THE CANCER LETTER

Vol. 23 No. 27
July 11, 1997

Price $265 Per Year US
$285 Per Year Elsewhere

NCI To Fund Research Collaboration At HMOs, Health Care Provider Networks

In an attempt to involve managed-care physicians and patients in cancer research, NCI plans to provide $16.5 million over the next four years to encourage research collaboration among health maintenance organizations and other health care provider networks.

Advisors to NCI recently approved the set-aside of funds from the Institute's research project grants budget to support one or two competitive grants to health care organizations to conduct cancer prevention and control research.

HMOs and other provider networks could be useful for

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In Brief

Ovarian Cancer Coalition Opens Office; Winchester Leads Surgical Oncologists

THE NATIONAL OVARIAN CANCER COALITION has officially opened national headquarters in Boca Raton, FL. NOCC began as a local initiative in 1995. "The demand for information from women with ovarian cancer and the healthcare community nationwide was overwhelming and confirmed my belief that there are simply not enough resources available to women and families facing this horrible diagnosis," said **Gail Hayward**, founder and president of NOCC. "This convinced us to establish an organization that could begin to fill this void on a national level." A toll-free information line for newly-diagnosed women, survivors, family members, and medical professionals has been established at 1-888-OVARIAN. . . . **DAVID WINCHESTER** was named president of the Society of Surgical Oncology at the society's annual meeting in Chicago. Winchester is professor of surgery at Northwestern University Medical School and chairman of the department of surgery and head of surgical oncology at Evanston Hospital, Evanston, IL. . . . **RALPH YOUNT** was named president and chairman of the board of the Federation of American Societies for Experimental Biology. Yount is the Meyer Distinguished Professor and professor of biochemistry and chemistry at Washington State University, Pullman. FASEB also named **William Brinkley** vice president and president-elect of the organization. Brinkley is vice president for graduate sciences and dean of the Graduate School of Biomedical Sciences at Baylor College of Medicine, Houston.

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Survivorship Research, Informatics Center, Approved

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epidemiologic and cancer prevention research because of their centralized, long-term data on large and diverse patient populations, NCI administrators said.

Some members of the NCI Board of Scientific Advisors enthusiastically agreed. "NCI has to be aware of what's going on in clinical care—150 million Americans are in some sort of HMO," said BSA member Suzanne Fletcher, professor in ambulatory care and prevention, Harvard Medical School. "NCI has got to grab hold of that resource for clinical research. Research in these settings is nascent, but farther along than we think. I don't know how to get around that other than to get going."

But other BSA members felt just as strongly that a special set-aside was unnecessary because there would be too few organizations with the ability to compete for the grants. "I don't see anything limiting HMOs from applying for regular investigator-initiated grants," said BSA member Sharon Murphy, chairman of the Pediatric Oncology Group and professor of pediatrics, Northwestern University School of Medicine.

Murphy also questioned whether NCI should begin a large grants program in cancer prevention before responding to a recent report critical of the Institute's prevention research program (**The Cancer Letter**, June 27).

After a lengthy discussion at its June 19 meeting, the board voted 14 to 8, with two abstentions, to approve the concept statement for the new program, proposed by the Division of Cancer Prevention and Control.

In other action at the meeting, the board:

—unanimously approved the set-aside of $15 million for a new grants program to support research on long-term cancer survivors;

—approved, on a vote of 17 to 1, with seven abstentions, the set-aside of $4.6 million for an informatics center for breast and colon cancer family registries. Six board members abstained from voting because their institutions are involved in the registries.

Excerpts from the concept statements follow:

*[Concept statements represent proposals by NCI divisions for future Requests for Applications or Requests for Proposals. Actual issuance of grant or contract solicitations, as well as funding levels, are not certain. **The Cancer Letter** publishes NCI RFAs and RFPs as they become available. For further information, contact the program director listed for each concept statement.]*

Cancer Research Networks Across Health Care Systems. Concept for an RFA, cooperative agreement, $4 million first-year set-aside, total $16.5 million over four years; one to two awards. Program director: Martin Brown, Division of Cancer Prevention and Control.

The goal of this concept is to encourage the expansion of collaborative cancer research among health care provider organizations—ranging from traditional staff model health maintenance organizations to extended health care networks associated with academic medical centers which are oriented to community care, have access to large, stable and diverse patient populations and are able to take advantage of existing integrated data-bases which can provide patient-level information on epidemiology, patterns of care and costs related to cancer prevention and control. The proposed mechanism is a cooperative agreement that would support the development of Cancer Research Networks (CRNs) across health care systems. A CRN would consist of a research consortium of health care provider organizations which possess in-house clinical research capacity or which collaborate with clinical researchers affiliated with academic health centers.

In the conduct of collaborative studies across multiple health care provider organizations, the CRN will accomplish two major objectives:

—Formulate and implement a joint CRN research agenda facilitated by ongoing meetings and

THE CANCER LETTER
An Independent Newsletter
Member, Newsletter Publishers Association

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World Wide Web URL: http://www.cancerletter.com

Subscription $265 per year US, $285 elsewhere. ISSN 0096-3917. Published 48 times a year by The Cancer Letter Inc.

Founded Dec. 21, 1973 by Jerry D. Boyd

communication. These meetings would be structured to foster collaboration between clinical practice and research personnel within individual CRN organizations, between researchers at different CRN organizations and between CRN researchers, research affiliated with academic medical centers and NCI.

—Develop standardized data collection instruments, surveys and analytical methods to promote the development of consistent and uniform data bases, and tissue banks that can be shared across member institutions and utilized in joint research projects using uniform protocols when appropriate.

NCI anticipates the development of increased cancer research capacity through increased sharing of specific expertise thereby raising research competence of all CRN members. This would enable more CRN based researchers to participate more fully in existing NCI-sponsored research mechanisms, such as CCOPs and Cooperative Groups and to collaborate with NCI-sponsored cancer centers.

Proposals in response to this RFA would be required to describe two main components: a research study component and an infrastructure component. The research study component would describe the specific collaborative studies that the CRN proposes to conduct. The infrastructure component would describe the proposed means by which the CRN would build the collaborative cancer research capacity of the consortium to support the proposed studies.

Types of Studies Anticipated: Areas of research which would be particularly enhanced by this mechanism include, but are not limited to:

—Epidemiological studies in which longitudinal medical records are particularly useful in identifying cancer risk factors; including the potential risks associated with pharmaceuticals, medical devices, and other forms of treatment.

—Studies of the long-term risk of second cancers or other late effects of cancer treatment.

—Studies of the feasibility, cost-effectiveness and dissemination of efficacious bio-behavioral cancer prevention and control interventions.

—Studies of innovative behavioral cancer prevention and control interventions targeted to specific populations in different organization settings, e.g., physician practice, ancillary health personnel, or public education.

—Studies of delivery systems for counseling and other approaches used for genetic testing, surveillance and prophylaxis.

—Research on the costs and benefits to patient enrollees and health care provider institutions which result from participation in NCI trials. One purpose of this research is to identify strategies for increasing accrual to NCI trials.

—Methodological research on the incorporation of quality-of-life, patient satisfaction and economic endpoints in NCI trials through direct clinical trial data collection or by other methods such as modeling using retrospective data.

—Studies of indirect costs, quality-of-life, complications and recurrence as a function of treatment approach, care setting and referral patterns.

—Studies of interventions to prevent morbidity associated with cancer and its treatment.

—Studies of existing patterns of care for cancer prevention, screening, treatment, and rehabilitation in relationship to existing evidence of efficacy, cost-effectiveness, clinical recommendations and practice guidelines.

—Studies of the effectiveness of preventive medicine and evidence-based medical practice.

—Studies of the diffusion of state-of-the-art cancer prevention, screening, treatment, care and rehabilitation.

—Studies of the formulation and implementation of organizational policy regarding the dissemination of innovative technology, e.g., counseling, screening for genetic predisposition to cancer and newly approved advanced diagnostic imaging tools.

—Studies of the feasibility, effectiveness and cost of using clinical informatic systems to identify, recruit and track organization members for targeted cancer prevention and screening interventions.

—Studies of the feasibility, effectiveness and cost of using clinical informatic systems to aid patient/physician decision making for cancer prevention, screening and treatment.

—Studies of the feasibility, effectiveness and cost of using clinical informatic systems as an aid to multi-disciplinary management of cancer care.

Applications may be submitted by domestic health care provider organizations acting jointly as a research consortium (the CRN). A domestic application may not include an international component. Networks must be comprised of an existing consortium or network of HCPOs, with total enrollment of at least 2-3 million adults (ages 18 and over). Also, network HCPO covered populations must include diverse populations with respect to race/ethnicity approximately representative of major race/ethnic groups in the U.S. Applicants must demonstrate a shared commitment among all participating HCPOs to working together on individually proposed research studies. Applicants must show evidence of the ability to access and organize data collection from all participating HCPOs in the network. Applicants are encouraged to demonstrate the capability of data linkages with local centralized tumor registries, pathology and radiologic facilities, and state vital records. If these capabilities do not currently reside within one or more of the participating HCPOs, the applicant may assemble a group with plans to develop the necessary expertise across all HCPOs in the network. Each applicant must have

access to a resource unit that supports research data management locally. Affiliation of one or more of the HCPOs with clinical researchers associated with an academic medical center is considered desirable, particularly where it will expand the research expertise required for proposed studies.

A proposed CRN will be evaluated using the following criteria:

—Research capacity and experience. The institutional research capacity and experience of each member of the CRN must be documented, including the number and qualifications of in-house research staff. All research capacity and experience related to cancer research must be documented, including institutional affiliations with academic medical centers, collaboration with or membership in existing NCI cancer centers, cooperative groups, CCOP research bases, or consortia. Emphasis should be placed on the research capacity and experience which is expected to be most relevant to the activities of the proposed CRN. Individual HCPO members of the CRN must demonstrate a capacity and willingness to facilitate professional interaction between research and clinical care staff of the HCPO.

—The applicant must describe or propose an organizational structure consisting of a network or consortium of HCPOs with documented institutional commitment from each member of the proposed CRN to participate in the proposed activities of the CRN. The CRN need not have a centralized physical location but it must have an identifiable Steering Committee which represents members of the CRN and works with an NCI Program Director in the context of a Cooperative Agreement. The Steering Comunittee would convene Working Groups for planning and supervising the specific research activities of the CRN.

—The nature of plan membership of the CRN members must be documented. The following characteristics of the HCPO and plan membership are relevant to the application: size of enrollment; geographical location of enrollment; socio-demographic characteristics of membership (age, gender, race/ethnicity, socioeconomic status, health status); length and continuity of enrollment (for enrollees with and without a history of cancer); benefit coverage; longevity and stability of HCPO; size and composition (practice specialty) of medical staff; structure (fee-for-service, staff model, IPA, point-of-service, etc.); type and/or proportion of services offered "within plan" and "contracted-out."

—The nature of CRN member data systems must be documented: type of systems available for the acquisition, storage and analysis of epidemiological, clinical and resource use and cost data; extent of data system automation; extent of retrospective data that is available; capacity to link data across CRN members; capacity for centralized data coordination and management; type of data elements, if any, that cannot be shared for research purposes because of individual member business considerations or for reasons of provider or patient confidentiality considerations.

—Linkage to cancer registry. The feasibility and willingness of CRN members to link data to a SEER cancer registry or other population-based (e.g., state cancer registries) or hospital-based tumor registries should be described.

—Linkage to other data resources. The feasibility and willingness of CRN members to link to other types of data resources, such as registries related to cancer genetics, health related survey data, demographic and socioeconomic data, data on use of out-of-plan services, etc., should be described.

—Linkage to existing NCI-supported research organizations, such as institutions participating in clinical trial research or large multi-center epidemiological research studies.

—The applicant must describe how the activities of the CRN can result in the increased capacity of individual members of the CRN or the CRN as a whole to conduct research under existing NCI mechanisms.

—The applicant CRN must describe specific activities and studies planned for the funding period.

—The applicant CRN must specify a set of criteria and a process to be used to consider adding new member HCPOs to the CRN. Addition of new members would require the consultation and approval of the NCI Program Director.

NCI oversight of the CRN will be the responsibility of the NCI Program Director, with the advice of a CRN Review Committee composed of NCI professional staff. The NCI Program Director will be a member of the CRN Steering Committee.

Funded CRNs and NCI will jointly develop appropriate confidentiality for data collection, processing, storage and analysis to ensure the confidentiality of data on individual HCPO patients, health care providers or institutions involved in CRN research projects.

Long-Term Cancer Survivors: Research Initiatives. Concept for an RFA, first year set-aside $3 million, total $15 million over two to five years (from cancer control funds), 12 to 15 awards. Program director: Claudette Varricchio, Community Oncology and Rehabilitation Branch, Division of Cancer Prevention and Control.

The purpose of this proposed RFA is to promote research which will lead to a decrease in the physiologic and psychologic morbidity associated with long term (more than 5 years) survival by addressing specific areas that affect cancer survivors to a greater extent than members of the population at large. This RFA intends to address questions related to what is experienced by the cancer survivor; what happens physiologically and psychologically to persons who have experienced cancer.

This RFA does not include research questions that seek to answer questions related to explanations of differences between survivors and those who do not survive cancer. However, it will be important to ascertain whether the differences between survivors with and without serious sequelae are based on therapy or other factors. This RFA requests applications that will provide the information about incidence and scope of effects on survivors, their relationship to treatment, and where appropriate, propose to test interventions, and the timing of interventions, to reduce the late morbidity of cancer and cancer therapy and promote as normal a life as possible for the survivor. To achieve these purposes, a descriptive phase may be included to generate hypotheses about the intervention to be tested. It is expected that the proposals will represent multi-disciplinary approaches and multiple end points.

Since some research results concerning short term survivors has been published, this RFA will address issues related to long term survivors based on an integration of the recommendations of the Workshop on Unresolved Issues in Cancer Survivorship and priority areas identified by NCI staff. This RFA will provide funding through the ROT, R29 and R03 mechanisms. The science proposed will determine the appropriate funding mechanism and the programmatic assignment to NCI divisions. The applications may include methodology studies, the development of appropriate assessment approaches for both physiologic and psychosocial long term effects.

Areas to be explored under the R01 and R29 mechanisms may include, but are not limited to:

—Prevalence and longitudinal incidence studies of physiologic late effects, e.g. cardiac toxicities and events, pulmonary compromise, late effects of limb sparing, minimal breast surgery and reconstructive surgery, ovarian failure, renal failure and neurologic defects.

—Prevalence and longitudinal incidence studies of psychosocial late effects, e.g. job and insurance discrimination, sexuality, quality of life, depression, cognitive function and mentation.

—Prevalence and longitudinal incidence studies of second cancers, including investigation of risk factors.

—Reproductive function, e.g. fertility and health of offspring.

—Economic impact, e.g. cost of follow-up medical care monitoring, outcomes of follow-up that affect cost, comparisons of how follow-up care is delivered, relative cost of specialty based follow-up care compared to primary physician-based care, evaluation of effectiveness and cost of psychosocial and other interventions that will impact on survivorship outcomes.

—Evaluation of the effectiveness of prevention interventions to prevent sequelae, e.g. cardioprotective agents, prevention of second cancers, maintenance of fertility, early interventions during treatment to lessen negative impact of sequelae.

—Exploration of the impact of survivorship related to insurance and employment discriminations including that related to genetics.

—Studies in offspring, e.g. birth defects, delayed developmental milestones and malformation rates.

Small grant applications (R03) may be appropriate for exploratory and validation studies in the following areas:

—Development and testing of diverse methodologic approaches specific to cancer survivors, e.g. instrument development, adaptation and validation of existing measures for use in special populations.

—Targeted prevalence studies of specific cancer-related effects on survivors to determine the need for large scale studies.

Informatics Support for Breast and Colon Cancer Cooperative Family Registries. Concept for an RFA, cooperative agreement, first year set-aside $850,000, total $4.6 million over five years, one award. Program director: A. Sheon, Division of Cancer Epidemiology and Genetics.

The Cooperative Family Registry for Breast Cancer Studies (CFRBCS) is a network of investigators at six sites who have had cooperative agreements since 1995 to collect pedigree information, epidemiologic and clinical data, and biological specimens from individuals and patients with a family history of breast cancer to provide a resource for basic, clinical, epidemiologic, and behavioral breast cancer genetics research, and to identify a population at high risk for breast cancer that could benefit from new preventive and therapeutic strategies.

Recipients of the CFRBCS Cooperative Agreement Awards include: Northem California Cancer Center (D. West); Ontario Cancer Treatment and Research Foundation (I. Andrulis); Memorial Sloan-Kettering Cancer Center (R. Senie); University of Melbourne (J. Hopper); Fox Chase Cancer Center (M. Daly); and Huntsman Cancer Institute (S. Buys). In addition, Hoda Anton-Culver, University of California, Irvine, received an R01 award to conduct research similar to that being conducted by the CFRBCS investigators. That award was converted to a U01 and this site now participates as an additional node in the Registry.

In 1996, NCI awarded supplements to four CFRBCS sites to collect data from and perform genetic characterization on specimens from Ashkenazi Jewish individuals. These data will provide an important opportunity to confirm and extend findings from the recently completed study of Ashkenazi Jews in the Washington, DC, area. Cross-site analysis of these data, too, await award of an informatics center.

Similar to the CFRBCS, the Cooperative Family Registry for Epidemiologic Studies of Colon Cancer Studies (CFRCCS) is envisioned to be a multicenter Registry which serves as a research resource to the scientific community. The proposed Informatics Center shall provide support to the CFRCCS as well as the

CFRBCS. CFRCCS awards are pending to the following investigators: Mayo Foundation (N. Lindor); University of Queensland (J. Jass); Fred Hutchinson Cancer Research Center (J. Potter); University of Southern California (R. Haile); University of Hawaii (L. Le Marchand); and Ontario Cancer Treatment and Research Foundation (S. Gallinger).

There is an urgent need to provide for coordination of the central database that will permit ready access to cross-site core data from the Breast Cancer Registry, conduct range and quality control checks, and ensure the confidentiality of the highly sensitive data. The central database will also include data collected in pilot studies approved by the Advisory Committee, and data generated from studies conducted by outside investigators who use Registry data for their investigations. Once the Colon Cancer Registry is up and running, it too shall require support for analysis and quality control of cross-site data.

The Extemal Advisory Committee for the CFRBCS has urged the NCI to expeditiously provide for the Central Data Base to permit cross-site analysis of Registry data.

This proposed RFA will support one group to develop the informatics infrastructure to support the CFRBCS and the CFRCCS. Specifically, in collaboration with investigators from the Registries' clinical centers, the Informatics Center shall: provide training materials and conduct on site training when needed to ensure consistency and quality control of data collection; provide information and software to support local entry of data which will go into the central databases; perform quality control checks of data collected and entered at local sites but submitted to the central databases, and provide timely feedback to sites to enhance quality control of data collection and entry; provide service statistics to NCI program officials and the Advisory and Steering Committees concerning recruitment, retention, and protocol compliance; conduct analyses of cross-site data at the request of Registry investigators or Program Officials; develop and maintain anonymous databases for use as a research resource; and promote information dissemination through newsletters and a WWW site.

In Congress

Scientists Campaign Against NIH Alternative Medicine Office

A group of prominent scientists earlier this week urged Congress to eliminate the NIH Office of Alternative Medicine.

In separate letters addressed to Rep. John Porter (R-IL), chairman of the Labor, HHS and Education Appropriations Subcommittee, at least five scientists said the NIH office that was created to use the criteria of science to evaluate the modalities of alternative medicine has instead become a promoter of the alternatives.

Since its founding in 1992, OAM has had the enthusiastic backing of powerful politicians, particularly Sen. Tom Harkin (D-IA), former chairman, and now the ranking minority member of the Labor, HHS & Education Appropriations Subcommittee. Generally, at the time of appropriations, OAM receives significantly higher funding than the administration requests.

Now, many observers wonder whether the letters from scientists would trigger a Congressional backlash against the office. The answers could emerge July 15, as the House appropriators gather to mark up the appropriations bill that includes funding for NIH.

OAM has a budget of $11.994 million this year, and the Administration's budget for 1998 proposes a $7.5 million appropriation.

The campaign against OAM appears to have been spearheaded by physicists.

"I wish to alert you to the concern of physicists over the direction taken by the OAM, and to urge you that funding for this office be terminated," D. Allan Bromley, Yale University professor and president of the American Physical Society, wrote in a letter to Rep. John Porter (R-IL), chairman of the Labor, HHS & Education Appropriations Subcommittee.

"The OAM has emerged as an undiscriminating advocate of unconventional medicine," Bromley wrote in a letter dated July 8. "It has bestowed the considerable prestige of the NIH on a variety of highly dubious practices, some of which clearly violate the laws of physics and more nearly resemble witchcraft than medicine.

"Not only has this diverted precious resources from promising scientific programs, it has given credibility that serious scientists dismiss as quackery," wrote Bromley, who served as the scientific advisor to former President George Bush.

Another letter from Ursula Goodenough, professor of biology at Washington University in St. Louis and past president of the American Society of Cell Biology, said OAM has failed to conduct scientific testing of alternative treatments.

"Nothing coming from OAM indicates that it is conducting or planning any studies that would put any alternative treatments to scientific test," Goodenough wrote in a letter dated July 7. "The

premise is rather to `find out why they work.' As near as I can tell, if a `research project' fails to find this out, the conclusion will be that the question should be asked some other way, not that it was the wrong question.

"There is no evidence of the skepticism that scientists bring to their own ideas and the ideas of others. Everything is `promising.' Everything is `time-honored practice,' the `wisdom of ancient times.'

"It's really a disaster," Goodenough wrote.

Sources said Porter was expected to receive letters from Maxine Singer, president of the Carnegie Institute, Paul Berg, a Nobel laureate and biology professor at Stanford University, and Robert Park, professor of physics at the University of Maryland and director of public information for the American Physical Society.

"Appalling Ignorance of Basic Physics"

The physicists took their first swipe at OAM last fall, when Robert Schrieffer, then APS president, wrote a letter to a fellow Nobel laureate, NIH Director Harold Varmus.

"I write to express the dismay of physicists at certain statements, linked to the OAM, that seriously misrepresent basic laws of physics," Schrieffer, professor of physics at Florida State University and chief of the National High Magnetic Field Lab, wrote in a letter dated Oct. 10, 1996.

"While all scientists must share a concern for the sad state of scientific literacy among the general public, physicists are particularly disturbed by distortions that make it appear that discoveries of modern physics lend support to unscientific claims.

"A most remarkable report, Alternative Medicine: Expanding Medical Horizons (NIH Publication No 94-066), for example, invokes quantum mechanics as a likely explanation of `the ability of humans to affect physiological systems at a distance by mental means,' and frequent reference is made throughout the report to the body's `energy fields.'

"Quantum mechanics offers no support for psychic intervention, nor do such energy fields have any basis in physics. An entire chapter dealing with bioelectromagnetics demonstrates an appalling ignorance of basic physics," Schrieffer wrote.

A book on homeopathy co-written by OAM Director Wayne Jonas and advisory council member Jennifer Jacobs was "even more disturbing," Schrieffer wrote.

"A chapter, Theory and Research: The Scientific Investigation of Homeopathy, displays not only ignorance of basic quantum mechanics, molecular physics and chaos, terms that are used with abandon, but with the very concept of the scientific method."

Jonas did not return a reporter's call, and OAM spokesman Anita Greene declined to comment on the letters.

Bills On Drug Reimbursement For Medicare Patients Differ

The House and Senate are expected to reconcile the divergent proposals on reimbursement for drugs administered to Medicare patients.

The Senate version of the Medicare reform bill, approved by the Finance Committee last week, was far less favorable to oncologists than the House version drafted last month (**The Cancer Letter**, June 20).

Like the House bill, the Senate bill limits reimbursement to 95 percent of the "average wholesale price" for drugs. Unlike the House version, the Senate bill pegs all price increases to the Consumer Price Index and gives the HHS Secretary the discretion to select the AWP compendia or produce a new one.

The Senate language allows the HHS Secretary to determine which AWP index would be used to set reimbursement. "The amount payable for the drug or biological [would be] equal to 95 percent of AWP, as specified by the Secretary," the bill states.

Under the Senate bill, the Secretary is expected to "conduct such studies or surveys as are necessary to determine AWP of any drug or biological."

Every year, the prices charged by physicians for drugs would be adjusted by "the percentage increase in the CPI for urban consumers for the 12-month period ending with June of the previous year," the Senate bill states.

Currently, Medicare reimburses office-based oncologists at AWP.

"The Senate language appears to allow [the Health Care Financing Administration] to determine supposed average wholesale prices on its own, and may even authorize HCFA to substitute a wholly different price," Joseph Bailes, chairman of the Clinical Practice Committee of the American Society of Clinical Oncology wrote in a letter to members of

a conference committee that is expected to reconcile the House and Senate versions of the bill.

In the letter, dated July 9, Bailes argued that using CPI as a limit to potential increases is similarly inappropriate. "Since oncologists have no control over the prices charged by drug manufacturers and wholesalers, it would be extremely unfair if oncologists suffer reduced reimbursement of their drug costs because the prices charged to them have risen faster than the CPI," Bailes wrote.

"Cancer patients benefit from convenient, cost-effective office-based care," Bailes wrote. "Without adequate reimbursement for drug therapies, oncologists will no longer be in a position to provide these services."

The date for a House-Senate conference to reconcile the two versions of the Medicare reform bill has not been set. The Senate members of the bill reconciliation conference are expected to include Barbara Boxer (D-CA), Kent Conrad (D-ND), Pete Domenici (R-NM), Phil Gramm (R-TX), Charles Grassley (R-IA), Frank Lautenberg (D-NJ), Trent Lott (R-MS), Daniel Patrick Moynihan (D-NY), Don Nickels (R-OK) and William Roth (R-DE).

The tentative list of House members expected to be involved in the conference includes Richard Armey (R-TX), Michael Bilirakis (R-FL), Thomas Bliley (R-VA), Thomas DeLay (R-TX), John Dingell (D-MI), Newt Gingrich (R-GA), Dennis Hastert (R-IL), David Hobson (R-OH), John Kasich (R-OH), and Charles Rangel (D-NY).

Both the House and Senate language may be more favorable for oncology practices than the Administration plan to eliminate the physicians' markup on drugs in fiscal 1998. The proposal, contained in the appropriations legislation submitted by the President, sought to reimburse oncologists on "actual acquisition costs" of the drugs.

Under the Administration proposal, reimbursement would have been the lowest of:

—The physician's actual acquisition cost,

—The average wholesale price.

—The median actual acquisition cost of all drugs or biologicals for the 12 month period.

The Administration proposal defined the actual acquisition cost as "the physician's cost, based on the most economical case size in inventory on the date of dispensing, or, if less, the most economical case size purchased within six months of dispensing."

Under the President's proposal, the actual acquisition cost included "all discounts, rebates, or any other benefit in cash or in kind (included, but not limited to, travel, equipment, or free products)."

In a related development, the Senate version of the bill did not contain a provision for reimbursement of oral anti-nausea drugs taken with chemotherapy. The language of providing such coverage was included in the House bill.

Funding Opportunities

Program Announcement

Title: **Primary Prevention Skin Cancer Strategies for Children, Parents, and Caregivers**

The Centers for Disease Control and Prevention announces the availability of fiscal 1997 funds for cooperative agreement projects for primary prevention of skin cancer, and to build a national primary prevention effort that targets children (aged 0-13), parents, and caregivers. Project activities will be developed to complement previous and ongoing efforts of the National Skin Cancer Prevention Education Program and focus on two program options. Applicants may choose one or both of the options.

Option One: Develop and conduct a skin cancer primary prevention intervention.

Option Two: Develop partnerships, coalitions, or interest groups with the lay, professional, and scientific community that supplement and support the primary prevention efforts of the NSCPEP.

Eligible applicants are public and private not-for-profit organizations, governments, and their agencies. Approximately $800,000 is available in FY 1997 to fund approximately four awards. A minimum of one award will be made for each of the Options. The average award will be $200,000, with awards ranging from approximately $150,000 to $250,000. It is expected that the awards will begin on or about Sept. 30, 1997, and will be for a 12-month budget period within a project period of up to 3 years.

Inquiries: Call all 404/332-4561 and leave a message with name, address, and telephone number, and refer to Announcement 775. Further assistance may be obtained from Glynnis D. Taylor, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention, 255 East Paces Ferry Road NE., Room 314, Mailstop E-18, Atlanta, GA 30305, tel: 404/842-6593, or email: gld1@cdc.gov. Programmatic technical assistance may be obtained from Barbara A. Bewerse, Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, CDCP, 4770 Buford Highway NE., Mailstop K-57, Atlanta, GA 30341-3724, tel:404/488-4347, email: byb0@cdc.gov.