Cancer Centers Administrators Forum

Update from the Office of Cancer Centers

Henry P. Ciolino, Ph.D.
Acting Director

NIH NATIONAL CANCER INSTITUTE

April 4, 2016

Outline

1. *CCSG Funding Policy*
2. *NCAB Part 2 Recommendations*
3. *CCSG FOA – general considerations*
4. *CCSG FOA – specific recommendations*
5. *P30 Supplements*
6. *Director Meeting - May 2*

Concerns About Implementing a Formula That Reduces Some CCSG Awards

- **The CCSG funds infrastructure – something not amenable to fluctuations in funding**
- **NCI has invested billions of dollars in building up this infrastructure – dismantling it at some Centers to increase it at others isn't efficient**
- **The CCSG buys institutional commitment – we are concerned that reducing a Center's CCSG award might jeopardize its influence in its academic home and make it more difficult to leverage other sources of funding**
- **No Center has seen a significant increase in its CCSG award in several cycles – everyone has lost ground to biomedical inflation**

Rebalancing Phases

- **Phase 1 (FY16): Establish base awards by type of Center and bring all Centers up to the new base, as recommended by the NCAB**
- **Phase 2 (FY18 – FY22): Allocate new CCSG funds using the NCAB-recommended metrics of the size of the cancer-relevant research base of a Center and the merit achieved in the review of its next competitive application**
- **Phase 3 (FY23-): Reconsider rebalancing; continue the effort with more new money, or adopt a zero-based formula as recommended by the NCAB**

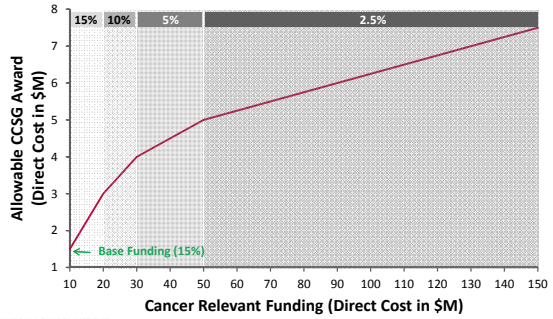
The New Base Awards – Increases for 21/69 Cancer Centers

BASIC (2/7; 29%)		
Center	FY15 Budget	Base FY16
Purdue	1,060,500	1,200,000
Jackson	1,156,367	1,200,000

CLINICAL (12/17; 71%)		
Center	FY15 Budget	Base FY16
Indiana	999,867	1,400,000
Emory	1,000,000	1,400,000
Mt. Sinai	1,000,000	1,400,000
MUSC	1,000,000	1,400,000
Oregon	1,000,000	1,400,000
Hawaii	1,000,000	1,400,000
Kansas	1,000,000	1,400,000
Kentucky	1,000,000	1,400,000
Maryland	1,000,000	1,400,000
Nebraska	1,000,000	1,400,000
VCU	1,000,000	1,400,000
UT-SA	1,204,014	1,400,000

COMPREHENSIVE (7/45; 16%)		
Center	FY15 Budget	Base FY16
Wake	1,000,000	1,500,000
UT-SW	1,000,000	1,500,000
Utah	1,111,000	1,500,000
Arizona	1,257,443	1,500,000
New Mexico	1,272,293	1,500,000
City of Hope	1,300,357	1,500,000
Georgetown	1,454,514	1,500,000

The New Benchmark Ratio: Determining a Comprehensive Cancer Center's Maximum Award



Using the CCSG Merit Score to Determine the Ultimate Direct Cost Award

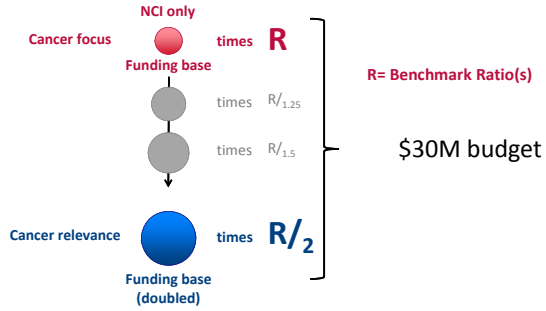
Merit Score	% of requested increase	Merit Score	% of requested increase
10	100%	26	20%
11	95%	27	15%
12	90%	28	10%
13	85%	29	5%
14	80%	30	0 (no change)
15	75%	31	0 (no change)
16	70%	32	0 (no change)
17	65%	33	0 (no change)
18	60%	34	0 (no change)
19	55%	35	0 (no change)
20	50%	36	-20% (from current award)
21	45%	37	-20%
22	40%	38	-20%
23	35%	39	-20%
24	30%	40	Diet
25	25%	40+	Diet

Core Principles

1. The calculation of budget eligibility should not affect how centers write their applications (except the budget pages)
2. The calculation should not depend on reviewers
3. Estimates of cancer focus/relevance must be objective and apply to all grants
4. The process must be simple and transparent

The Office of Cancer Centers will calculate budget eligibility of each center prior to their submission using RePORTER. The grants list will be shared with the center so they can check for accuracy. Review will not be given this list.

Increasing the Funding Base Requires a Decrease in the Benchmark Ratio(s) to Remain Within Budget



Using the Research, Condition, and Disease Categorization (RCDC) "Cancer Fingerprint" in RePORTER

- It provides an independent assessment of a center's portfolio that will not affect how a center prepares its application
- Cancer relevance is determined in an objective manner that measures all NIH grants by the same standards
- It will be simple and transparent, as the NCAB recommended
- It will accommodate centers with members that receive significant cancer-focused grants from Other NIH institutes while retaining NCI funding as the primary determinant of new CCSG funding

Four Centers

	Funding (Direct Costs)		Potential Increase (%)	
Center	NCI	Other NIH	NCI Only	All NIH
A	$20.1M	$31.6M	66	147
B	$16.7M	$1.3M	44	54
C	$53.0M	$7.8M	70	46
D	$22.9M	$6.7M	34	59

All Centers

Range of Potential Increases (%) By Center Type (Average/Median)

Basic	10-87	(39/37)
Clinical	10-106	(36/21)
Comprehensive	10-274	(41/18)

Non-NIH Funding Sources

The Working Group recommended unanimously to exclude all non-NIH funding:

- There is no way to independently verify funding – the only source for funding information is the CCSG application
- The Cancer Fingerprint cannot be applied to these grants
- Complicates the budget calculation – there are 27 different organizations
- Funding from some of the organizations is not available to all centers
- Non-NIH sources represent 17% of all funding reported by centers

Some Considerations

- The Cancer Fingerprint will not "tag" all the NIH grants you will include in your application - it's stricter than (some of) you! (could we address cancer focus review issues using the Fingerprint?)
- RePORTER does not recognize the cancer center as an entity – it recognizes the academic home; we need to decide what institutions should be included in each center's portfolio
- We will have to use the previous fiscal year for all receipt dates
- Some mechanisms may be excluded even if matches the Cancer Fingerprint – NCTN, CTSA, etc.
- Remind your center that peer-review projects that are excluded from the budget calculation can still affect funding by contributing to a better impact score – don't marginalize those PIs

More Considerations

- We have better internal systems! Query, Verify, Report (QVR)
- The Cancer Fingerprint isn't available until the budget is released – January applicants won't be able to check our calculation
- Will this affect rigor of review?
- Can we ensure that reviewers don't assume a cancer-irrelevant (new term) grant is included in the application to boost budget eligibility?
- Can NCI sustain Phase 2 over 5 years? Safeguards?
- Should new centers (Type 1s) come in at the base?
- What will Phase 3 look like?

Do you foresee problems?

NCAB Recommendations

- Increase Efficiency and Effectiveness of Site Visits
  - Evaluate the impact and merit of the site visit - No
  - Eliminate shared resource visits - Yes
  - Eliminate posters - No
- Increase Clarity of Requirements and Review Criteria
  - Eliminate redundancy of review criteria – we'll try
  - Eliminate grouping of shared resources - Yes
  - Add specific metrics for comprehensiveness – tell us how!
- Streamline Data Collection – RePORTER and CTRP
- Streamline Annual Progress Reports - Yes

CCSG PAR-16 and PAR-19:
How can we help reviewers focus on the forest and ignore the trees?

- Components vs. Concepts (Trees vs. Forest)
  - Education and Training
  - Clinical Research
  - Catchment Area
  - Cancer Health Disparities
  - Shared Resources (?)
- Can we eliminate components?
  - Early Phase Clinical Research – move to Developmental Funds?
  - Planning and Evaluation – is this appropriate in Administration?
  - Others?

But, the list of stakeholders is looooong.....

- Internal
  - DEA
  - Jim Doroshow and DCTD (clinical)
  - SPL
  - Doug Lowy
- External
  - BSA WG
  - CTAC
  - NCAB
  - Parent Committee
  - Center Directors

The biggest hurdle is NIH (Office of Extramural Activities)!

Research Programs Review Criteria

- What is the overall scientific quality of the Program?
  - *What is the impact of the research of the Program, as demonstrated by……?*
- What is the extent of cancer focus in the peer-reviewed research base?
  - *What is the ratio of NCI to other peer-review funding?*
- How successful is the Program in fostering productive transdisciplinary and/or translational research collaboration among its members, with members of other programs, and with other external partners?
  - *How collaborative is the Program, as demonstrated by……..?*

Research Program Review Criteria cont.

- As appropriate to the type of Program, what is the evidence that research relevant to the catchment area is being addressed, (*e.g.*, problems affecting racial and ethnic minorities, rural residents, women, children, elderly, persons of low socioeconomic status), cancer sites of high incidence/mortality, environmental exposures, behavioral factors, or other issues (in addition to research questions of broad applicability)?
- What is the value added by the Center to programmatic efforts in terms of shared resources and other services?
  - *Huh?*

Comprehensiveness

- How adequate are the depth and breadth of science in each of the three major areas of basic laboratory; clinical; and prevention, control and population sciences?
- What is the degree of evidence for strong transdisciplinary research bridging these sciences?
- How effectively has the Center: 1) defined the cancer problems relevant to its catchment area and 2) served its catchment area (as well as the broader population) via the research it supports?
- How is the scientific mission of the Cancer Center enabled by training and education of biomedical scientists and health care professionals?

P30 Supplements - 2016

- Supplement policies - Why do we torture you every year?
- Supplements
  - CCITLA – closed
  - Non-AIDS defining cancers - closed
  - Burkitt's lymphoma - closed
  - ETCTN Supplements – closes April 19
  - Canine immunotherapy – coming soon (maybe)
  - Population health assessments – coming soon (maybe)
  - Others - coming soon (maybe)

NIH NATIONAL CANCER INSTITUTE

www.cancer.gov www.cancer.gov/espanol