about people who want to do translational or applied research—NCI will support basic research that simply provides increased understanding of both regulation of signaling and the cancer process, without necessarily having an immediate translational implication or application.

**PG:** *And that covers everything? That's the vision.*

**DL:** Those are the areas that I tried to highlight yesterday.

**PG:** *As a scientist, you've made an enormous contribution to public health. Do you see NCI being more focused on making a difference to real people today? Should NCI stay in the lab or be in the center of public health debates, for example?*

**DL:** Well, I think we are already in the center of many of those debates, but it's important to recognize that the role of the NCI is to provide the evidence that leads to policy. We do not set policy.

Our role is primarily a scientific one, and to try to help our colleagues who are responsible for setting policy. And to understand the science and where we think the science will be leading us.

**PG:** *Do you think scientists can make a better case for higher appropriations?*

**DL:** I think that we need all stakeholders to make a case. I think each group has a different but important perspective: the advocates, the clinicians, patients, as well as the scientists. I think all of these groups all have an important stake in it. And American citizens have a

stake in this because the rate of progress that we can make is obviously limited by our resources.

**PG:** *Things are not going very well on the Hill. I'm just wondering how it can be improved.*

**DL:** I'm going to be testifying on April 30 [at the Senate appropriations hearing] and trying to make the case that what has been proposed for the FY16 budget is something that the NCI certainly could make very good use of, if there was an increase in funds.

**PG:** *Do you think the balance between intramural and extramural research at NCI is what it should be? Should it be tweaked?*

**DL:** I think we need to continually look at the relative distribution that we have in all areas of the NCI—and I wouldn't single out this as a special case, but scientific research is organic. And we always need to look for the opportunities and where can we make the most impact from a strategic point of view.

**PG:** *Do you see yourself making changes in funding of cancer centers or cooperative groups?*

**DL:** With the cancer centers, as you probably know, we have been seriously considering trying to add more funds to the cancer center grants. There already was a committee that made some recommendations, and we have pulled together another committee of cancer center directors.

But it's not yet ready to make announcements of what we're going to do, because in almost all the decisions that we make, we try to get input from many different sources before going forward.

**PG:** *So something is in the works for the centers?*

**DL:** Certainly. Harold had talked about that at the last joint NCAB and BSA meeting.

I think that we place a very high value on the role of the NCI cancer centers in the cancer research effort, and we are looking for ways to try to make their impact even greater. And one way of doing that is to increase our overall budget commitment to the cancer center grants.

**PG:** *What about NCTN? Are you seeing it as where it should be?*

**DL:** I think that the reorganization seems to be in place and functioning relatively efficiently. I think, especially with the Precision Medicine initiative, that there is a lot of enthusiasm and support for the clinical trials network and we're looking forward to having a major impact on progress.

**PG:** *Do you see money changing a little bit?*

**DL:** As I said before, we need to continually look at the distribution of funds that we allocate to the areas of investment at the NCI. I would not single this out.

**PG:** *The other thing is the ROIs. Do you see*

*returning to the payline—the old system?*

**DL:** The R01 grants are very important, and we want to be able to fund a large number of them. But our resources end up being limited, and we end up having issues in trying to provide a sufficient amount of money for the awards that we make.

So this is going to be an important issue going forward that we will be asking for input from our advisors on how to handle it. One of the important areas, the Outstanding Investigator Award, which is going to give seven years of funding—we hope that will allow them to really try to stretch their wings in terms of trying to work on the most exciting science, even if it takes a little bit longer, rather than just focusing on what the obvious next set of experiments might be.

**PG:** *But as far as the process for R01s?*

**DL:** It will continue to be a process where we rely heavily on the study section evaluation of the grant and where NCI reviews those to make sure that we are supporting the most meritorious applications.

**PG:** *I guess what I was really focusing on was this area of uncertainty.*

**DL:** Certainly for the remainder of FY15 we will continue with the same processes to be fair and consistent to all applications.

**PG:** *Is there anything we've overlooked or anything you'd like to emphasize?*

**DL:** I'm looking forward to the new role and interacting with even more people than I have interacted with before, and I'm looking forward to getting their input on how the NCI can have the biggest impact. I think that all stakeholders are important for this process.

## **MD Anderson Officials Say Exec Salaries Appropriate**

(Continued from page 1)

With incentive pay, supplemental annuity and deferred compensation included, the 2015 raise could boost Dmitrovsky's total paycheck by as much as 22.9 percent compared to fiscal 2014. Buchholz's compensation could increase by 31.4 percent.

In 2014, basic science faculty members received an incentive payment of \$2,000. Incentive pay for clinical staff was calculated as a percentage of base pay linked to the amount of their work in clinical operations and other factors, officials said. There was no merit raise in 2014, because MD Anderson didn't meet the institutional financial goal required to trigger that merit pay, officials said.

In fiscal year 2015, faculty members received 4 percent merit raises, based on performance in the FY2014 fiscal year. The budget for fiscal 2016 includes a 3 percent merit increase for faculty as well as an incentive program, which is in the midst of being updated, according to slides presented to the center's Budget Advisory Committee April 6. [The document is posted here.](#)

Dmitrovsky's base salary will jump from \$788,700 to \$805,000 and Buchholz's will increase from \$783,600 to \$805,000. With incentive pay and other bonuses, Buchholz could earn as much as \$1,350,108 and Dmitrovsky could earn \$1,346,356. The 2015 compensation figures are estimates provided as part of "[Administrative Accountability Reports](#)" required by the state.

These reports estimate the most each administrator stands to earn during the ongoing fiscal year, provided that they hit all performance targets. The documents are generated to ensure an executive's pay doesn't exceed approved levels.

In 2014, with bonuses and incentive pay, Dmitrovsky's W-2 form reported that he earned \$1,095,174 from MD Anderson. Buchholz's W-2 reported his earnings at \$1,027,233 last year.

However, compensation for the two executives was "not at equity with other members of our executive leadership team, particularly with regard to deferred compensation offerings," MD Anderson President Ronald DePinho wrote to the Board of Regents.

It would be difficult to argue that MD Anderson is a place of peace and harmony that nurtures fuzzy feelings in its faculty.

Four faculty surveys conducted over the past two years reflected low morale and high dissatisfaction with executive leadership on a broad range of issues.

Last month, on a visit to campus, the UT System Chancellor William McRaven declared that "trust has been broken" between the MD Anderson faculty and administration. McRaven's solution: shared governance (The Cancer Letter, [March 20](#)).

During his visit, McRaven asked the Faculty Senate to prepare a "white paper" proposing solutions to outlining problems at MD Anderson. That document is likely to note disparity in compensation between faculty members and DePinho's executive team.

Last week, the American Association of University Professors noted similar problems. AAUP is now likely to censure the illustrious cancer center over its handling of tenure disputes, an issue that falls squarely into the portfolios of Dmitrovsky and Buchholz (The Cancer Letter, [April 10](#)).

## 2012 - 2015 Compensation for MD Anderson Leadership

Name	Title	*2015 Max. Projected Compensation	2014 Total Direct Compensation	2013 Total Direct Compensation	2012 Total Direct Compensation
Ronald DePinho	President, Professor	\$1,890,446	\$1,890,446	\$1,845,200	\$1,801,065
Leon Leach	Executive Vice President	\$1,606,434	\$1,553,860	\$1,468,169	\$1,438,403
Thomas Buchholz	Physician-in-Chief, EVP	\$1,350,108	\$1,027,233	\$1,000,932	\$854,255
Ethan Dmitrovsky	Provost, EVP	\$1,346,356	\$1,095,174	\$160,016	\$0
Robert Fontaine	Executive Chief of Staff	\$1,390,964	\$1,293,935	\$1,222,397	\$794,984
Thomas Burke	EVP, MDA Cancer Network	\$1,573,366	\$1,523,928	\$1,442,632	\$1,430,189

\*Source: The Higher Education Administrative Accountability Report (Special Provisions, Sec. 5 FY 2015)

Strife has opened a schism within the faculty: three former chairs of the Faculty Senate recently launched a petition in support of DePinho's administration, prompting eight other former Faculty Senate chairs to send out a letter describing the atmosphere of plunging morale and what they described as "loyalty oaths" (The Cancer Letter, [Feb. 27](#), [March 27](#)).

Documents show that the wheels of bureaucracy that produced the raises for Dmitrovsky and Buchholz began to turn last September.

DePinho asked for the raises, and Raymond Greenberg, UT System's executive vice chancellor for health affairs, signed off on the request.

The proposal then went to the UT System Board of Regents, which [unanimously approved it](#) at their February meeting. According to the motion to approve, the compensation changes were "in the best interest" of MD Anderson.

DePinho's rationale for the raises? As presented to the UT System:

- "Dr. Dmitrovsky has excelled well beyond expectations in his role since joining MD Anderson's executive leadership team more than a year ago. He has expertly led numerous key recruitments while retaining accomplished faculty at an exceptional rate; organized his office's broad administrative functions and responsibilities to best serve the needs of our faculty as well as the research and academic interests of MD Anderson; developed institutional agreements to make shared core facilities available for use by researchers at MD Anderson, UT System health institutions and others in the Texas Medical Center; and implemented several important faculty engagement initiatives that have involved interaction with all 66 academic departments. With such accomplishments in mind, I note that Dr. Dmitrovsky's compensation

is currently not at equity with other members of our executive leadership team, particularly with regard to deferred compensation offerings."

- "Since joining our executive leadership team this year, Dr. Buchholz has effectively directed our expansive clinical enterprise that includes 1,000 physicians and more than 3,000 nurses, and which has served 122,000 patients. Without delay, Dr. Buchholz began strengthening relationships with clinical leaders and faculty throughout the institution while addressing institutional priorities. He has contributed greatly to the development and initiation of MD Anderson's 10-year strategic plan, a key initiative for our future success. While his overall responsibilities have continued to mount, Dr. Buchholz's compensation currently is not at equity with other members of our executive team, particularly with regard to deferred compensation offerings."

According to documents provided to The Cancer Letter, the two officials' compensation was set based on studies by the Mercer, Sullivan Cotter and Integrated Healthcare Strategic Executive Compensation Survey. Documents submitted to the UT System suggest that compensation for Dmitrovsky and Buchholz hovers around the 75th percentile for "total direct compensation" for officials in similar positions.

The documents supporting the raises [are posted here](#).

### "Not a Proven Business School Strategy"

"At a time when at any institution's morale is in jeopardy, the first step toward rebuilding it is not salary increases for top management. This is not a proven business school strategy," said Arthur Caplan, the Drs. William F. and Virginia Connolly Mitty Professor and head of the Division of Medical Ethics at New York University Langone Medical Center.

"It's a ghastly mistake to exacerbate income

**Higher Education - Administrative Accountability Report  
Special Provisions, Sec.5 - FY2015**

Name	Title	Salary	Increase Over 2014	Practice Plan Benefits	Other	Estimated Maximum Compensation	Increase Over 2014
Ronald DePinho	President, Professor	\$1,439,000	0.00%	\$405,900	\$45,446	\$1,890,446	0.00%
Leon Leach	Executive Vice President	\$807,300	2.01%	\$105,787	\$693,347	\$1,606,434	3.38%
Thomas Buchholz	Physician-in-Chief, EVP	\$805,000	4.79%	\$244,956	\$300,152	\$1,350,108	31.43%
Ethan Dmitrovsky	Provost, EVP	\$805,000	4.11%	\$244,756	\$296,000	\$1,346,356	22.94%
Robert Fontaine	Executive Chief of Staff	\$688,100	6.91%	\$10,333	\$692,530	\$1,390,964	7.50%
Thomas Burke	EVP, MDA Cancer Network	\$788,800	2.00%	\$240,281	\$544,285	\$1,573,366	3.24%

- The 2015 total compensation is a projection of the highest possible amount the officials stand to earn.
- Last month, the MD Anderson Executive Committee was expanded to include representatives, selected by their peers, from the division heads, clinical department chairs and basic science department, the chair of the Executive Committee of the Faculty Senate, and other vice presidents and senior vice presidents.

inequality at a time when the institution is under severe pressure and the culture is aggravated by the gap between management and the workforce being too big,” Caplan said to The Cancer Letter. “They are caving in morale.”

In a statement responding to questions from The Cancer Letter, MD Anderson officials said that the levels of compensation for top administrators are primarily set by “market factors.”

“Understandably, our faculty and leadership are compensated at a higher level than some other cancer centers,” the cancer center’s officials said. “However, our competition for top talent includes many other organizations including large health care systems as well as other health related entities. Our target for compensation for leadership is at the 75th percentile for market competitive positions, a strategy supported by The University of Texas System.”

In the statement, [which appears in full here](#), MD Anderson officials said its Human Resources department reviews market surveys, which include Towers Watson Top Management Survey, Mercer Benchmark Database–Executive, and Mercer Integrated Health Networks Compensation Survey.

“The surveys we review include various peer organizations for MD Anderson, including other academic health centers, other large hospitals, other cancer centers, research organizations and private health businesses,” officials said. “The information we receive from the survey organizations is blinded, meaning the data provides ranges of pay for positions that align with MD Anderson positions.

“Our goal is to set wages at a fair level. Wages are also set at levels to help MD Anderson recruit and retain talented MD Anderson staff, faculty and leaders

from across the country to the highly competitive Texas Medical Center,” the official statements said. “No two organizations are alike so compensation differences between organizations might be based on differing job duties. For example, some academic health organizations appoint a vice president to oversee research operations. At MD Anderson, our provost, who manages the academic portion of MD Anderson, also oversees research.

“Other factors that may impact compensation differences include years of experience, level of education or types of degrees; and recent job performance.”

David Farquhar, professor emeritus of cancer medicine, who founded the Faculty Senate’s salary review committee and served as the Faculty Senate chair in 1998 and 1999, said this process had been producing inflated salaries for top executives. The recent raises for Dmitrovsky and Buchholz are a part of what appears to be the MD Anderson pattern of “grossly overpaying” its administrators, he said.

“At a time of dwindling federal research dollars and increased faculty austerity measures, compensation packages for senior administrators at MD Anderson have run amok. Four executive vice presidents and one executive chief of staff now earn between \$1,300,000 and \$1,700,000 annually,” Farquhar said. “There appears be no meaningful oversight or accountability by UT System to curb this financial gluttony. To put this in perspective, \$1,500,000 would support the salary of the average Texas schoolteacher or fireman for 30 years—essentially a lifetime.

“Alternatively, it would fund the salaries of 20 top-notch cancer research assistant professors for one year. MD Anderson administration justifies these exorbitant compensation packages by partially

benchmarking themselves against the corporate sector. That is preposterous. MD Anderson is not a corporation. It issues neither private nor public stock. It is a nonprofit, tax-exempt, medical organization that is part of state government, the University of Texas System. MD Anderson does not pay federal taxes, property taxes, or sales taxes. To the contrary, it receives taxpayer dollars through an annual subsidy from the state of Texas.

“It receives additional taxpayer dollars through federal and state grants and contracts. It also benefits from generous philanthropic gifts from private and corporate donors. If the six MD Anderson senior executives were paid even one-half of their current salaries, they would be more than adequately compensated for what they do. The \$4.5 million savings could then be used to provide annual bonuses of \$3,000 each for the 1,500 most deserving employees, those who work in the trenches and give their all to the mission of MD Anderson.

“Alternatively, it could be used to support the cancer treatment bills of 150 needy families, each to the tune of \$30,000,” Farquhar said.

### **The Question of Comparables**

Compensation for members of DePinho’s executive group, including Dmitrovsky and Buchholz, is on the par with that of presidents and CEOs of cancer centers and deans of medical schools, an informal spot-check of compensation packages shows.

Houston is a highly competitive market, and across town, at Baylor College of Medicine, Paul Sigworth, vice president for clinical affairs was paid \$515,518 in 2012, the most recent year for which tax forms are publicly available. Compensation for Paul Klotman, president and CEO of BCM, was \$1,419,289.

Now, let’s look at MD Anderson’s cross-state competitor: UT Southwestern.

Gregory Fitz, who holds the titles of executive vice president for academic affairs, provost and dean, is slated to earn \$807,340 this year, according to projections submitted to Texas state legislature.

Second-tier compensation at MD Anderson is in the same range as that of Daniel Podolsky, president of UT Southwestern, who is slated to earn \$1,372,997 this year.

Seattle-based Fred Hutchinson Cancer Center has been ahead of MD Anderson in obtaining NIH funding and is now just a bit behind the Houston competitor in securing NCI finding (The Cancer Letter, [Oct. 31, 2014](#)).

In 2012, Frederick Appelbaum, senior vice president and director of the Clinical Research Division, was paid \$645,453, less than half of what Buchholz

and Dmitrovsky are earning this year. Lawrence Corey, FHCC president and director, was paid \$834,703.

At St. Jude Children’s Research Hospital, a beneficiary of phenomenally successful fundraising campaigns, Richard Gilbertson, director of the cancer center was paid \$627,911 in 2012. William Evans, director and CEO of the entire St. Jude, earned \$977,444.

According to 2013 tax filing, Jose Baselga, physician-in-chief at Memorial Sloan-Kettering Cancer Center earned \$1,023,913, about what his counterpart Buchholz earned before the recent raise. Thomas Kelly, former provost of the MSKCC graduate school and director of the Sloan-Kettering Institute, earned \$1,380,554.

After this year’s raise, the MD Anderson provost and physician-in-chief are about \$109,302 behind Ed Benz, president and CEO of Dana-Farber Cancer Institute, whose total compensation was \$1,420,202, the institution’s tax 2012 filings show. However, DePinho, a former Dana-Farber scientist and two other MD Anderson executives this year are earning more than Benz’s last publicly known compensation package.

Dmitrovsky and Buchholz are also earning hundreds of thousands more than the top executives at the American Cancer Society, the American Association for Cancer Research and the American Society of Clinical Oncology.

At ACS, John Seffrin was paid \$934,301 in 2013. AACR’s Margaret Foti was paid \$918,527, and ASCO’s Allen Lichter was paid \$804,775, tax filings show.

MD Anderson, Dmitrovsky and Buchholz aren’t the highest paid members of the executive team.

DePinho is slated to earn \$1,890,446 in 2015. The next highest paid official is Leon Leach, executive vice president, at \$1,606,434, followed by Thomas Burke, the former physician-in-chief who now runs outreach, at \$1,573,366.

Dan Fontaine, the executive chief of staff, could earn \$1,390,964 this year.

In fact, DePinho, Leach and Burke are positioned to earn more than the UT System Chancellor McRaven, whose compensation package for a year of work includes the base salary of \$1.2 million, the annual retention payment of \$100,000 and another \$200,000 contingent on performance review. (McRaven also received \$300,000 as a one-time contract commencement payment and is slated to receive another \$300,000 as a contract completion payment in 2018).

In a statement to The Cancer Letter, MD Anderson officials said these compensation packages are appropriate.

“MD Anderson Cancer Center has been ranked No. 1 or No. 2 in cancer care since US News first began ranking cancer providers in 1990,” the statement reads. “The high level of expertise and skill reflected in those rankings correlates with the compensation levels of our providers, researchers and leaders. We are also one of the largest cancer centers in terms of patients served, our research operations, and the number of locations around the United States and the world that leverage our expertise in order to provide better cancer care for patients who cannot travel to Houston.

“Although we do not know the exact salaries of other cancer center leaders, in order to achieve our mission, MD Anderson seeks out and recruits top cancer and healthcare talent both nationally and internationally to collectively treat both common and rare cancers and collaborate with other talented researchers in the field. We also seek to obtain and retain skilled leaders to ensure MD Anderson’s future is as bright as its past.”

State officials impose controls on these compensation packages, MD Anderson officials said.

“The UT System sets the compensation for MD Anderson’s president. The UT System also manages any adjustments to this compensation level,” the statement reads. “When researching this story, you saw some of these controls. Administrative Accountability Reports are annual reports required by the state of Texas to track leader salaries at institutions across the state and to ensure pay structures are appropriate.

“In addition, UT System approval is required when total proposed compensation for an employee will be over \$500 thousand. Board of Regents approval is required when total proposed compensation is over \$1 million. That policy can be found here: <http://www.utsystem.edu/board-of-regents/policy-library/policies/uts144-compensation-highly-compensated-employees>.”

*Matthew Bin Han Ong contributed to this story.*

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## Lawmakers Repeal Medicare SGR in Bipartisan Vote

President Barack Obama signed the Medicare Access and Children’s Health Insurance Program Reauthorization Act on April 14, permanently repealing the Medicare sustainable growth rate formula.

The bill received overwhelming bipartisan support: The House of Representatives voted 392 to 37 on April 2, and the Senate approved it with a 92 to 8 vote April 14.

Originally enacted as part of the Balanced Budget Act of 1997, the SGR has been amended 17 times with short-term patches to prevent severe annual cuts to physician payments. A 21.2 percent rate reduction for all physicians was scheduled to take effect April 15.

“With Congress passing this historic legislation to finally end the 13-year SGR roller coaster ride, Medicare beneficiaries and their physicians can breathe easier knowing that they will no longer face the perennial threat of payment cuts that risk disruption of care and cause anxiety among patients,” American Society of Clinical Oncology President Peter Yu said in a statement. “The Congressional bipartisan, bicameral leadership that forged this much-anticipated resolution has taken an important step to restore stability and confidence in Medicare.

“The American Society of Clinical Oncology looks forward to working with policymakers to ensure that this new law is effectively implemented and paves the way to new payment models that foster high-quality, value-based health care for all Americans with cancer.”

The bill’s Merit-Based Incentive Payment System and Alternative Payment Model payment structures will increase physician pay by 0.5 percent in the second half of 2015, and an additional 0.5 percent annually from 2016 through the end of 2019—the 2019 rates would be maintained through 2025 with no additional increases.

“Repealing the SGR has been an ASTRO priority for years, and passage of this legislation represents a long-awaited, historic victory for our patients,” said Bruce Haffty, chair of the American Society for Radiation Oncology board of directors. “Permanently repealing the SGR and replacing it with a stabilized reimbursement plan focused on quality will strengthen Medicare and allow us to enhance cancer care for the more than one million patients treated with radiation therapy each year.”

Current Medicare programs that reward electronic health records and quality reporting will be merged



by 2019 to encourage participation and to reduce the administrative burden. The Children's Health Insurance Program also received funding for two more years, and \$7.2 billion was allocated for community health centers.

"[The bill restores] stability for physicians serving Medicare patients in communities across the country," said Steven D'Amato, president of the Association of Community Cancer Centers. "ACCC thanks the legislators in both houses who voted in support of SGR repeal. We also salute our ACCC members for their persistent, multi-year advocacy efforts on behalf of SGR reform."

Previous short-term SGR fixes have too often been paid for out of technical component reductions in diagnostic imaging, said Bibb Allen, chair of the American College of Radiology Board of Chancellors.

"It is long past time to put some stability into the physician payment system. However, infinite policy details must be worked out to ensure it is implemented appropriately," Allen said in a statement.

"The legislation moves us away from fee-for-service to value-based alternative payment models, most not yet designed, but this is the future and the future is now."

### *In Brief*

## **NCI Renews Purdue University Cancer Center Designation**

"Notably, the center has clear examples of having translated a number of its discoveries," the review stated. "The center is poised to move to a new level of national impact in drug discovery and development." The center was first established as an NCI basic science cancer center in 1978.

Of the 68 NCI-designated cancer centers, only seven are basic laboratory cancer centers, which conduct laboratory research and do not provide patient treatment. The center's discovery groups focus on bladder cancer, brain cancer, breast cancer, prostate cancer and links between obesity and cancer.

The center has established partnerships with Indiana University Simon Cancer Center in Indianapolis, IU Health Arnett in Lafayette, Indiana, and is a member of The Big Ten Cancer Research Consortium.

"The grant from the NCI will help us maintain and grow these shared resources so we can continue to nurture multidisciplinary collaborations and lead in the field of basic cancer research," said Douglas

Cuttell, the center's managing director. "It also will enhance our ability to attract top talent and to expand into emerging areas of cancer research. For example, over the next five years we plan to expand genomics and bioinformatics work that can feed into the field of personalized medicine."

The center plays a significant role in the Purdue Moves drug discovery initiative, and has expanded its physical presence through the new Bindley Multidisciplinary Cancer Research Facility and space at the new Drug Discovery Facility.

"More than 14 million people in the U.S. have a history of cancer and more than one million new cases will be diagnosed this year," said Timothy Ratliff, the Robert Wallace Miller Director of the Purdue University Center for Cancer Research. "We want to eliminate any hurdles or gaps in the path from research concept to a tool or treatment available to patients."

**JOSEPH GULFO** was named executive director of the Rothman Institute of Innovation and Entrepreneurship at **Fairleigh Dickinson University**.

The university also launched the Initiative for Patient Centered Innovation, to be led by Gulfo, in collaboration with the School of Pharmacy's Center for Healthcare Innovation and Technology. Among the programs to be undertaken include the Medical Innovation Impact Index, shadow advisory committee panels, and audits of regulations and guidance documents.

Gulfo is the author of *Innovation Breakdown: How the FDA and Wall Street Cripple Medical Advances* and a contributor to *Inc.com*. He has more than 25 years of experience in the pharmaceutical and medical device industries and received the American Business Awards Maverick of the Year Award in 2012. He also teaches graduate courses on strategic innovation management in FDU's MBA program.

**DON GABRIEL** joined the Global Clinical Development & Operations team of **United BioSource Corp.**, a subsidiary of Express Scripts. Gabriel will direct UBC's consultative services to pharmaceutical sponsors developing oncology therapies.

A bone marrow transplant physician, Gabriel held a long tenure at the University of North Carolina where he served as professor of medicine, associate chief of staff, assistant dean for clinical services, acting chief of medical oncology, and service chief liaison of the Division of Hematology/Oncology.

He has co-developed an optical laser-based technology used to identify and characterize suspended

particles in the blood, including circulating tumor cells.

“Joining UBC gives me the opportunity to work with an organization that is using cutting edge clinical study design to search deep into the biochemistry of new molecules and help take those molecules to the next stage of development,” said Gabriel.

### **CHILDREN’S HOSPITAL OF WISCONSIN** opened its **MACC Fund Center** clinic and **Northwestern Mutual Day Hospital**.

“Children’s Hospital of Wisconsin is grateful for its long standing partnership with the MACC Fund, an organization exceptionally dedicated to children with cancer and blood disorders,” said Peggy Troy, CEO of the Children’s Hospital of Wisconsin. “Through the support of the MACC Fund and Northwestern Mutual, we are able to continue our mission to advance diagnosis and treatments, provide excellence in clinical care, expand training and research efforts, and improve access and outcomes.”

The new care areas on the fifth floor of Children’s Hospital are co-located with the MACC Fund Center inpatient unit and critical care unit. Designed with the help of 10 former MACC Fund Center patients and their families, the renovation features a 10,384-square-foot clinic with the latest technology for improved care delivery, 18 exam rooms and a neuropsychiatric testing suite.

The 10,329-square-foot day hospital includes an activities center, 14 private infusion suites, and a specialized chemotherapy pharmacy.

“We are proud to introduce the Northwestern Mutual Day Hospital, which will enable the doctors, nurses and staff to provide a best-in-class experience to the patients and their families, integrating technology and support services,” said John Kordsmeier, president of the Northwestern Mutual Foundation. “When a child receives a cancer diagnosis, the family does as well. We want to help ensure that when a family is undergoing treatment, they have a family-friendly environment that allows kids to be kids.”

Since the MACC Fund Center program began in 1980: more than 5,000 children have received care through the Oncology Program; more than 1,000 children have received blood and marrow transplants; and 300 children are actively managed for sickle cell disease annually, and 250 new patients are treated for other blood disorders.

**ROCHE** acquired **CAPP Medical**, a genomics research company founded by members of Stanford

University, to advance the development of technology for cancer screening and monitoring through the detection of circulating tumor DNA in blood.

CAPP Medical’s novel technology is designed to isolate and quantify small amounts of ctDNA through a blood draw, which can be used for cancer therapy selection and monitoring tumor response and resistance to therapy.

“Roche believes focused and high quality next generation sequencing assays using simple blood draws have the potential to significantly advance the time of cancer diagnosis and change routine cancer diagnostic monitoring and may be highly cost effective compared to today’s current standard of using PET and CT imaging to monitor tumor progression,” said Roland Diggelmann, COO of Roche Diagnostics.

CAPP Medical is a privately held company founded in October 2013. CAPP Medical’s technology focuses on assay design and the bioinformatics that allow for the detection of multiple mutations with a single assay.

## *Drugs and Targets* **Health Canada Approves New Indication for Xtandi**

**Health Canada approved a new indication for the use of Xtandi (enzalutamide)** capsules to treat patients with metastatic castration-resistant prostate cancer who are asymptomatic or mildly symptomatic after failure of androgen deprivation therapy.

The drug, sponsored by Astellas Pharma Canada Inc., was initially approved for use in patients with mCRPC who previously received docetaxel in the setting of medical or surgical castration.

This new approved use follows a Priority Review of the Supplementary New Drug Submission by Health Canada that was based on results of the phase III PREVAIL trial.

The trial was a randomized, placebo-controlled, multinational clinical trial that enrolled 1,717 chemotherapy-naïve patients with progressive metastatic prostate cancer who had failed ADT. The PREVAIL trial included thirteen Canadian trial sites including Kelowna, Vancouver, Victoria, Calgary, Edmonton, Winnipeg, London, Hamilton, Toronto, Ottawa, Montreal, Quebec City, and Halifax.

In the trial, men receiving enzalutamide therapy exhibited a statistically significant improvement in both overall survival and delayed time to radiographic progression or death as compared to those on placebo.

Specifically, enzalutamide significantly reduced the risk of radiographic progression or death by 81 percent compared with placebo (HR=0.19;  $p < 0.0001$ ). Enzalutamide also significantly reduced the risk of death by 29 per cent compared with placebo (HR=0.71;  $p < 0.0001$ ) and significantly delayed the start of chemotherapy by a median of 17 months compared with placebo (HR=0.35,  $p < 0.001$ ).

**Bayer HealthCare expanded its global clinical development program for the investigational oncology compound copanlisib (BAY 80-6946),** which now includes two new phase III studies in indolent non-Hodgkin's lymphomas and one additional phase II study in diffuse large B-cell lymphoma.

Copanlisib is an intravenous pan-class I phosphatidylinositol-3-kinase inhibitor with predominant inhibitory activity against both PI3K and PI3K isoforms. The PI3K pathway is one of the most frequently altered pathways in cancer and the PI3K isoforms trigger many cellular functions such as growth control, metabolism and transcription initiation.

The three studies will open for enrollment by mid-2015. Copanlisib was recently granted orphan drug designation by the FDA for investigation in follicular lymphoma.

CHRONOS-2 will be a phase III, randomized, double-blind, placebo-controlled study of copanlisib in rituximab refractory indolent NHL patients who have previously been treated with rituximab and alkylating agents (NCT02369016).

CHRONOS-3 will be a phase III, randomized, double-blind study evaluating the efficacy and safety of copanlisib in combination with rituximab versus rituximab monotherapy in patients with relapsed

iNHL who have received at least one prior line of treatment, including rituximab and an alkylating agent (NCT02367040).

The phase II, open-label, single arm study will evaluate patients with relapsed or refractory DLBCL with copanlisib and assess the relationship between efficacy and potentially predictive biomarkers (NCT02391116).

**Immunocore Ltd. and MedImmune**, the global biologics research and development arm of AstraZeneca, **entered into a second collaboration.**

Immunocore will conduct a phase Ib/II clinical trial combining MedImmune's investigational checkpoint inhibitors MEDI4736 (anti-PD-L1) and/or tremelimumab (anti-CTLA-4) with IMCgp100, Immunocore's lead T-cell receptor based investigational therapeutic, for the potential treatment of patients with metastatic melanoma.

MedImmune has an exclusive relationship with Immunocore for the development of IMCgp100 in combination with MEDI4736 and/or tremelimumab, and will have first right of negotiation for the future commercial development of these combinations for tumors expressing gp100.

Immunocore and MedImmune will collaborate to establish a dosing regimen for IMCgp100 combined with MEDI4736 and/or tremelimumab, as part of the phase Ib study. The phase II study will assess the safety and efficacy of the different combinations.

The companies have a pre-existing research collaboration and licensing agreement, which began in January 2014, to develop novel cancer therapies using Immunocore's Immune Mobilising Monoclonal T-Cell Receptor Against Cancer (ImmTAC) technology.

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