

Response to Request for Information: Proposal to Cap the Number of Simultaneous Research Project Grants per Principal Investigator to Support More Researchers and Maximize Scientific Productivity and Innovation
Notice Number: NOT-OD-26-086

July 31, 2026

Northwestern submitted the following responses in alignment with the topics outlined in the National Institutes of Health [Request for Information](#).

Pros and/or cons on the policy

Northwestern shares NIH's goals of broadening participation and maximizing public benefit. A numerical cap, however, treats unlike mechanisms and leadership roles alike, making an R03 or R21 equivalent to a P01, U19, or R35. It could deter MPI collaboration, disrupt meritorious translational and longitudinal research, and substitute award count for case-specific scientific judgment. Targeted support and enhanced review would advance NIH's goals more precisely.

The optimal number of RPGs for the cap (2,3 or 4)

No cap; use enhanced case-specific review.

Strengths and weaknesses of the proposed implementation strategies

Of NIH's two approaches, a renewal-based phase-in is less disruptive than requiring compliance within one year. Yet both could force institutions to terminate awards or replace PIs to accept grants. PI leadership is not interchangeable; substitutions can compromise expertise, relationships, regulatory accountability, and coordination. If NIH proceeds, it should pilot the policy, publish evaluation criteria, permit limited exceptions, and reject a one-year transition.

Possible unintended consequences or policy loopholes

Counting MPI awards would deter cross-disciplinary collaboration; excluding them could invite restructuring to evade the cap. Other responses may include combining unrelated aims, nominal PI substitutions, inflated budgets, or migration to mechanisms outside the cap. The policy could interrupt clinical or longitudinal studies and destabilize trainees, staff, shared technologies, and multi-institutional networks while degrading NIH administrative data.

Other Comments

Northwestern University recommends that NIH not implement an NIH-wide numerical RPG cap. NIH's diminishing-returns studies warrant attention, but portfolio-level associations based largely on publications do not establish that award count reliably measures an investigator's capacity or a project's marginal value. RPG mechanisms vary greatly in budget, duration, purpose, complexity, and leadership: an R03 or R21 would consume the same slot as a P01, U19, or R35, while several focused grants would be treated differently from one larger enterprise.

NIH already receives Current and Pending (Other) Support, person-month commitments, and Just-in-Time information to identify scientific, budgetary, commitment, and capacity concerns. These tools provide a foundation for enhanced, case-specific review of a third and subsequent RPG without an automatic prohibition.

Northwestern's NHLBI-funded R33 on engineered heart tissues (R33HL168758) illustrates what is at stake. Investigators from the Feinberg School of Medicine and McCormick School of Engineering brought together independently funded programs in cardiovascular genetics, clinical cardiology, biomedical engineering, materials science, flexible electronics, tissue engineering, and microfabrication. Their individual grants support fundamental discovery; this additional collaborative award translates those advances into a platform for testing patient-specific treatments for heart failure and arrhythmias, a major unmet clinical need. Because R33s count under the proposed policy, the shared award would consume one RPG slot for each investigator. Under a rigid cap, such a translational project could be the grant that cannot proceed precisely because its investigators also lead productive discovery programs.

Any consideration of a cap should begin as a time-limited pilot with public evaluation criteria. Any model should also permit narrowly drawn exceptions that serve the national scientific interest, including continuity of clinical or longitudinal research, unique leadership of a national network, or temporary overlap caused by award timing. Institutes and Centers should adjudicate exceptions under consistent NIH-wide criteria, with time limits and aggregate public reporting. NIH should evaluate effects not only on the number of funded PIs but also on scientific output, innovation, collaboration, workforce stability, mentoring, geography, institutional participation, and the nation's capacity to respond to urgent health needs.

In 2017, NIH considered the Grant Support Index but instead pursued the Next Generation Researchers Initiative, prioritizing meritorious R01-equivalent applications from early-stage and later other at-risk investigators. ESIs serving as first-time PIs on new R01-equivalent awards rose from 978 in FY2016 to a peak of 1,609 in FY2022, although subsequent levels declined. This history shows that targeted workforce policies can expand opportunity without a rigid NIH-wide cap.

Northwestern therefore recommends that NIH:

- expand and evaluate dedicated paylines, bridge mechanisms, and other support for early-stage, at-risk mid-career, first-time, and historically underfunded investigators and institutions;
- apply enhanced programmatic or advisory-council review to a third and subsequent RPG, considering scientific need, role and effort, existing resources, mentoring, and marginal value;
- reward established investigators who create meaningful leadership, mentorship, and independent funding opportunities for junior scientists;
- pilot and evaluate targeted portfolio-balancing strategies in selected Institutes and Centers before NIH-wide implementation; and

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- explain transparently how any released funds would be allocated and whether broader distribution produces additional high-quality science rather than rearranging scarcity.

A targeted, transparent strategy, paired with enhanced review of additional awards, would broaden opportunity while preserving the collaborative and merit-driven research enterprise on which future discovery depends. Above all, medical and scientific success should not be capped *a priori*, thereby undermining meritocracy and competition.