THE CANCER LETTER

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Varmus Pledges No Funding Gap for NCORP, Blames Snafu on "Unclear Communication"

By Paul Goldberg

Following an explosion of criticism, NCI said funding for community oncology clinics would not be interrupted.

In "an open letter to the cancer community" April 10, NCI Director Harold Varmus assured researchers that funding for the NCI Community Clinical Oncology Program sites would continue as it morphs into the NCI Community Oncology Research Program.

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What the Physician Pay Report Won't Tell You

By Matthew Bin Han Ong

For a good time, go to the Medicare database and key in the name of your physician friend, foe, or whatever, and presto!—you will see how much that person had billed Medicare in 2012.

This will make for hours of guilty pleasure, especially if you are willing to set aside concerns about not just privacy, but accuracy.

Do this:

1. Go to the data released by the Centers for Medicare & Medicaid Services posted online April 9 in The New York Times.

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In Brief

Goldsmith Named CEO of CancerCare

PATRICIA GOLDSMITH was named CEO of **CancerCare**.

Goldsmith previously served as executive vice president and chief operating officer at the National Comprehensive Cancer Network, where she was responsible for overall operations and provided oversight for national programs and initiatives. She will take the job May 5.

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Cancer Groups Challenge NCI

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"While this was always our intention, this has not been clearly communicated," Varmus wrote.

Official correspondence and interviews indicate that the NCI plan, as originally described, was to force these clinics to find the resources to fill the funding gap between June 1—the day CCOP ends—and sometime in September, when NCORP begins.

Taking an unusual public stance, community clinical researchers said the funding gap, which was announced in correspondence from NCI, would have put patients at risk.

"There are thousands of patients on trials that require close monitoring," the principal investigators of the CCOPs wrote in a letter to Varmus. "We have a legal, ethical and moral obligation to our patients to provide a safe environment for patients receiving investigational and life-preserving cancer treatments. This obligation will be severely hampered if there is no gap funding."

A copy of the letter, dated April 4, but sent to the institute sometime this week, was obtained by The Cancer Letter. On April 10, Varmus responded with the open letter that blamed unclear communication for the dispute.

While intentions are difficult to assess independently, documents obtained by The Cancer Letter show that information about the funding gap was, in fact, conveyed in writing by officials of the NCI Office of Grant Management, and that CCOP investigators, as well as the American Society of Clinical Oncology, which took up their cause, made significant efforts to find out whether NCI indeed intended to interrupt funding.

Also, when the controversy first surfaced last week, NCI officials didn't take the opportunity to state unequivocally that there would be no gap in funding (The Cancer Letter, April 4). An NCI statement issued later that day similarly stopped short of stating that there would be no gap in funding.

If the institute had, in fact, altered its plans, this would demonstrate its vulnerability to public pressure.

For decades, researchers have sought to settle their disputes with NCI behind closed doors. The institute hasn't seen significant public and congressional scrutiny for more than two decades, and its spending priorities during the subsequent doubling of the NIH budget went essentially unexamined as they shifted wildly from director to director.

In recent weeks, Varmus's cuts in the clinical research programs seemed to be fraying nerves—and changing the NCI-Knows-Best attitude.

Last week, the chairs of the adult clinical trials groups wrote a letter to Varmus, putting him on notice that his policies, which they say amount to a 40-percent cut in spending on clinical research, have touched off a "crisis" in clinical research.

NCI officials challenged this calculation, but the chairs have not received a formal response.

ASCO supported the letter from the group chairs. On top of that, Clifford Hudis, president of the society, publicly criticized the institute for the CCOP funding gap (The Cancer Letter, April 4). The ASCO statement first brought the gap into public view.

Richard Schilsky, ASCO's chief medical officer, said the society is "encouraged to receive assurance, as stated in Dr. Varmus' letter of April 10, that CCOP grantees that receive positive peer review and are funded through NCORP will not experience a gap in funding—as they had previously understood would be the case."

However, Schilsky said that "further clarification to CCOP PIs about how to access bridge funding will be essential."

"We understand that NCI has worked hard to preserve a stable level of funding for the NCTN in the face of severe budget constraints," Schilsky said. "However, we remain concerned that the distribution of funds among the various components of the NCTN will place severe constraints on NCTN operations and limit its ability to activate new studies. ASCO looks forward to working with NCI to address these concerns."

This controversy is playing out as the institute

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stands poised to launch a new generation of smart clinical trials—and before full details of its plans for clinical trials network groups and the NCORP program are announced.

Phil Stella, the principal investigator of the Michigan Cancer Research Consortium and one of the authors of the CCOP investigators' letter to Varmus, said he has no complaints about the staff of the NCI Division of Cancer Prevention or the division's leadership.

The problem is broader: it's about research priorities, he said. "How are we as a nation going to prioritize the funds that we have, and what are the priorities of the NCI?" Stella said to The Cancer Letter. "It should be discussed publicly. This is a big issue, that should be brought out into the light."

The Gap Opens

Many doctors who participate in CCOPs commit money from their practices to this endeavor. Institutions, too, end up having to throw in subsidies.

Consider the Kalamazoo, Mich., CCOP. It receives about $550,000 a year from NCI and another $500,000 from the Western Michigan Cancer Center, said Joseph Mirro, the cancer center's CEO and chief medical officer.

"Reimbursement per patient is less than it actually costs for us to conduct the research," Mirro said to The Cancer Letter. "We do it, because we feel it's extremely important to patient care and extremely valuable to our patients. It advances knowledge, which is good for our country, and it's good for our docs, too."

Historically, about 30 percent of patients who enter the NCI treatment, prevention, and control trials are accrued through CCOPs. When it comes to accrual of the underserved populations to prevention trials, CCOPs play a particularly important role, according to materials posted on the institute's website.

The Kalamazoo CCOP embraced change. When NCORP was envisioned, it filed a joint application with the larger Grand Rapids CCOP, forming a single entity, which would serve the entire western part of Michigan.

Both Kalamazoo and Grand Rapids had ongoing funding for their CCOPs. The assumption at both places was that NCI would phase out the CCOPs program, but the money earmarked for their use would continue to flow.

"Our understanding was that these programs would dovetail into one another," said Gilbert Padula, the principal investigator of the Grand Rapids CCOP.

On March 6, all the CCOPs received a letter from Crystal Wolfrey, chief grants management officer at the NCI Office of Grants Administration. "Beginning June 1, 2014, funding for participation in the NCI community research program will no longer be provided through a previously funded CCOP/MB-CCOP award," the letter stated. The research sites will be informed about the outcome of their NCORP applications "in early summer for anticipated start dates in September 2014."

The letter is posted on The Cancer Letter website. Wolfrey's office is a component of the NCI Office of the Director.

Did Wolfrey's letter mean that there would be no funding between June 1 and sometime in September?

Officials at CCOPs said that NCI officials acknowledged that this would be the case. At one conference call and in emails that included pasted-in explanations, institute officials said that the interruption in funding should be viewed as analogous to reapplication for competing continuation of their CCOP grants.

"Our recommendation is that sites approach this gap between CCOP and NCORP similarly," said one email sent by a grants management official to multiple CCOPs. "If you are going to have activities ongoing that would be attributable to the CCOP, you may continue doing so and supporting them through other sources.

"If your NCORP application is selected and funded, you can then pre-access sources through the pre-award approval provided by NIH.

"Please understand that any pre-award activity when related expenses are incurred are at your own risk for your organization. The federal government is not obligated to support such expenses if award is not made."

Where would this leave community investigators? Would this not amount to a 25 percent cut, assuming that NCORP funding remains constant?

Consider Michigan. In Grand Rapids, the CCOP would have had to find about $100,000 a month, $300,000 altogether, to get from June to September.

In Kalamazoo, its NCORP merger partner would need to find another $150,000 to get by. "I've got a shortfall at a minimum of about $150,000 for that period of time," said Mirro. "That's if I am very careful. It could be $300,000."

In Ann Arbor, the shortfall would be $400,000.

The loss for the state's clinical trials over three months would have been around $850,000. And that's without knowing whether the NCORP grants would be approved—and at what level.

The message from NCI seemed clear to everyone who heard it.

"[NCI officials] reiterated that there will be this gap, and your parent institution would be expected to

cover the cost," Stella said to The Cancer Letter. "Of course, that's ludicrous, because they already have their budgets for the year."

CCOPs can't just take a summer off.

"We have to find a way to follow those patients who are already on trials," said Padula before Varmus's open letter. "From the regulatory and compliance perspective, we have to continue to monitor those patients."

Padula said he planned to reach out to local consortium hospitals to try to secure bridge funding. If that fails, "we would have to vastly limit the clinical trials that are presented to the IRB and we would have to activate significantly fewer trials during the summer months."

In Kalamazoo, Mirro said he didn't have much leeway. "This is critically important, and somehow I am going to have to figure out how to do it," he said before receiving the letter from Varmus. "Because this is critically important to cancer patient care. I have patients on study now. I can't just quit collecting data on those patients. It's going to have to come out of somewhere else, and healthcare reform is squeezing most of healthcare providers in the U.S. We are seeing a severe degradation in reimbursement, even though we are doing more work. I am going to have to sit down and figure out where I cut, whom I cut, to make this work."

Investigators in Michigan said they contacted their legislators. Stella said his institution has contacted Sen. Carl Levin (D-Mich.), and Mirro said his staff alerted Rep. Fred Upton (R-Mich).As chair of the House Committee on Energy & Commerce, Upton is positioned to exercise oversight over NCI.

"Upton knows his district, he knows we are here, he knows we have this grant, he knows Kalamazoo and Lakeland are also in his district, and he knows that Grand Rapids supports some of his district with patient care," Mirro said.

CCOP Letter to Varmus

The letter to Varmus was signed by 56 of the 64 CCOP PIs.

The text of the CCOP letter to Varmus follows:

Dear Dr. Varmus,

The current CCOP grant recipients were informed in a letter dated 3/6/14 from Crystal Wolfrey, Chief of the Office of Grants Administration, and in a follow-up phone call with Sean Hines and Worta McCaskill-Stevens on Monday 3/26 that there would be essentially no bridge funding from 6/1/14, when the current CCOP grant terminates, to September 2014, when the NCORP grants would be funded.

This funding gap presents major challenges to the community sites that are participating in the CCOP program in fulfilling their obligations under the current grant. We are curious where the allocated funds for the CCOP program were re-directed, given the fact that the majority of CCOP's had ongoing funding commitments for this period.

On the CCOP conference call, we were advised that some CCOP's have "restricted funds" available. Access to restricted funds helps only a minority of the CCOPs. For those CCOPs that do have potential access to restricted funds, the funds available are inadequate to support clinical operations for a 3 month period. There are thousands of patients on trials that require close monitoring. In addition we have an obligation to continue to accrue new patients so they can have uninterrupted access to these potentially life-saving treatments.

The CCOP sites simply cannot afford to treat patients on NCI sponsored trials with limited or no funds. We will not have access to institutional funds during this funding hiatus as hospital budgets have long since been approved. As was the case during the federal "sequester period" staff may have to be furloughed at CCOP institutions.

This situation raises significant safety concerns in regards to patient toxicity monitoring and data submission to respective study bases. We have a legal, ethical and moral obligation to our patients to provide a safe environment for patients receiving investigational and life-preserving cancer treatments. This obligation will be severely hampered if there is no gap funding.

With this in mind, we respectfully request the following:

1) Access to funds previously earmarked to CCOPs to bridge the funding gap (We were informed that all grant award notices are being amended to remove the funding previously awarded for 6/1/14 to 5/31/15).

2) The CCOP funding should be equivalent to previously awarded amount .

3) No restrictions on new accruals during this transition.

4) If delays in the NCORP roll-out occur, appropriate and adequate funding should be provided to cover the entire gap period.

5) For those CCOPS who are not awarded an NCORP grant, close-out funds should be available to continue to monitor and report on patients who are actively being treated on study and follow-ups.

June 1st is rapidly approaching and obviously CCOP's will need to make decisions based on this funding issue, including potentially stopping accrual now to reduce the staffing necessary to run operations during the program transition.

The CCOP programs and their patients have been significant contributors to the NCI Clinical Trials efforts for almost 30 years and an important part of the NCTN going forward but we cannot fulfill our obligation to patients and the research enterprise without consistent and adequate funding. We request prompt attention to these concerns.

Sincerely,
CCOP PIs
CC: Worta McCaskill-Stevens, MD, MS
James Doroshow, MD
Jeffrey Abrams, MD

Varmus Responds:

Dear Colleagues,

As you are aware, the National Cancer Institute (NCI) is in the process of combining its two community-based research networks to create a single network that builds on the strengths of the Community Clinical Oncology Program/Minority-Based Community Clinical Oncology Program (CCOPs) and the NCI Community Cancer Centers Program (NCCCP).

This network, the NCI Community Oncology Research Program (NCORP), will support a wide range of clinical research, including treatment-focused as well as cancer prevention and control–based clinical trials; population-based studies; and behavioral, health services, and outcomes research.

It will encompass community-based cancer specialty organizations in the same manner as have the CCOPs and NCCCP, and will work closely with the National Clinical Trials Network (NCTN).

The transition to any new large clinical research structure is never easy either for the agency administering it or for those people and institutions applying to participate in it. The creation of the NCORP is no exception.

Some of the difficulties are easily mitigated but others require greater efforts to ensure that the fundamental principles and values of clinical research are upheld. NCI remains fully committed to these principles, most especially our obligation to patients.

Current NCI grantees conducting community-based clinical research have voiced concerns about the maintenance of funding between the end of the current round of annual CCOP awards (June 1, 2014) and the start of the NCORP (now estimated to be August 1, 2014).

With Fiscal Year 2014 budgets now in place, our grantees can be assured that NCI will fund all CCOPs at their current levels during this period. While this was always our intention, this has not been clearly communicated.

Furthermore, currently funded investigators should continue the active, uninterrupted accrual of patients to new or ongoing clinical trials during this interval. As in the past, full funding for all research activities required to carry out approved studies will be provided.

Those CCOP/MB-CCOP institutions that successfully compete to become NCORP members should have a seamless stream of funding as the new consortium structure commences.

NCI will work with sites that either do not successfully compete for an NCORP award or choose not to transition into the new network. NCI will make funds available, as necessary, to assist these sites to implement their affiliation with another site or to carry out the process of closing their NCI-supported activities.

For those sites, decisions will be made on a case-by-case basis, in accord with factors such as accrual rates and number of patients in follow up. NCI remains committed to every patient enrolled in a clinical trial and will ensure that they continue to have the opportunity to receive the full benefit of those trials.

The CCOPs and MB-CCOPs, including their dedicated physicians and staff, have played an essential role in the national clinical trials enterprise. An effective transition into NCORP, along with the continued care of patients, will be an important measure of the new network's success.

We must work together to adapt swiftly and effectively to achieve the goals of the new system—namely, to take advantage of recent advances in our understanding of cancer and to bring new knowledge into clinical trials conducted in the community. Our patients deserve nothing less.

- Harold Varmus

Research Funding

Obama Signs Law Authorizing $126 Mil for Pediatric Research

By Conor Hale

President Obama signed a bill authorizing $126 million for pediatric medical research over the next 10 years, following a rare showing of bipartisanship on Capitol Hill.

The bill, known as the Gabriella Miller Kids First Research Act, is named after a 10-year-old girl who died from a brain tumor in October 2013. Miller was an advocate for childhood cancer research and awareness, raising money for the Make-a-Wish Foundation and helping to establish the Smashing Walnuts Foundation, following her diagnosis in November 2012.

The pediatric research fund would reallocate money originally used to pay for national political conventions during presidential elections, and instead route it through the NIH Common Fund—under the condition that it be used to supplement grants for pediatric research—at a rate of $12.6 million per year. The bill itself does not directly appropriate any funds, but does authorize the transfer of the money. According to members of the House Energy and Commerce Committee, NIH spent $3.6 billion last year on pediatric research.

"We're going to need some cooperation from Congress to continue to work on a bipartisan basis to actually allocate those dollars in an effective way," President Barack Obama said as he signed the bill into law April 3, in front of members of the Miller family. "I know that NIH is very eager to work on these pediatric cancers because obviously nothing is more challenging for a family than to go through something like this."

The bill was passed the House Dec. 11, by a vote of 295 to 103, with many Democrats joining Republicans, and was passed by unanimous consent in the Senate March 11, with no formal vote taken.

Many House Democrats voted against the bill, saying that $12.6 million a year is not near the money removed from NIH's budget due to sequestration, while those who voted for it described it as better than nothing.

"Sequestration cut $1.6 billion from NIH last year—$1.6 billion," said Senate Majority Leader Harry Reid (D-Nev.), as he expressed his concerns on the floor before moving the bill forward. "In the omnibus we passed, we gave them current level funding, but that hole for NIH is still there. NIH has lost huge amounts of money over the past few years in the way that we have struggled to get financing for our country." Sequestration cut $255 million from the NCI budget.

"This is a small amount of money, but it will be extremely helpful to the NIH," he said. "I would hope my Republican colleagues would join with us in increasing funding for the National Institutes of Health."

"This is a small amount of money, but it will be extremely helpful to the NIH," said Reid. "I would hope my Republican colleagues would join with us in increasing funding for the National Institutes of Health."

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Critics: CMS Database Is Inaccurate, Lacks Context

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2. Select Hematology/Oncology under "Specialty", and key in 98026 as the ZIP code.

3. Scroll down, look for Jeffery Ward, and click on his name for a breakdown of his Medicare billings.

Ward, a medical oncologist at the Swedish Medical Center in Edmonds, Wash., specializing in hematology and hospice and palliative medicine, told us he doesn't mind being used in this illustration.

A quick glance shows that Ward billed Medicare $371,232 in 2012, and that he prescribed two anti-nausea drugs—Palonosetron and Granisetron—580 and 1,250 times, respectively.

The drugs, used primarily to mitigate symptoms resulting from chemotherapy, would suggest that Ward had administered chemotherapy 1,830 times in 2012. However, Ward's chemotherapy treatments were not recorded in the data.

"It was billed through me, and it's not in there," said Ward, speaking on behalf of the American Society of Clinical Oncology. "All of the physicians that were in our practice are listed on that page when you go to that ZIP code—I'm actually the highest billing one, and none of us have chemotherapy listed there, except one, and the only chemotherapy drug he has is rituximab, but that makes him stand out about $200,000 higher than the rest of us.

"Why? I don't know.

"I'm convinced that my billing was over $1 million, including the $371,232. And there are other oncologists in my state where it shows well over $1 million in billing, and it's because their chemotherapy is in there."

Ward is the immediate past chair of ASCO's Clinical Practice Committee.

Medicare officials say that the data they released will enable the public to conduct a wide range of analyses, comparing 6,000 types of services and procedures provided, as well as the payments received by individual health providers.

"Currently, consumers have limited information about how physicians and other health care professionals practice medicine," HHS Secretary Kathleen Sebelius said in a statement April 9. "This data will help fill that gap by offering insight into the Medicare portion of a physician's practice. The data released today afford researchers, policymakers and the public a new window into health care spending and physician practice patterns."

The data were released as a result of litigation by The Wall Street Journal, which has posted its own searchable database.

Context Matters

The Medicare data can be easily interpreted out of context, said Matthew Farber, director of provider economics and public policy at the Association of Community Cancer Centers.

"Much like when CMS released hospital cost data last year, taking the data out of context really isn't all that helpful and can be potentially misleading to patients or to the providers or to payors—any host of audiences will look at this data and try and glean some information out of it.

"Oncology care is unique in many ways in that our doctors are giving a lot of the treatments in the offices, they're using some very high-cost treatments to do so," Farber said to The Cancer Letter. "If you don't take that into account or don't at least recognize that in reporting of these payments or these Medicare claims, you're only getting half the story.

"Our biggest concern is that people are going to look at this and say, 'Oh, that's money that's straight revenue, that's money that the doctors are pocketing,' when indeed that's not the full situation.

"People are still kind of trying to wrap their heads around this," Farber said. "I think a lot of people are looking themselves up to see where they are on the list and see whether it's right or wrong, or if there are any surprises there.

"They may be looking at some of their colleagues and competitors even, but I think, at least in the oncology community, we all know that any information taken in the abstract is not going to get anyone very far," Farber said. "And the hope is that we're not going to have patients or payors or media taking up on this story and running with it without really getting the back story and trying to get the whole picture and looking at what these payments actually mean—how much money goes to pay for the drugs, how much money goes to pay for this or that, so it's not as if, 'Oh, they billed for $3 million to Medicare, so therefore they must have made $3 million.'"

The way CMS released the data can be misleading, said Matthew Brow, vice president of business development and public policy at The US Oncology Network.

"All this information is looking at how much the physician charged for care, and how much Medicare paid for the physician, and in reality, the physician as a group for the services that the physician provided to

Medicare beneficiaries," Brow said to The Cancer Letter. "It's important to keep in mind that nothing CMS is showing is netting out the expenses that the practice or the physician himself or herself actually experiences."

Many practices and hospitals bill Medicare under a hospital's tax ID number or through a supervising physician, and the released numbers do not reflect the actual dollars received by individual doctors, or deductions after physician payments to drug companies.

"In an oncology practice, a lot of the billing that you do for Medicare is for drugs, and we know that in 2012, 94.3 percent of that money goes to drug companies," Ward said. "Instead of billing Medicare, the pharmaceutical companies bill us, and we bill Medicare. And so it makes oncology look like a huge biller, where you really ought to be saying, 'Oncology bills this much and the pharmaceutical companies are billing this much.'"

It is problematic to use the data for comparisons between oncologists and other physicians, or even across oncology subspecialties, said Ted Okon, executive director of the Community Oncology Alliance.

"If you look from oncologist to oncologist, depending on what the cancer type they treat, that's going to determine not only what drugs, but what other treatment is used," Okon said to The Cancer Letter. "You also have the situation of where the demographics of the patient population is going to change."

Hospital-based physicians will appear to be billing more because the hospital is typically getting a higher rate and charging more, Brow said.

"That makes it hard to even do an apples-to-apples comparison across specialties, much less across different specialties," Brow said. "Because it's all at the aggregate level, it's really hard to get a sense for relative costs and relative cost-effectiveness, and it would be totally unreasonable to look at the number and say, 'Well, he billed $4 million and Bob billed $2 million, so Bob is more cost-effective.' The fact could be that Bob only works two days a week, or his practice is relatively light on Medicare patients, or he doesn't see Medicare patients by his choice."

Transparency, or PR Stunt?

The physician pay report may help get private researchers and the public involved in ferreting out misuse of services and fraud in Medicare, said Jonathan Blum, principal deputy administrator at CMS, in an interview with Bloomberg April 9.

"We know there's waste in the system," Blum said. "We know there's fraud in the system. While we've made tremendous investments to reduce that fraud, we want the public's help to identify spending that doesn't make sense, that appears to be wasteful, that appears to be fraudulent."

The problem is that asking critical questions based on the data without context and accuracy means that people are going to be accused of things they haven't done, critics say.

"I think that if these data were put in clear context, and if the data was broken down in a way that showed reality, then that's the kind of transparency and cost issues that I think patients and the public may have a right to," said Ward. "This data could be used several different ways. So one way to use the data is as a health services research tool. I think that for people who are in research and figuring out how medicine is practiced, who are developing policy and who are working on payment reform issues, this data can be very valuable.

"I'm a little bit disturbed by the fact that CMS has advertised this as, 'We now want the public and the media to help us find fraud,'" Ward said. "Medicare has had these data for a long time. To release it all and just say, 'This is going to help us find fraud,' means other people are going to massage the data and look at it, and ask critical questions.

"I don't think Medicare has spent any time or effort trying to check the accuracy of the data, or to put it into context, or do any of those things. They just put raw data out there because they have it, because the court had said they should, and they were giddy at the prospects of being able to do so."

COA's Okon echoed that sentiment: "But if you can't compare one physician to another, or if those comparisons are invalid, our biggest concern is not the transparency—the data runs the risk of confusing patients. CMS doesn't have to release this data for the public to have vigilantes out there looking at outliers; this is something they should be doing.

"What we should have expected but didn't expect was that CMS would be so giddy that it would provide the news outlets plenty of time to develop the tools to easily extract the data," Okon said. "I think it's very unfortunate that CMS chose not to release data that

physicians can actually check for accuracy. We had no chance for correcting and checking it, or preparing what we should say to our patients."

Medicare could be just releasing evidence as a way to say, 'Look, we need to reduce some Medicare expenditures,'" ACCC's Farber said.

"But the worrisome part for oncology and others, is taking the data in the abstract," Farber said. "It's a disservice to everything that our members do and all the people who help treat these cancer patients, to try and make those decisions without looking at the whole picture."

CMS had the opportunity to spend time and resources focusing on potential fraud, and do that without a public disclosure of all the data, said US Oncology's Brow.

"If they were really concerned about health care costs, they'd be figuring out how to incentivize more patients to seek care in community settings and physician offices instead of higher-cost hospital settings," Brow said.

"They'd be looking at the beneficiaries and benefit design for beneficiaries, putting in differential copayments and bill insurance for choosing more expensive are or less expensive care. That would be a much more practical way to get at the cost question."

Providers will continue to make sure all necessary and relevant parties are educated about the data, Farber said.

"I'm sure groups like US Oncology, ASCO and ourselves will get together to make sure that if it's members of Congress or the administration at CMS, payors, whomever that we have to talk, that they do understand the full picture," Farber said. "There's no rash decision that's going to be made solely based on the release of this information."

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AACR Annual Meeting

AACR Presents 2014 Awards, Arteaga Becomes President

The American Association for Cancer Research presented its 2014 awards at its annual meeting, held April 5-9 in San Diego.

The AACR also inaugurated its officers for the next year during its annual business meeting. **Carlos Arteaga** was named president of the organization.

Arteaga is professor of medicine and cancer biology at Vanderbilt University School of Medicine, where he holds the Donna S. Hall chair in breast cancer research. He serves as associate director for translational/clinical research; director of the Breast Cancer Program; director of the Vanderbilt-Ingram Cancer Center Research Network; and director of Center for Cancer Targeted Therapies at Vanderbilt-Ingram Cancer Center.

Arteaga's research interests include oncogene signaling and molecular therapeutics in breast cancer with an emphasis on targeted therapies, mechanisms of drug resistance, translational research, and investigator-initiated clinical trials.

Additionally, **José Baselga**, physician-in-chief at Memorial Sloan Kettering Cancer Center, was inducted as president-elect and **Charles Sawyers**, chair of the Human Oncology and Pathogenesis Program at Memorial Sloan Kettering Cancer Center, now serves as past-president.

The 2014 AACR award winners are:

• **Douglas Hanahan**, director of the Swiss Institute for Experimental Cancer Research at the Swiss Federal Institute of Technology, was presented the award for Lifetime Achievement in Cancer Research. Hanahan helped develop one of the first transgenic mouse models of cancer and demonstrated that oncogenes could initiate multistep tumorigenesis. He also used his transgenic mice to study the immune system and made groundbreaking contributions to understanding autoimmunity.

• **Webster Cavenee**, director of the Ludwig Institute for Cancer Research, was presented with the Margaret Foti Award for Leadership and Extraordinary Achievements in Cancer Research, for his work in cancer genetics, his leadership in the fight against glioblastoma multiforme, and his more than 25 years of service to the AACR, which included his election as AACR president.

• The Team Science Award was presented to the **Duke University/Johns Hopkins University/**

National Cancer Institute Malignant Brain Tumor Group, led by Darell Doty Bigner. The team was selected because of the impact their research has had on the understanding of the biology of glioblastoma multiforme, the most common and lethal brain cancer.

• **Charis Eng**, the Sondra J. and Stephen R. Hardis endowed chair in cancer genomic medicine and founding director of the Genomic Medicine Institute at the Cleveland Clinic's Lerner Research Institute, was honored with the Women in Cancer Research Charlotte Friend Memorial Lectureship. Eng was the founding chair of the International Cowden Consortium, which mapped and identified the PTEN tumor suppressor gene as the susceptibility gene for Cowden syndrome.

• **David Botstein**, the Anthony B. Evnin professor of genomics at Princeton University and chief scientific officer of Calico, Google's new startup focusing on health, was awarded the Irving Weinstein Foundation Distinguished Lectureship for his work on cancer and genetics, including laying the groundwork for what would become the Human Genome Project.

• **Levi Garraway**, associate professor of medicine at Dana-Farber Cancer Institute, was awarded the AACR-Minorities in Cancer Research Jane Cooke Wright Lectureship for his research in the field of cancer genomics and functional approaches to characterize solid tumors, especially melanoma and prostate cancer.

• **Elaine Fuchs**, the Rebecca C. Lancefield professor and head of the Laboratory of Mammalian Cell Biology and Development at The Rockefeller University and an investigator of the Howard Hughes Medical Institute, was presented the Pezcoller Foundation-AACR International Award for Cancer Research for her studies using reverse genetics to understand the biological basis of normal and abnormal skin development and function, including clarification of the molecular mechanisms underlying the ability of skin stem cells to produce the epidermis and its appendages.

• **Rakesh Jain**, director of the Edwin L. Steele Laboratory in the Department of Radiation Oncology at Massachusetts General Hospital, was presented with the Princess Takamatsu Memorial Lectureship for his work in tumor biology, leadership in developing diverse international collaborations, and his scientific mentorship.

• **Nima Sharifi**, the Kendrick family endowed chair for prostate cancer research at the Cleveland Clinic, was given the award for Outstanding Achievement in Cancer Research, for his contributions as a young investigator to the clinical importance of androgen synthesis in advanced hormone-resistant prostate cancers.

• **James Allison**, chair of the Department of Immunology, executive director of the Immunology Platform, associate director of the Center for Cancer Immunology Research, deputy director of the David H. Koch Center for Applied Research in Genitourinary Cancer, and the Lilian H. Smith distinguished chair of immunology at MD Anderson Cancer Center, was presented the G.H.A. Clowes Memorial Award. Allison is also leader of the Stand Up To Cancer-Cancer Research Institute Dream Team: Immunologic Checkpoint Blockade and Adoptive Cell Transfer in Cancer Therapy.

• **Dale Boger**, Richard and Alice Cramer professor of chemistry and chair of the Department of Chemistry and the Skaggs Institute for Cancer Research at the Scripps Research Institute, was presented the award for Outstanding Achievement in Chemistry in Cancer Research for his research in combining novel synthetic methodology to develop natural products and designing second-generation synthetic compounds as anticancer agents.

• **Curtis Harris**, head of the molecular genetics and carcinogenesis section of the NCI Center for Cancer Research, was presented with the AACR-American Cancer Society Award for Excellence in Cancer Epidemiology and Prevention for his studies of gene-environment interactions, especially the link between the environmental carcinogen aflatoxin B1 and a specific mutation in the TP53 tumor-suppressor gene in patients with hepatocellular carcinoma.

• **John DiPersio**, chief of the Division of Oncology and deputy director of the Siteman Cancer Center at Barnes-Jewish Hospital and Washington University School of Medicine in St. Louis, was presented with the Joseph H. Burchenal Memorial Award for Outstanding Achievement in Clinical Cancer Research. DiPersio's research interests include the control of graft-versus-host disease using genetic and epigenetic therapy, the biology of stem cell mobilization, sensitization of leukemic cells via stroma-leukemia cell blockage, and the genomics of de novo and relapsed AML.

• **Jedd Wolchok**, chief of Melanoma and Immunotherapeutics Service and associate director of the Ludwig Center for Cancer Immunotherapy at Memorial Sloan Kettering Cancer Center, was presented the Richard and Hinda Rosenthal Memorial Award, for his contributions to the field of immunotherapy for

melanoma, and his role in the development of the anti-CTLA-4 antibody ipilimumab.

• **Robert Schreiber**, alumni endowed professor of pathology and immunology, professor of molecular microbiology, and director of the Center for Human Immunology and Immunotherapy Programs at Washington University School of Medicine in St. Louis, was presented with the AACR-Cancer Research Institute Lloyd J. Old Award in Cancer Immunology. Schreiber was recognized for discoveries including the identification of IFNγ as a key cytokine in antitumor immunity and the development of the cancer immunoediting concept, which integrates the host protective and tumor promoting functions of the immune system and provides a framework for the design of cancer immunotherapies.

In Brief

Goldsmith Named CEO Of CancerCare

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Prior to joining NCCN, she was vice president for institutional development and public affairs and marketing at the H. Lee Moffitt Cancer Center & Research Institute.

BECKY DEKAY was named president of the **Association of Community Cancer Centers** at its annual meeting April 2. She is director of oncology services at the Feist-Weiller Cancer Center at LSU Health Shreveport.

DeKay has been active in ACCC since joining the staff of LSU Health Shreveport in 2003. She has served on the governmental affairs committee, chaired both the membership and the strategic planning committees, and has published articles in the association's journal. More recently, she served as ACCC treasurer for two years.

BERT HOWARD O'NEIL was named the inaugural Joseph W. and Jackie J. Cusick Professor of Oncology and a professor of medicine at **the Indiana University School of Medicine**. He is also the phase I director and director of the gastrointestinal cancer research program at the IU Simon Cancer Center, and he will represent the cancer center on the Big Ten Cancer Research Consortium steering committee.

O'Neil was most recently an associate professor of medicine and director of the gastrointestinal malignancies research program at the University of North Carolina at Chapel Hill. He also was the medical director of the UNC Lineberger Comprehensive Cancer Center's clinical protocol office. His area of expertise is in gastrointestinal cancers, with a concentration on pancreas, colorectal, and hepatocellular carcinomas.

The professorship was established by Jackie Cusick in memory of her husband Joseph, who co-founded, co-owned and co-operated NCA Group. He was instrumental in building New Hope Presbyterian Church in Fishers, Ind. It is the intent of the donor that the holder be involved in clinical or basic science research aimed at enhancing treatment for patients with gastrointestinal cancers.

MD ANDERSON CANCER CENTER formed a research alliance with **GlaxoSmithKline** to strengthen its efforts in advancing anticancer immunotherapies.

This marks the fourth and final collaboration in a plan to partner with pharmaceutical companies as part of MD Anderson's Moon Shots Program. GSK and MD Anderson will work to identify therapeutic approaches, evaluate patient responses in clinical trials, and develop immunotherapy drugs.

THE AMERICAN ASSOCIATION FOR CANCER RESEARCH is now accepting applications for the Stand Up To Cancer-Cancer Research U.K. Translational Research Fellowship, which will provide up to four grants for postdoctoral or clinical research fellows, each up to $315,000, over a four-year period.

This grant opportunity is provided by SU2C and Cancer Research U.K. and is the first joint research project resulting from the collaboration between the two groups announced in 2012.

The fellowship will provide four years of research support to early-career investigators in the U.S. and U.K. Research projects must be translational in nature and address critical problems in cancer with the potential to deliver benefit to patients.

The proposed work must be performed in two phases, one in the U.S. and one in the U.K. Each phase must be one to three years in length, and the total support period for this fellowship is a maximum of four years.

Project proposals are due by noon ET July 28, via proposalCENTRAL.

For general information on eligibility criteria, the application process, and other details about this grant, visit the AACR website.