



February 13, 2014

The Honorable Fred Upton, Chairman  
U. S. House of Representatives  
The House Committee on Energy & Commerce  
2125 Rayburn House Office Building  
Washington, D.C. 20515

The Honorable Diana DeGette  
U.S. House of Representatives  
2368 Rayburn House Office Building  
Washington, D.C. 20515

Dear Chairman Upton and Ms. DeGette:

On behalf of the 30 million men, women, and children affected by one of the nearly 7,000 known rare diseases, the National Organization for Rare Disorders (NORD) thanks you and the Energy and Commerce Committee for your continuing support of the rare disease community.

We welcome the opportunity to provide preliminary comments on the 21<sup>st</sup> Century Cures Act Discussion Draft. These comments do not encompass NORD's full opinion on this discussion draft, the individual provisions within, and the provisions NORD believes the discussion draft has yet to address. Our comments will permit the Committee to consider the rare disease patient community's perspective on a number of the provisions as the initiative continues. NORD will submit full comments when our full review is complete.

### **Provisions Contained Within the 21<sup>st</sup> Century Cures Act Discussion Draft:**

While we are encouraged by many of the provisions contained within the discussion draft, we cannot support the discussion draft in its current form. Many of the provisions are too burdensome and prescriptive on the Food and Drug Administration (FDA) with little to no additional resources. If this initiative is to succeed, the Committee must give the National Institutes of Health and the FDA the appropriate resources to implement these reforms.

Finally, while we are heartened by many of the patient-focused provisions, we believe various improvements must be made to these provisions in order to truly aid patients. These specific improvements will be contained within our full comments.

In the meantime, below are NORD's current thoughts on several of the key provisions contained within the discussion draft.

### **Title I: Putting Patients First By Incorporating Their Perspectives Into The Regulatory Process And Addressing Unmet Needs:**

**Subtitle A – Patient-Focused Drug Development:** NORD strongly supports the Committee’s efforts to strengthen the patient’s voice within the FDA drug review process by creating a structured framework for the incorporation of patient experience data. As the language is currently structured, however, we are concerned this provision may create an undue burden on the FDA while adding only limited value for patients. While we are in full agreement with the spirit of the provision, we recommend the Committee revisit the language.

**Subtitles E and F – Priority Review for Breakthrough Devices and Accelerated Approval for Breakthrough Devices:** NORD strongly supports the establishment of breakthrough and accelerated approval pathways for medical devices. This provision would greatly benefit the rare disease community in need of innovative therapies.

**Subtitle G – Expanded Access:** NORD supports this expanded access provision, and has worked with Congressman McCaul’s office to ensure that the needs of the patient community are met. We believe the provisions will provide greater transparency for patients and their doctors. At the same time, the proposal will set the stage for future meaningful reforms. We thank the Committee for including this provision within the discussion draft, and encourage inclusion in 21<sup>st</sup> Century Cures legislation.

**Subtitle L – Dormant Therapies:** NORD supports the creation of incentives for the investigation and development of dormant therapies. Potential treatments and cures for rare diseases lie in promising compounds with little to no patent life remaining. However, NORD cannot support a patent protection period of 15 years for such therapies as this is far too long a protection period, especially compared to other exclusivity period lengths already in existence.

**Subtitle N – Orphan Product Extensions Now:** NORD is in full support of this provision. The vast majority of rare disease patients are treated off-label, often causing various problems in insurance coverage for their treatment. This proposal would create an incentive for placing rare disease conditions on the label, thus greatly increasing the likelihood insurance would cover the therapy for the rare condition. We encourage the Committee to include this provision within future legislation.

## **Title Two: Building The Foundation For 21<sup>st</sup> Century Medicine, Including Helping Young Scientists**

**Subtitle D – Genetically Targeted Platform Technologies for Rare Diseases:** NORD is currently reviewing this provision, and will provide the Committee with our comments in our full response to the discussion draft.

## **Title Five: Modernizing Medical Product Regulation:**

**Subtitle D – Medical Device Reform: Section 5067 – Humanitarian device exemption application to in vitro diagnostics:** NORD supports allowing the FDA to apply the Humanitarian Device Exemption to products that impact more than 4,000 patients, as the 4,000 patient limit is an arbitrary number having no scientific rationale. In fact, limiting diagnostics to a more stringent number than therapies goes against logic, as individuals who carry a gene

should be tested to determine whether they have the disorder or not. Thus, NORD supports this provision. We look forward to working with the Committee and other stakeholders to ensure the FDA has the flexibility to apply the Humanitarian Device Exemption to all appropriate opportunities.

### **Provisions Absent From the 21<sup>st</sup> Century Cures Act Discussion Draft:**

We are also concerned with the absence of several key patient-focused provisions that we believe should be contained in the next iteration of the bill. These include, but are not limited to:

**FDA Office of Patient Relations:** While NORD is heartened by many of the patient engagement provisions contained within the 21<sup>st</sup> Century Cures Act Discussion draft, we are constantly reminded of the lack of visibility and resources of the current patient relations office within the FDA. By elevating the office to the level of the Commissioner and adding additional resources, the 21<sup>st</sup> Century Cures Act could provide patients with a central location within the FDA to seek assistance on matters of expanded access, finding a review division, becoming a special government employee, and more. Without this office, the patient engagement initiatives contained within this discussion draft will only strain the limited resources the FDA has for patient engagement even further.

**National IRB Reliance Agreement:** NORD has crafted a proposal to allow institutions to share patient consent forms generated at an accredited institution through a reliance network without local re-review. This provision would establish a system whereby applicants for federal biomedical research grants and contracts may establish an IRB of record whose approval of consent forms could be used by any other site in the same research study without seeking additional local institutional approval. The legislation would also de-risk using these consent forms for the local institution. This would greatly aid rare and common disease research, and would drastically cut down on the resources and time needed to receive approval from each individual center's IRB. We would welcome the opportunity to discuss the inclusion of this proposal within the next discussion draft.

**Orphan Products Board:** The Committee could make great strides in increasing coordination on rare disease research, product development, and reimbursement by including language in the next iteration of the 21<sup>st</sup> Century Cures Act that would require the currently dormant (but statutorily mandated - 42 U.S. Code § 236) Orphan Products Board to report to Congress on its activities.

**Patients' Access to Treatments Act:** NORD recently joined with the Coalition for Accessible Treatments in advocating for the inclusion of the Patients' Access to Treatments Act within the 21<sup>st</sup> Century Cures Act. While we are heartened by many of the provisions contained within the discussion draft, they will have little to no positive effect if patients cannot access these therapies due to prohibitive co-insurance levels within specialty tiers. The Committee must address this issue, either by including the Patients' Access to Treatments Act in the next iteration of the 21<sup>st</sup> Century Cures Act, or developing an alternative solution to ensure patients can access these life-altering and often life-saving treatments.

**Medicare Part D Access to Off-Label Therapies:** Medicare Part D requires the existence of a published peer-reviewed study showing a therapy works in an off-label indication before Medicare Part D can provide reimbursement. This is particularly problematic for the estimated 80% of rare disease patients who are treated off-label. We would welcome the opportunity to work with the Committee to develop a solution to this growing access problem.

**Pediatric Rare Disease Priority Review Voucher Program:** The Pediatric Rare Disease Priority Review Voucher program, passed under FDASIA, has been highly successful in incentivizing drug development in rare, pediatric conditions. But after three uses, it is currently set to sunset. NORD encourages the Committee to make this program permanent.

NORD is also concerned with the lack of uniformity on the definition of “pediatric” across all Centers at the FDA, as this law defines pediatric differently than other FDA statutes. We encourage the Committee to work with the FDA to develop a uniform definition of “pediatric.”

**FDA Conflict-of-Interest Rules for Patient Advocates:** The FDA’s very narrow interpretation of what constitutes a “conflict of interest” disqualifies many high-qualified patient advocates from participating in the drug review process as special government employees. Because the rare disease community works in concert with all stakeholders, i.e. medical researchers, industry, and physicians, in the hopes of encouraging increased research as well as product development, there is the perception that patients and patient advocates are inherently “conflicted,” and therefore ineligible to participate in Advisory Committees and other FDA activities. We request that the Committee look at these limitations, and address the current situation to ensure the patient voice is heard.

Thank you again for the opportunity to engage in this exciting and much-needed initiative, and we will include recommendations in our full comments for how to improve the provisions included within the discussion draft. We look forward to working with you and the Energy and Commerce Committee as the 21<sup>st</sup> Century Cures Initiative continues, and we are grateful for your recognition of these extremely important issues within the rare disease community.

For questions regarding NORD or these comments, please contact Diane Dorman, Vice President of Public Policy, at [ddorman@rarediseases.org](mailto:ddorman@rarediseases.org) or (202) 588-5700 ext. 102, or (202) 258-6457.

Sincerely,



Peter L. Saltonstall  
NORD President and CEO



Our Mission: To drive efforts to cure psoriatic disease and improve the lives of those affected.

February 13, 2015

Committee on Energy and Commerce  
Chairman Fred Upton  
2125 Rayburn House Office Building  
Washington DC 20515

Re: 21<sup>st</sup> Century Cures Initiative

Dear Chairman Upton:

On behalf of 7.5 million Americans living with psoriasis and psoriatic arthritis – our nation’s most common autoimmune disease – we are writing to commend you for undertaking the 21<sup>st</sup> Century Cures Initiative. We applaud your effort to improve the discovery, development and delivery of medical treatments and cures and the significant amount of work that has gone into this effort over the past eight to 10 months. Based on the recent roundtables and hearings held by the Committee on the 21<sup>st</sup> Century Cures Initiative, it is clear that the Committee’s draft legislation strives to include patients in the biomedical research process and address unmet medical needs issues around chronic disease.

As the Committee seeks to build upon the foundation in the discussion draft, the National Psoriasis Foundation (NPF) urges you to strongly consider the following specific recommendations:

- Further strengthen and enhance the patient-focused drug development and related provisions to maximize the level of meaningful patient engagement throughout the Food and Drug Administration (FDA) review process and recognize that the personalized nature of many diseases and conditions often require multiple points of view;
- Allow greater sharing of patient data with researchers for the purposes of improving quality of patient care; and
- Ensure patients have access to affordable treatments and therapies by the Patients’ Access to Treatment Act (PATA).

### **Background on Psoriasis**

The National Psoriasis Foundation exists to drive efforts to cure psoriatic disease and improve the lives of those affected. The most prevalent autoimmune disorder in the nation, psoriasis is a noncontagious, chronic, inflammatory, painful, disfiguring and disabling disease for which there is no cure. Psoriasis appears on the skin, most often as red, scaly patches that itch, can bleed, and requires sophisticated medical intervention. Up to 30 percent of people with psoriasis also develop psoriatic arthritis. Of serious concern is the mounting evidence that psoriasis is not just a disease of the skin and joints but is in fact, a systemic, inflammatory disease associated with an elevated risk for other serious, chronic and life-threatening conditions – including cardiovascular disease, diabetes, depression, stroke, and malignancies. In addition to the often painful and physically devastating impact of psoriatic disease, it often is accompanied by many serious psychological issues as well.<sup>i</sup> As many as 60 percent of psoriasis patients report clinically significant psychiatric symptoms such as

depression and may receive a psychiatric diagnosis.<sup>ii</sup> Patients with psoriasis have a 39 percent increased risk of depression, a 31 percent increased risk of anxiety and a 44 percent increased risk of suicidality. Patients with severe psoriasis have a 72 percent increased risk of depression.<sup>iii</sup>

People with severe psoriasis die four years younger, on average, than people without the disease.<sup>iv</sup> This patient population also experiences a lack of access to appropriate treatments that can result in serious adverse impacts to functioning, including loss of mobility, pain, isolation and depression, and may be associated with comorbid conditions.<sup>v</sup>

It is critical that individuals living with psoriasis have access to the wide range of treatment options approved today and, hopefully, the many more that will be approved in the years to come. Psoriasis is a relentless and unpredictable disease, individual and diverse, presenting differently from one person to the next. Treatments that work for one person may not for others. Many patients cycle through accepted treatment options unsuccessfully, or temporarily successfully, and are ultimately left at the end of the treatment road with no alternatives.<sup>vi</sup> The individualist nature of the disease makes step therapy, fail first provisions and increasingly narrow formularies particularly detrimental to patients with psoriatic disease.

### **FDA – Patient Focused Drug Development**

The epidemiology of psoriasis and psoriatic arthritis in the U.S. is poorly understood. We do not yet understand the natural history of the diseases, how it affects various populations differently, and how treatments impact disease progression. Thereby, there are several public health aspects of psoriasis which are not formally captured in clinical trials. The PFDD initiative is an opportunity to bring attention to the way clinical trials in drugs and devices are conducted within our community.

For instance, the percentage of women and minority participants in clinical trials isn't enough for clinical relevance. Pregnant women with psoriasis may be at increased risk for adverse pregnancy outcomes due to comorbidities or other factors associated with the disease.<sup>vii</sup> Additionally, pregnant women with severe psoriasis have an increased risk of low birth weight infants.<sup>viii</sup> Psoriasis in childhood is not uncommon and pediatric psoriasis patients are an underserved population as they are often prohibited from entry into clinical trials. Psoriasis treatment options are initially developed only for adult patients, leading to widespread off-label use for children. There are currently only a few FDA approved psoriasis treatments for pediatric patients. Also in contrast to adult patients with psoriasis, only a few epidemiological studies of pediatric patients with psoriasis have been published to date. The incidence of pediatric psoriasis increases with increasing age.<sup>ix</sup> The overall rate of comorbid chronic conditions in psoriasis patients under age 20 is double that of their peers who do not have psoriasis. Increased rates of depression, diabetes, arthritis, Crohn's disease, obesity, hypertension and high cholesterol were associated with juvenile psoriasis.<sup>x</sup> Considering that most patients experience their first flares before the age of 16, there is a need for clinical trials to close these research gaps regarding psoriasis in pregnant women and pediatric patients.

There is no known cure for psoriasis and the available treatment options do not treat all of the symptoms of psoriasis. FDA approved treatments include topical solutions, phototherapy, traditional systemic agents, as well as biological therapies with the possibility of spontaneous remission. All FDA approved psoriasis treatment options have side effects and most have inadequate efficacy as the majority of patients and dermatologists note that they are unsatisfied with the results obtained from past and current treatment options. Although specific therapeutic recommendations exist for psoriasis, it is important that future treatment options are tailored to meet individual patient needs. The drug development and approval process is not a one-size-fits-all proposition, as various treatment options work very differently for each psoriasis patient.

Thereby, NPF recommends the development of biomarkers for psoriatic disease, for assessment of disease severity, prediction of the outcome of therapeutic interventions, and for distinction between the different clinical variants of the disease. A field of great importance is identification of biomarkers for prediction of development of comorbidities, such as arthritis, cardiovascular disease, and the metabolic syndrome. In psoriatic disease, biomarkers could be relevant for distinction between the different clinical variants of the disease, for assessment of disease activity and severity, and for prediction of the outcome of a therapeutic intervention. Biomarkers could also allow the selection of patient-tailored therapy to maximize the beneficial effect.<sup>xi</sup>

Furthermore, the advancement of Patient Preference Assessment (PPA) can establish a framework for patient organizations to provide input to FDA at various stages of drug development for their disease state. For NPF, this includes monitoring and addressing the health related quality of life effects as well as the comorbidities associated with psoriasis. The need to capture self-reported patient outcomes from psoriasis patients including development of better surveys to assess psoriasis severity is vital to the PFDD.

Placing patients at the center of the drug development process will spur the development of therapies for the conditions that matter to most patients with psoriatic disease.

### **Create Flexibility for Researchers to Share Data Sets**

Biomedical research is critical to achieve scientific breakthroughs to develop improved treatments with fewer side effects and, ultimately, cures or means of prevention. Big data is changing the pace of research and will hopefully help expedite research breakthroughs going forward. At present, strict data use agreements largely prohibit researchers who have access to these limited data sets from building stronger and more meaningful data sets, which greatly limit the usefulness of the data. As the draft legislation recommends, the creation of a "21<sup>st</sup> Century Cures Consortium" modeled after the European Union's Innovative Medicines Initiative would bring together federal agencies – including the National Institutes of Health (NIH), FDA, and Centers for Medicare & Medicaid Services – data will become exponentially vital to identifying gaps and opportunities, while accelerating discovery, development of cures, treatments, and prevention.

Thereby, we support both provisions of building a 21<sup>st</sup> Century data sharing framework and accessing sharing and using health data for research purposes. Researchers must be given more flexibility to work with the data within specified parameters in order to fully realize the potential value of the data as it pertains to clinical research and discovery. Presently, patient data is not operationally used for researchers while patients have shown to be generally willing to share their own medical records to support the uses of data to research.

### **Expand Access to Affordable Therapies**

The psoriatic disease community is very fortunate to have a number of treatments options today along with a robust pipeline with about 40 candidate treatments – drugs, injectables and topicals – in various stages of clinical evaluation. At the same, as also noted above, there is no cure for psoriasis or psoriatic arthritis, and patient response to treatments varies widely. As the Committee has heard from multiple patient advocates, if patients cannot access these treatments and cures, the discovery and development you seek to foster and accelerate will not deliver the benefits to the very people they are intended to help.

From NPF's recent patient survey, 40 percent of respondents say cost is an issue in accessing treatment. Despite having insurance, the majority of psoriasis and psoriatic arthritis patients pay more than \$2,500 in out-of-pocket costs per year; copayments for biologic drugs for psoriasis cost an average of \$1,500 per year; and one-third of patients say they encounter financial strain to pay for their biologic drug. Patients with psoriasis and psoriatic arthritis are adversely affected by high out-of-pocket costs associated with specialty pharmaceutical, costs that continue to rise at unprecedented levels. Many insurers and pharmacy benefit managers (PBMs) place specialty drugs used to treat psoriatic diseases into their drug formulary category requiring the highest level of

copayments. Additionally, in recent years, we have seen PBMs move to tighten access further by developing formularies that exclude numerous specialty drugs, including drugs used to treat patients with psoriatic disease. While the policy was eventually amended, the final version still places such treatments in a high-cost tier, increasing patient copayments and, for an increasing number of patients, placing the treatment out of reach.

The NPF believes that the existing legislation PATA will help address access and affordability of medications by limiting cost-sharing requirements applicable to medications in a specialty drug tier to the dollar amount applicable to drugs in a non-preferred brand drug tier. Such a policy recognizes the costs of such drugs but places appropriate limits on tiering to help make the treatments more accessible to patients in need. PATA has enjoyed the support of more than 140 members of Congress and a broad array of stakeholders. Given this support, we urge you consider incorporating PATA in your next discussion draft.

## Conclusion

The NPF thanks you and your colleagues, again, for this opportunity to comment on the draft legislation. We believe that the recommendations we have put forward can make a tremendous difference in the lives of 7.5 million Americans living with psoriatic disease. We are optimistic about the legislation and working with the Committee and members further as the legislation is finalized. If you have any questions about these comments, please contact Mr. Quardricos Driskell, NPF's Health Policy Manager at [qdriskell@psoriasis.org](mailto:qdriskell@psoriasis.org) or at (404) 455-5650. Thank you in advance for your consideration.

Sincerely,

  
Lean McCormick Howard, J.D.  
Vice President, Government Relations and Advocacy

LH:QBD  
Enclosure

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<sup>v</sup> Kimball AB, Gladman D, Gelfand JM, Gordon K, Horn EJ, Korman NJ, Korver G, Krueger GG, Strober BE, Lebwohl MG; National Psoriasis Foundation. National Psoriasis Foundation clinical consensus on psoriasis comorbidities and recommendations for screening. *J Am Acad Dermatol*. 2008 Jun;58(6):1031-42. And: Armstrong AW, Schupp C, Bebo B. Psoriasis comorbidities: results from the National Psoriasis Foundation surveys 2003 to 2011. *Dermatology*. 2012; 225 (2): 121-6. And: Yeung H, Takeshita J, Mehta NN, Kimmel SE, Ogdie A, Margolis DJ, Shin DB, Attor R, Troxel AB, Gelfand JM. Psoriasis severity and the prevalence of major medical comorbidity: a population-based study. *JAMA Dermatol*. 2013 Oct;149(10):1173-9.

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<sup>vii</sup> Bandoli G, Johnson DL, Jones KL, Lopez Jimenez J, Salas E, Mirrasoul N, Van Voorhees AS, Chambers CD. Potentially modifiable risk factors for adverse pregnancy outcomes in women with psoriasis. *British Journal of Dermatology*. 2010 Aug;163(2):334-9.

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<sup>xi</sup> Molteni S, Reali E. Biomarkers in the pathogenesis, diagnosis, and treatment of psoriasis. *Psoriasis: Target and Therapy.* 2012, Volume 2012:2, pp 55-66

The Honorable Fred Upton  
Chairman  
House Energy & Commerce  
2125 Rayburn House Office Building  
Washington, DC 20515

The Honorable Frank Pallone  
Ranking Member  
House Energy & Commerce  
2125 Rayburn House Office Building  
Washington, DC 2051

February 18, 2015

Dear Chairman Upton and Ranking Member Pallone:

We thank you for the opportunity to continue to provide input on how technology can be harnessed to advance our nation's health care system, reduce costs, and increase the overall quality of care that patients receive. The National Transitions of Care Coalition (NTOCC) shares your commitment to promulgate policies that promote innovation in health technology, particularly efforts that make it possible for health care providers to better manage patient care through secure use and sharing of health information.

NTOCC is a non-profit organization of leading multidisciplinary health care organizations and stakeholders dedicated to providing solutions that improve the quality of health care through stronger collaboration between providers, patients, and family caregivers. The organization was formed in 2006 to raise awareness about the importance of transitions in improving health care quality, reducing medication errors, and enhancing clinical outcomes among health care professionals, government leaders, patients, and family caregivers.

As you are aware, patients, particularly the elderly and individuals with chronic or serious illnesses, face significant challenges when moving from one care setting to another within our fragmented health care system. Poor communication during transitions from one care setting to another can lead to confusion about the patient's condition and appropriate care, duplicative tests, inconsistent patient monitoring, medication errors, delays in diagnosis, and lack of follow through on referrals. These failures create serious concerns for patient safety, quality of care, and health outcomes.

NTOCC was encouraged that the underlying draft addresses many issues that have been affecting the health care community as a whole, especially with the delivery of care in today's ever changing environment. NTOCC believes that the capacity for health information technology (HIT) to improve communication and information sharing will help address the threats to safety and quality of care during care transitions. NTOCC appreciates the Committee's language granting the Secretary discretion to waive any limitations within 1834(m) of the Social Security Act relating to what qualifies as an originating site. We encourage the Committee to go one step further and designate the patient's home as an originating site in statute. This would ensure the ability for providers, patients, and caregivers to have a smooth transition of care into the home.

NTOCC also appreciated the Committee's dedication to reimburse telehealth services that reduce hospital readmissions. NTOCC encourages the Committee to include language surrounding a comprehensive medications management plan for all individuals transitioning from one care facility to another care facility or their home. Poor communication during transitions can lead to medication errors, duplicative tests, inconsistent patient monitoring, and lack of follow through on referrals, all of which contribute to poor health outcomes for patients and avoidable hospital readmissions.

NTOCC has developed several tools, such as our *Medicare Reconciliation Elements*, to assist providers in creating their own forms for performing medication reconciliation to ensure that key information is communicated. In addition, NTOCC has developed *My Medicine List* to help patients and family caregivers track their own medications as they navigate transitions. NTOCC strongly believes that patients and family caregivers should be empowered to take an active role when a care transition occurs. It is critical for them to have a clear understanding of the care plan, including how to take medications, how the medications relate to their condition or diagnosis, and potential benefits and risks of medications.

NTOCC believes that while there have been major innovations in HIT that are leading to improvements in patient care, barriers still remain to utilizing technology to its fullest capacity. Without addressing these impediments, the promise of HIT's effect on overall transitions of care improvement will not be realized. As the committee continues their work, NTOCC urges the Committee to consider addressing how interoperability limitations negatively affect transitions of care. Interoperability among the various technology systems—such as the administrative systems, medical record systems, diagnostic tools, transcription and security, and others—is critical for effective transitions of care. There exists a pervasive inability to connect disparate health technology software programs to one another, resulting in poor communication across the continuum of care. Connectivity between acute and primary care, between post-acute and community-based services, between patients and health technology resources, and every touch-point within that ecosystem, is uneven at best.

NTOCC shares the Committees' goals of promoting policies that employ technology to drive improved care coordination and quality of the delivery of care, especially during transitions of care. We appreciate the opportunity to submit these comments and look forward to continuing to work with the Committee on this important issue. Please direct any questions to Jessica Layson at (202) 466-8700 or [JLayson@vennstrategies.com](mailto:JLayson@vennstrategies.com).

Sincerely,

A large black rectangular redaction box covering the signature area.

Cheri Lattimer  
Executive Director

Dear All,

Provided below are Novartis comments with regards to the 21<sup>st</sup> Century Cures proposal. We appreciate your “open door” access, inclusiveness of stakeholder engagement, and opportunity to provide feedback. As a life science company, Novartis supports the efforts to provide enhancements to the discovery, development and delivery of innovative products.

We look forward to working with you throughout the legislative process. In the meantime, please do not hesitate to contact us if we can be a resource.

Regards,  
Dan Casserly

Chairman Upton and Congresswoman DeGette,

Novartis commends your leadership and the Energy and Commerce Committee for its continued commitment to the 21<sup>st</sup> Century Cures initiative. We congratulate the bi-partisan Representatives who have contributed to this the initial discussion document and are grateful for the opportunity to provide feedback.

At Novartis our mission is to care and cure. We want to discover and develop innovative products to prevent and cure diseases, to ease suffering and to enhance the quality of life. Many of the concepts that have been raised in the initial discussion document align well with our goals and we believe can help accelerate “the cycle of discovery, development, and delivery of promising new treatments and cures.”

Below please find our initial thoughts regarding select provisions within the discussion document, some ideas to strengthen specific concepts and a concept to consider adding that is currently absent.

**Patient Focused Drug Development (Sec. 1001)**

Novartis supports the creation of a structure for “patient experience data” to be collected and used in determining benefit and risk. The concepts in this section could help open the door to more conversation about reasonable risks that are willing to be considered compared to the unmet needs for any particular disease. Patient data, and input, should help the FDA consider perspectives from those living with cancer and disabling chronic disease. **However**, the concept proposes a workshop involving multiple stake-holders but excludes the biopharma industry from participation. Novartis encourages the Committee to include the industry in the public workshops and methods development processes outlined in the Section. Additionally, efforts should be made to incorporate patients’ perspectives on risks is incorporated into regulatory decision-making via the benefit-risk profile of a product. Therefore, legislation should ensure that information captured from patients is appropriately synthesized and incorporated into a product’s benefit-risk framework.

**Surrogate Endpoint Qualification (Sec. 1021-1024)**

The concepts in this section build nicely off of work already underway at FDA as part of the Advancing Regulatory Science and Critical Path initiatives. Novartis supports requiring FDA to develop and issue draft and final guidance (including public consultation) soon after enactment and the potential use of public-private partnerships for review of biomarkers. Progress in this space will be positive for diseases

where clinical endpoints are impractical like oncology. **However**, we are concerned that bill is too narrow in focus with respect to limiting required FDA work to surrogate endpoints. Instead we suggest that the process encompasses qualification of all drug development tools, including biomarkers and PRO's . Further the concept does not indicate whether any user fee resources from PDUFA are used to fund the potential public-private partnership.

#### **Expanded Access to Investigational Treatments (Sec. 1121-1125)**

Novartis supports enabling patients to have access to medicines they need in a fast and responsible manner. A science-based approach to safe and effective medicines is through the conduct of clinical trials to support a marketing approval by the FDA. Novartis looks forward to working with patients and stakeholders to increase awareness of the availability of clinical trials. And, when a clinical trial is not available, Novartis has internal policies, consistent with FDA regulations, for handling requests for access to investigational drugs. **However**, Novartis does not support a statutory mandate linking the development, or posting, of expanded access policies to regulatory designation mechanisms. Further, any requirements regarding expanded access must not deter eligible patients from enrolling in clinical trials. Clinical trials provide important information about whether therapies are safe and effective and how to use them. Such data is essential to ensure sound treatment decisions.

#### **Limited Population Antibiotic Drug Development (Sec. 1061-1064)**

Novartis supports legislation that would seek to encourage the development of new antibiotics and offer incentives for the development of new treatments. We support the "wild card" concept for difficult unmet needs such as antibiotics/antifungals. Further, we support the notion that the limited-population pathway would apply to antibiotic (and antifungals) only. While some may suggest expansion beyond antibiotics, further expansion could be a slippery slope for FDA to impose its authority into the practice of medicine where a product, once on the open market, is restricted in its use but not for reasons of safety or efficacy. **However**, Novartis believes that any linkage of the exclusivity to "donations" to the NIH must be very carefully framed so that it does not become bad precedent or cause an unpredictable funding stream for the NIH. Further, Novartis encourages the Committee to consider legislation that would provide sponsors who develop products in the neonatal space to receive a one-year, transferrable wildcard exclusivity. The vast majority of drugs used in this highly vulnerable population have not undergone sufficient study to receive US FDA labelling outlining their safe and effective use in neonates. Many conditions for which pharmacologic therapy is used or indicated in neonatal medicine are unique to the perinatal period because of the distinctive developmental status of premature and newborn infants, characterized by immaturity and transitional physiology. Often there is no analogous condition in the adult population. The existing regulatory paradigm which ties pediatric incentives and obligations to an adult indication, is not yielding therapies that are developed to address the unique needs of the most vulnerable population of pediatric patients. In order for any significant progress to be made in the development therapies to address neonatal disease, a new model of incentives unique to neonates must be adopted.

#### **Data Summaries for Label Supplements (Sec. 1181)**

Novartis believes this provision could greatly streamline the review process for addition indications to a drug label. The language would essentially codify, and motivate, more broad/frequent use of regulatory flexibility that already exists. While there is precedent already in oncology for approval of supplemental indications without full traditional data-sets we are not familiar with examples of potential use outside of oncology.

### **Clinical Research Modernization/Central IRB's (Sec. 3001-3002)**

Novartis is very supportive of this proposal. This concept could make clinical research simpler and cost effective but still protect the subjects in those trials. In principle, we believe that this proposal should achieve its objectives to reduce delays caused by duplication of efforts at multiple IRBs, each functioning on its own timeline. The delays are multiplied by the number of protocol amendments requiring additional IRB approvals. It is clear that the local IRB must actively agree to “delegate” the review to a “lead IRB”. **However**, the proposal could use more detail. Specifically, it would be useful to clarify that for a particular large multisite study it could be possible to have a small number of “lead” IRBs, not just a single one. In this way there could be a way to take into account geographic, community factors or other differences. For example, there might be an IRB to cover a particular type of institution where there might be concerns about specific vulnerable populations. All such sites can then delegate to that IRB. This is only an option, not a requirement. Other observations include:

- On page 2 line 25, continuing to page 3 – “The Secretary shall make available assistance to any Federal department or agency seeking....” We are not clear what type of “assistance” is being proposed.
- Page 8 line 8 – Although joint or shared review are part of the current framework and the current bill indicates that this is potential component (i.e., “may” in line 7), it would seem that in order to achieve the stated objectives of the bill, one would seek to only use the joint or shared review when there are specific reasons or concern, otherwise there is a potential for delay. We propose that the word “may” (Line 7) should carry forward if this concept becomes law.
- Page 9 line 17 – it is not completely clear how one would use both local IRBs and central or lead IRBs. We do not think allowing both a local and central IRB to review the study and have oversight of the same study makes sense and could lead to conflicts. For example, which of these has the “final say”? What happens when they disagree? It should be one or the other.

### **Bayesian Statistics and Adaptive Trial Designs (Sec. 3031)**

Novartis strongly supports and believes the greater use of adaptive trial designs and Bayesian statistics will be very helpful for oncology, rare populations and precision medicine.

### **Local and National Coverage Decision Reforms (Sec. 4161)**

Novartis supports more transparency in the process used by Medicare contractors for developing local coverage policies and we believe the proposed language is a positive improvement. Novartis recommends deleting the reference to “National” coverage decisions in the title of the section and note that the section language applies only to the Local Coverage Determination process.

### **Ensuring Local Medicare Administrative Contractors Evaluate Data Related to Category III Codes (Sec. 4341)**

Novartis supports the Committee’s efforts to improve the coding process. In addition to the current proposal, Novartis also recommends that the Committee add additional language requiring contactors to cover these codes unless a formal explanation and rationale for non-coverage is provided. Medicare’s contractors frequently deny Category III codes without any review of the merit for coverage and payment. This provision should be amended to require that contractors not be permitted to deny coverage for these codes without first conducting an evaluation of all relevant data.

### **Missing from the Discussion Document**

Novartis suggests the Committee consider the inclusion of a provision to allow Medicare Part D beneficiaries to appeal for a lower-tier cost-sharing amount when they have a medication placed on a specialty tier. Appealability is an especially important tool to improve patient access to needed therapies placed on a plan's specialty tier since cost-sharing for therapies can exceed 33 percent. While currently unavailable to Part D beneficiaries, this "appealability" of specialty-tier therapies often is available to patients in the commercial market and appealability, in general, is available to Part D beneficiaries for all drugs except those on the specialty tier. Thus, we encourage the Committee to include, as part of its 21st Century Cures legislation, the ability of Part D beneficiaries to appeal for a lower-tier cost-sharing amount to be applied to a specialty-tier therapy.

Novartis is eager to continue working with the Committee to advance the ideas and concepts in this discussion document so that we can help accelerate access to new treatments and cures. Please feel free to contact me at [dan.casserly@novartis.com](mailto:dan.casserly@novartis.com), or Shawn O'Neil of my staff, at [shawn.oneail@novartis.com](mailto:shawn.oneail@novartis.com) if we could be helpful or provide more detail to our comments.

Sincerely,

Dan Casserly

**Daniel Casserly**

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February 10, 2015

Dear Chairman Upton and Congresswoman DeGette:

I am writing on behalf of Organovo to provide comments on the initial draft of the 21<sup>st</sup> Century Cure legislation. Organovo is a rapidly growing biotechnology company headquartered in San Diego, California where we now employ over 60 individuals. Organovo designs and creates functional, 3D human tissues for medical research and therapeutic applications using our proprietary bioprinting platform. We use a 3D printer that places “bioink” in precise locations, allowing cell types to align themselves in a manner that resembles the organization of native human tissues. These 3D human tissues can be employed in drug discovery and development, biological research, and as therapeutic implants for the treatment of damaged or degenerating tissues and organs.

We are delighted that the Committee has placed language on accelerating approval for regenerative medicine technologies in Subtitle C, Section 2041 of the draft legislation. Although the FDA has been thoughtful in its guidance and regulation of cellular tissues to date, the need exists to create a clear regulatory environment that will help foster further development of new products by the 3D bioprinting industry in the United States. This can help provide patients and society with the full benefit of these innovative products. Regulatory clarity would stimulate innovation and investment in the industry and reinforce the United States’ position as the global leader in the field.

To promote U.S. leadership in this field and patient access to these life-saving therapies, we urge the Committee to make important refinements to Section 2041 consistent with the following four recommendations/observations and the draft legislative provisions provided as an attachment:

- Although we completely agree with and support the need for accelerated approval pathways for cell and tissue based products, we fear that merely asking the Food and Drug Administration (FDA) to issue guidance will not result in the outcome most meaningful to patients and industry. We need a dedicated approval pathway complete with not just accelerated review processes but also with conditional approval mechanisms.
- Such legislation has already been enacted in the European Union and Japan. In the United States, patients and industry remain at a significant disadvantage in accessing the cell and tissue based therapies that will be a critical part of how medicine evolves in the 21st century. Patients will suffer delayed access to novel technologies as first-in-human trials continue to migrate to Japan and Europe, rather than the US. Investors will still face uncertainty and hold back on making more investments unless a dedicated FDA pathway can be established.
- We strongly urge the Committee to place the specific legislative framework we have prepared (see attached) into the Cures draft legislation, allowing the FDA to build the necessary pathways for cell and tissue based therapies with funding through user fees.

- Very importantly, the attached legislative framework also helps define what therapies fall into this new category, avoiding issues of vague terminology such as “regenerative medicine.” This framework is the best and fastest way to ensure the result needed for patients and U.S. industry.

\* \* \* \* \*

Thank you for the opportunity to provide comments on this important legislation. Please do not hesitate to contact Dr. Eric David, Organovo’s Chief Strategy Officer at [emdavid@organovo.com](mailto:emdavid@organovo.com) or Harry Sporidis, Senior Policy Advisor at Polsinelli at [hsporidis@polsinelli.com](mailto:hsporidis@polsinelli.com) with any questions or feedback.

February 10, 2015



The Honorable Fred Upton  
Chairman  
House Energy and Commerce Committee  
2125 Rayburn House Office Building  
Washington, DC 20515

The Honorable Diana DeGette  
Member  
House Energy and Commerce Committee  
2125 Rayburn House Office Building  
Washington, DC 20515

*Re: 21st Century Cures Discussion Document*

Dear Chairman Upton and Representative DeGette:

The Ovarian Cancer National Alliance (hereafter the Alliance) greatly appreciates the opportunity to submit these comments in response to your request for feedback from the patient community regarding the 21st Century Cures Initiative. The Alliance is the foremost advocacy organization for all those whose lives have been impacted by ovarian cancer, advocating at a federal level for greater investment in federal research and for policies that promote the development of new diagnostics and therapies for ovarian cancer patients.

Ovarian cancer is a highly deadly disease, with only 45 percent of patients living five years after diagnosis. In fact, a full quarter of women diagnosed with ovarian cancer will die within one year of diagnosis. These rates have not significantly improved in the past 40 years. The poor prognosis for ovarian cancer is due to the fact that there is no early detection test and that, until recently, there were few available molecularly targeted therapeutics. Our community wants and needs innovation, but believes that innovation must go hand-in-hand with strong protections for research participants and patients.

While we are deeply appreciative of the committee's attention and commitment to the 21st Century Cures initiative, we urge you to move forward to finalize a draft of this bill with a balanced and bipartisan approach. As such, we offer several comments below regarding three major themes: inclusion of the patient perspective; safety and privacy protections for patients and research participants; and ensuring access to new therapies.

***Patient participation in the development of medical products***

The Alliance applauds the committee's attention to the important role that patients can play in the medical product development process. We have long advocated for greater patient involvement and have a successful program placing patients and survivors on federal panels tasked with reviewing research and medical products. We believe that patient input is critical to speeding the development of new cures that meet patients' needs and expectations. As such, we strongly support several of the proposals outlined in 21<sup>st</sup> Century Cures as detailed below.

- Title I, Subtitle A – Patient Focused Drug Development – The Alliance strongly supports efforts to expand the reach and scope of the FDA's Patient Focused Drug Development Workshops as required under PDUFA V. As the committee has wisely identified, the endpoints and side effects that are meaningful to patients differ by disease and may not be captured in clinical trials, including those for ovarian cancer. For many years, there had not been a novel therapeutic approved for ovarian cancer because it was not clear to pharmaceutical developers which endpoints were important to patients that would also meet

FDA's requirements for approval. While the Alliance has surveyed our community about the endpoints and what they expect from clinical trials, we require FDA input to provide clarity to industry on how to craft endpoints in clinical trial design. As such, the Alliance has long called for a patient focused drug development workshop in ovarian cancer, and looks forward to potentially having one in 2016 or 2017. We believe that this meeting will be immensely helpful to advance drug development in ovarian cancer, as similar workshops would be critical to accelerate the development of drugs for many conditions.

- Title I, Subtitle K – Cures Acceleration Network – The Alliance supports the proposal to expand the drug repurposing program within the National Center for Advancing Translational Science (NCATS). This innovative program has the power to bring new cures to patients faster by focusing on repurposing drugs that already have demonstrated safety. We urge the committee to work with their colleagues on appropriations to boost funding for this program within NCATS as well as for all of the basic, translational and clinical research funded by the larger National Institutes of Health.

### ***Safety and privacy protections for patients and research participants***

Several of the policy proposals included in the discussion draft give us serious pause as advocates for the patient community. We fear that these provisions may erode longstanding and important safety and privacy protections for patients and research participants, and therefore strongly urge the committee to not pursue their inclusion in the final bill.

- Title I, Subtitle J - Streamlined Data Review – This section would allow FDA to change the indication for a drug label based on the review of data summaries submitted by the drug sponsor, rather than the review of full data packages. Since different statistical analyses of full data sets can lead to different conclusions about safety and effectiveness, we urge the committee to abandon this approach and allow FDA to continue the full review of data packages, rather than mere summaries.
- Title II, Subtitle F – Building a 21<sup>st</sup> Century Data Sharing Framework – While we support the overarching goal of this subsection, including many of its specific tenets (interoperability, increased use of Medicare claims data and increased coordination between Congress and the President's Council of Advisors on Science and Technology), there are two tenets that are concerning. Section 2085 would allow non-deidentified patient data to be sold or distributed to "providers of services or suppliers." We do not support any disclosure of data that can be used to identify patients without prior, written, informed consent from the patient. Furthermore, another section of the Subtitle would allow clinical trial sponsors to choose whether or not to comply with the Common Rule if they instead comply with HIPAA. The Common Rule offers strong protections to research participants, whereas HIPAA regulates the disclosure of health information about patients; they are not equivalent. We do not support any proposal that rolls back critical privacy and safety protections for research participants.
- Title II, Subtitle G – Utilizing Real World Evidence and Title IV, Subtitle D, Section 5062 – Valid Scientific Evidence – These provisions would allow the FDA to use "real world data" instead of data generated by a randomized clinical trial (RCT) in the approval of new medical products. We believe that the data generated by RCTs is the only way to accurately assess the risks and benefits of a novel therapy or device. Real world data is unlikely to capture data about the true efficacy of a product, in what population it works best and the incidence of adverse events. We strongly caution the committee about including these provisions in the final bill.
- Title II, Subtitle M – Accessing, Sharing, and Using Health Data for Research Purposes – We support the un-siloing of patient data and its use in research, however, we strongly believe that patients should control whether or not to share their personal data. This section of the bill appears not to require

informed consent for patients to have their data shared, but instead works on an “opt-out” model. We strongly oppose this model and believe that patient control over whether to share their own data is sacrosanct. Given incomplete genetic discrimination protections, disclosure of some data, such as a diagnosis of hereditary ovarian cancer, could have real world implications for patients and should therefore be left to the patient to decide. Furthermore, a recent study showed that whole genome sequencing data can be personally identifiable. This led the President’s Commission on the Study of Bioethical Issues to issue a series of recommendations strengthening privacy protections for genomic data in their recent report *Privacy and Progress in Whole Genome Sequencing*. Given the shifting landscape of genomics and information availability, we caution the committee about lessening patient protections in this area.

### ***Ensuring patient access to new therapies***

The Alliance commends the committee’s attention to the issue of patient access to medical products. Innovation is meaningless unless patients can access these potentially life-saving therapies and devices. We offer detailed comments below.

- **Title I, Subtitle G – Expanded Access** – The Alliance strongly supports the committee’s efforts to provide clarity and transparency to patients seeking expanded access to investigational therapies. This issue is of critical importance in the ovarian cancer community, where there currently are very few FDA approved therapies. Most women with ovarian cancer will recur multiple times over the course of their treatment, often disqualifying them from clinical trial participation; as such, expanded access to investigational medications is one of a scant few remaining options. Navigating the expanded access ecosystem proves difficult for many patients and Congress’s help in simplifying the process is greatly appreciated. We urge Congress to move forward in reforming expanded access programs within pharmaceutical companies and providing greater transparency about how to access these programs.
- **Title IV, Subtitle I – Telemedicine** – Quality ovarian cancer treatment requires the involvement of many specialists, including gynecologic oncologists, palliative care specialists and genetic counselors. Patients who live in rural areas often lack access to these professionals, highlighting the transformational role that telemedicine could play in their care. The Alliance strongly supports policy solutions that connect rural patients with specialists through telemedicine, and applauds the committee’s inclusion of this section in the discussion draft.
- **Title IV, Subtitle K – Lowering Medicare Patients OOP Costs** – Treatment for ovarian cancer, like many cancers, is very expensive, creating a significant financial burden for many women and their families. Furthermore, the average age of diagnosis for ovarian cancer is 63, meaning that many women with ovarian cancer are Medicare beneficiaries living on fixed incomes, who cannot absorb the financial toxicity of an ovarian cancer diagnosis. The Alliance applauds the committee for taking steps to provide seniors with information about the out-of-pocket costs they can expect for their medical treatment. We think that the database proposed in this section would go a long way to providing seniors with this information, but worry that the creation and maintenance of this database represents an unfunded mandate to NIST and HHS.
- **Oral Chemotherapy Parity** – A first-in-class chemotherapy drug for the treatment of a subset of ovarian cancer was approved in late 2014. This drug is a game changer for many women living with ovarian cancer and is available as an oral medication, meaning that it is covered under a patients’ pharmacy benefit. However, due to the high cost of the drug, we are beginning to hear reports of patients choosing not to take this potentially lifesaving drug because their co-pay and co-insurance costs for the medication are too high. To ensure that patients continue to have access to innovative therapies, the

Alliance urges the Committee to include provisions from the Cancer Drug Coverage Parity Act. This bill requires any private health plan that covers chemotherapy to cover oral chemotherapy medication at a cost no less favorable than the cost of IV, port administered or injected anti-cancer medications.

***Placeholder language***

The Alliance eagerly awaits the publication of legislative language surrounding several placeholder provisions within the 21<sup>st</sup> Century Cures discussion draft. The areas outlined in these placeholders represent difficult, but important, policy issues that deserve the committee's attention and the larger community's consideration. We strongly urge the committee to solicit feedback on these initiatives as well, as they will contain important provisions affecting the development of new medical products and the conduct of biomedical research.

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The Alliance realizes that many of the tenets included in the 21<sup>st</sup> Century Cures bill will require sizable funding to be fully realized. We encourage the committee to work with your colleagues on the appropriations committee to identify potential sources of funding. As you and the appropriations committee consider offsets, we caution you against redirecting existing funding for biomedical research at the National Institutes of Health (NIH) in order to finance new projects. Given the tight budgets within the NIH and currently low grant approval percentage, all additional programs should complement, not subtract from, the NIH's existing research portfolio.

Thank you for the opportunity to share the ovarian cancer patient perspective as you craft the final 21<sup>st</sup> Century Cures bill. If you have any questions or require additional information, please contact Laura Koontz, PhD, at [lkoontz@ovariancancer.org](mailto:lkoontz@ovariancancer.org) or 202-331-1332.

Sincerely yours,



Calaneet H. Balas  
Chief Executive Officer  
Ovarian Cancer National Alliance



## Paralyzed Veterans of America

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Chartered by the Congress of the United States

February 19, 2015

Chairman Fred Upton  
Committee on Energy and Commerce  
2125 Rayburn House Office Building  
Washington, DC 20515

Ranking Member Frank Pallone  
Committee on Energy and Commerce  
2125 Rayburn House Office Building  
Washington, DC 20515

Dear Chairman Upton and Ranking Member Pallone:

On behalf of Paralyzed Veterans of America (PVA), I offer our support for the “21<sup>st</sup> Century Cures Act.” Specifically, PVA supports Subtitle G - Disposable Medical Technologies, authored by Representatives Renee Ellmers (R-NC) and G.K. Butterfield (D-NC). We strongly encourage you to maintain this provision in the final bill.

PVA is a congressionally chartered national non-profit veterans’ service organization dedicated to meeting the needs of its members, veterans who have sustained catastrophic spinal cord injury or dysfunction. All of PVA’s members use durable medical equipment (DME) in recovery, rehabilitation and ultimately to achieve independence.

Many of our members at times incur secondary issues as a result of the spinal cord injury, including decubitus ulcers from improper skin care, bruises and abrasions, and injuries due to falls or cuts. This can lead to re-admittance into a hospital or other health care facility. To treat these wounds, the Department of Veterans Affairs (VA) currently uses negative pressure therapy devices from two vendors—the wound vac from KCI for inpatient and outpatients and the Snap negative pressure therapy device for outpatients only. These are disposable devices that provide excellent outcomes resulting in quicker recovery and shorter stays in institutional settings.

Unfortunately, Medicare beneficiaries are losing access to disposable forms of devices and treatments that traditionally have been covered under the DME benefit. These include a wide variety of devices and treatments including wound care that is used to treat decubitus ulcers incurred by long-term wheelchair users and others who are non-ambulatory. Unfortunately, Medicare does not recognize the value of disposable technologies in the home because of a conflict with the decades-old definition of DME. These items are commonly reimbursed by private payers, as they are easier to use, less expensive, and provide excellent outcomes.

To this end, I urge you to include the provisions of Subtitle G - Disposable Medical Technologies in your “21<sup>st</sup> Century Cures” legislation upon formal introduction. This provision will ensure patients have access to disposable medical technologies that would otherwise be covered as DME, but due to advances in medical technology and treatment, they may no longer be considered “durable.” As such, we do not view this as

an expansion of the DME benefit, but rather, a protection against erosion of what was always intended to be covered under the Medicare DME benefit.

Sincerely,



Lee Page  
Senior Associate Advocacy Director

# LEADING THE FIGHT TO END DUCHENNE

February 10, 2015

The Honorable Fred Upton  
Chairman  
Committee on Energy & Commerce  
2125 Rayburn House Office Building  
Washington, DC 20515

The Honorable Diana DeGette  
Ranking Member  
Subcommittee on Oversight & Investigations  
Committee on Energy & Commerce  
2322A Rayburn House Office Building  
Washington, DC 20515

Dear Chairman Upton, Representative DeGette and Members of the Committee:

On behalf of Parent Project Muscular Dystrophy (PPMD) and the Duchenne muscular dystrophy (DMD) community, I want to applaud you and the entire Energy and Commerce Committee for the effort you undertook in composing the 21<sup>st</sup> Century Cures legislation. This comprehensive, thoughtful and bipartisan initiative to examine and update our national research and development infrastructure comes at such an important time to our community as new therapies for Duchenne are closer than ever to reaching families.

For more than 20 years, Parent Project Muscular Dystrophy (PPMD) has led the fight to end Duchenne Muscular Dystrophy. Duchenne is the most common fatal genetic disorder diagnosed in childhood, affecting about 1 in every 3,500 live male births, with about 20,000 new cases each year. The disease, which primarily impacts boys, is caused by the lack of the dystrophin protein. This absence causes muscles to weaken and deteriorate. As patients with Duchenne age, muscle wasting leaves them unable to walk, to move their arms and, ultimately, to breathe, maintain heart function, and live.

Not a single disease-modifying therapy has been approved to treat Duchenne in the U.S. However, thanks to a decade of more robust and strategic public and private sector support for Duchenne drug discovery and development, about a dozen candidate therapies are in various stages of clinical evaluation today. PPMD, and the entire Duchenne community, are quite hopeful that the first-ever new drug application for Duchenne will be filed within the next year, with several more to follow in the next two-to-three years.

## **Putting Patients First**

PPMD is encouraged by the emphasis of the draft legislation on patient-focused drug development (PFDD) which seeks to strengthen the patient's role in the medical product development process. Two years ago, we issued a white paper entitled "Putting Patients First" that centered on making sure that the patient plays a meaningful role in the drug development process. The Committee has done tremendous work advancing this field over the past few years, and we are very grateful for this commitment to the patient voice and impact. During the past year, PPMD also led a groundbreaking project to develop the first-ever, patient-initiated guidance document, which was submitted to FDA in late June of 2014. We have done extensive work surveying our community to obtain quantifiable community preference data on the benefit/risk equation and are in the process of developing additional projects in this space.

# LEADING THE FIGHT TO END DUCHENNE

However, we are concerned that despite encouraging comments from and informal interactions with the FDA surrounding our draft guidance, including identifying the area as an FDA draft guidance priority in 2015, we have yet to see concrete action from the agency despite our draft being submitted nearly eight months ago. **This experience leads us to believe quite strongly that in addition to the current PFDD provisions, the discussion draft should be enhanced to contain a concept we have billed the Patient-Focused Impact Assessment or PFIA.** At its core, the PFIA calls for creating a brief checklist that the FDA reviewers would complete at the time of review to say what PFDD authorities or tools they did – or did not – use in considering an application. Such a provision would create an essential feedback loop, helping shine some needed light on what is a largely opaque process. It also would help inform efforts by patient advocacy organizations and other stakeholders to develop PFDD tools with the necessary rigor for use by the agency.

PFIA topics could include benefit/risk data for the indicated populations, draft or final guidances, patient-preference data, patient-reported outcomes data, and the views of patients and other external experts on the application. The draft PFIA provision would require the FDA to compile an annual report summarizing the agency's use of PFDD tools and authorities within applications reviewed during the preceding year. We believe this piece is an important step in ensuring the FDA is utilizing patient focused drug development tools and urge the committee to include such a provision in the final legislation. Furthermore, more than 20 patient advocacy and related stakeholders including National Organization for Rare Disorders (NORD), The ALS Association (ALSA), The National Down Syndrome Society (NDSS) and Everylife Foundation for Rare Diseases have endorsed this concept, demonstrating its application far beyond the Duchenne community. The PFIA endorsement letter from last month and draft legislative provision are attached for reference.

## **Additional Provisions**

In addition to supporting the PFDD title and amending it to include the PFIA, PPMMD strongly endorses the call in Sec. 1001 for greater clarity from FDA as to the process for incorporating benefit-risk and other patient experiences and perspectives within the review process. Additionally, having led the landmark patient advocacy-led effort to create a draft Duchenne drug development guidance for industry, we are particularly impressed by the provision that encourages FDA guidance on the process for agency review of all draft guidance and how patient-initiated drug development tools will be used (Sec. 1001 (b)). This type of clarity is particularly critical if FDA expects other stakeholders, particularly patient organizations, to commit the significant resources for such projects.

PPMD also supports the provision for transparency requirements on drug companies regarding their expanded access program (programs for patients to access drugs before they're approved) (Sec. 1121), the support for research on repurposing drugs for new uses (Sec. 1202), and the Orphan Product Extensions Now (Sec. 1261) provision to provide an additional six months of market exclusivity for a drug on patent if the sponsor receives a rare disease indication. We believe that these provisions will provide a positive impact on the drug development process and decrease the amount of time that safe and effective medicines can be delivered to patients.

# LEADING THE FIGHT TO END DUCHENNE

Further, PPMD endorses the Clinical Research Modernization Act (Sec. 3001-3002) which would streamline the institutional review board process and reduce the unnecessary delays that comes with conducting clinical trials at multiple sites. We are similarly encouraged by the inclusion of the Genetically Targeted Platform Technologies for Rare Diseases provision which aims to clarify the accelerated approval pathway for genetically-targeted platform technology—such as the technology used in certain drugs being developed for Duchenne—and would welcome the opportunity to work with the Committee to further refine the language and ensure that safe and effective treatments are getting to patients as soon as possible.

Thank you again for undertaking this important initiative. We hope you will keep the Patient Focused Impact Assessment in mind as you continue to develop the 21<sup>st</sup> Century Cures legislation.

Sincerely,



Pat Furlong  
Founding President and CEO

**Chief Executive Officer**

Ted Thompson, J.D.

**Board of Directors**

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*The Parkinson's Institute*

Davis Phinney  
*The Davis Phinney Foundation  
for Parkinson's*

The Honorable Janet Reno

Cokie Roberts

February 11, 2015

The Honorable Fred Upton  
Energy & Commerce Committee  
2125 Rayburn House Office Building  
Washington, DC 20515

Dear Chairman Upton,

Thank you for the opportunity to comment on the discussion draft of the *21<sup>st</sup> Century Cures Act* released on January 27, 2015. We applaud your continued commitment to this important initiative and look forward to working with you as this work moves forward.

The Parkinson's Action Network (PAN) is the unified voice of the Parkinson's community advocating for better treatments and a cure. In partnership with other Parkinson's organizations and our powerful grassroots network, we educate the public and government leaders on better policies for research and an improved quality of life for people living with Parkinson's.

As the Energy & Commerce Committee continues its consideration of the *21<sup>st</sup> Century Cures Act*, we urge the Committee to work with Appropriators to provide sustainable and predictable funding to support research and development activities at the National Institutes of Health (NIH) and the Food and Drug Administration (FDA). With the addition of many mandates, reports, committees, and other responsibilities, additional funding should be made available to ensure the Agencies have the ability to not only continue their important day-to-day work but to also have the resources and staff available to implement the new provisions. We are concerned that without additional funding, implementation will suffer and our research enterprise will continue to struggle to compete globally.

We have provided specific comments on select provisions:

***Title I—Putting Patients First by Incorporating Their Perspectives into the Regulatory Process and Addressing Unmet Needs***

**Subtitle A—Patient Focused Drug Development:**

PAN thanks the Committee for including this provision focused on bringing the patient perspective into the clinical trial process by enhancing the structured risk-benefit assessment framework and providing additional guidance on collecting patient experience data.

- Under the definition of ‘patient experience data,’ is there a reason industry was not included in the list of entities collecting the data? Industry should be encouraged to collect patient experience data during the development and clinical trial process.

### **Subtitle C—Approval of Breakthrough Therapies and Subtitle F—Accelerated Approval of Breakthrough Devices.**

PAN supports these provisions.

### **Subtitle G—Expanded Access**

Sec. 1121:

- The provision would require the sponsor to submit its policy on accepting requests. If the sponsor does not offer expanded access, the provision does not require information on why the sponsor cannot or will not accept requests. One main concern from patients is not having clear information on why the sponsor is unable to provide access. This should be clarified in the provision.

### **Subtitle K—Cures Acceleration Network**

PAN supports the flexible research authority provision and the authorization of funding for the Cures Acceleration Network at the National Center for Advancing Translational Sciences.

### **Subtitle L—Dormant Therapies**

It is of great importance that Congress find new ways to incentivize the development of new treatments for unmet medical needs, especially central nervous system therapies. These areas have seen development time and costs soar in the face of high failure rates. We are pleased that you are considering the Dormant Therapies provision, but do have two main concerns:

- Sect. 1221, Protection Period: We are concerned the length of exclusivity included in the draft may be too long and would recommend the Committee consider shortening the protection period of this provision. The length of time should balance the need to have a predictable period in which to recoup investment with also allowing generic, cheaper drugs to enter the market. We recommend the Committee seek independent advice on what would be an appropriate length of time.
- Sect. 1222, Unmet Medical Needs: The provision does not define “one or more unmet medical needs.” In previous versions of the legislation, it was defined using the definition in the FDA’s Guidance to Industry: Expedited Programs for Serious Conditions. This definition, depending on interpretation, may be too broad or can exclude certain areas that should be defined as unmet medical needs. We recommend the Committee better articulate what would qualify under this new designation.

### **Subtitle M—New Therapeutic Entities and Subtitle N—Orphan Product Extensions Now**

PAN supports these provisions, which incentivize refurbishing already approved drugs and exploring new uses for drugs for rare diseases. We thank the Committee for exploring ways to incent industry to bring new products to market.

## ***Title II—Building the Foundation for 21<sup>st</sup> Century Medicine, including Helping Young Scientists***

### **Subtitle A—21<sup>st</sup> Century Cures Consortium Act**

While an interesting idea, we are concerned that this approach may not solicit the progress needed:

- Without a sizable investment from the federal government, the incentive to have small businesses or non-profit organizations participate may not be there, especially if overhead and administrative burdens are in place. For example, the Foundation for the National Institutes of Health charges 15 percent overhead, which can be a discouragement, not an incentive, to participate in their partnership programs. Otherwise, all of this work can be done without the Federal government.
- If the Consortium is established, we strongly recommend that in addition to the Board of Directors, a system for public input, particularly from the patient community, is in place.

### **Subtitle F—Building a 21<sup>st</sup> Century Data Sharing Framework**

Sec. 2081:

- PAN supports inclusion of this provision. By requiring that clinical trial opportunities posted on ClinicalTrials.gov include eligibility criteria using standardized technical vocabularies, electronic health record systems will be able to compare relevant trial requirements to a patient's clinical and claims data without exposing the patient's private information. Providers will then be able to easily identify and provide information on relevant trials that may be beneficial to an individual's care.
- This provision could help address a large barrier in the discovery of new treatments – low recruitment and retention rates in clinical trials – and the costs that flow with these barriers.

Sec. 2082:

- PAN supports the creation of a clinical trial data system to increase data sharing for research purposes. We would recommend also including data from other de-identified sources to reduce the data silos that currently exist in research.

### **Subtitle G—Utilizing Real-World Evidence**

PAN would suggest limiting this provision to just include guidance on the collection of real-world evidence. Before expanding to the submission of data for approval, the FDA should assess the validity of these experiments and how they could possibly be used in future approvals. In addition, many of these experiments are hard to conduct, so additional funding should be available for the conduct of observation studies and registries at the NIH.

### **Subtitle L—NIH Federal Data Sharing**

This provision takes an important step forward in encouraging data sharing and collaboration in biomedical research.

### **Subtitle N—21<sup>st</sup> Century Chronic Disease Initiative Act**

PAN supports this idea in concept; however, we do have two specific comments:

- The provision does not include a definition of chronic disease. Should this be defined? In addition, the provision states “outcomes of patients with a chronic disease.” Many people have multiple chronic diseases. The study should also focus on the outcomes of people living with multiple chronic conditions.

- An effort of this magnitude would require additional funding. Funding should be made available to support this effort instead of tapping each participating Institute or Center for resources.

#### **Subtitle O—Helping Young Emerging Scientists**

Sec. 2261:

- PAN recommends removal of this section. The NIH has created several programs aimed at young investigators and before creating a new program at NIH, Congress should assess the results of the report directed in Sec. 2262.

#### **Subtitle P—Fostering High-Risk, High-Reward Science**

PAN does not support this provision and recommends removal.

- With no definition of ‘high-risk, high-reward’ science, this provision could be interpreted in a wide variety of ways and ignores the innovative work being conducted by Institutes and Centers at NIH.
- We are very concerned that with a specific percentage of funding being allocated for this undefined initiative, we will continue to see funding siphoned away from needed scientific progress.

#### **Subtitle Q—Precision Medicine**

We look forward to seeing more details regarding the Precision Medicine Initiative.

### ***Title III—Modernizing Clinical Trials***

One area that this title does not touch upon is the need for more clinical trial awareness. Many Americans do not fully understand the concept or value of a clinical trial. Thus, many clinical trial sites fail to enroll the number of participants needed to proceed. One way to improve clinical trial recruitment would be to increase patient engagement within the clinical trial process by requiring the creation of a recruitment committee to review recruitment strategies, identify challenges, and improve communications between the research community and the patient community in clinical trials requiring volunteers.

#### **Subtitle A—Clinical Research Modernization**

PAN supports this provision to significantly reduce regulatory overlap and administrative inefficiencies for clinical trials. We thank the Committee for recognizing the importance of consulting with stakeholders, including patients, throughout the outlined process of issuing regulations/guidance.

#### **Subtitle B—Broader Application of Bayesian Statistics and Adaptive Trial Designs**

PAN supports this provision to establish and implement a framework for the incorporation of adaptive trial designs and other methods in clinical trials.

### ***Title IV— Accelerating the Discovery, Development, and Delivery Cycle and Continuing 21<sup>st</sup> Century Innovation at NIH, FDA, CDC, and CMS***

#### **Subtitle A – National Institutes of Health**

PAN supports continuing to ensure that the NIH is a robust and accountable federal agency that provides opportunities to advance the best science in critical areas of medical need. However, we do have

concerns that some of the provisions outlined in Subtitle A may have unintended consequences that produce structural and systemic imbalances among critical research priorities.

#### Section 4001:

- PAN supports the concept of encouraging NIH to engage in more deliberate strategic planning exercises with respect to its research agenda. However, we are concerned that characterizing strategic planning in terms of investment may send the wrong message, particularly if the term investment is not well defined, or if it is used to merely reflect a desire to fund only those research objectives that have the most immediately apparent returns.
- The concept of return on investment should be linked solely with what is best for patient outcomes, even if some investments are riskier in terms of immediate return.
- Assigning percentage floors for categories like “basic research” is also problematic because scientists are adept at tailoring most forms of research to fit in particular categories, effectively making the percentages moot. Funding awards should be based on the best science and opportunities for discovery.
- Identifying Mission Priority Focus Areas is one method for engaging NIH in strategic planning decisions. However, we are very concerned that if not properly structured, the creation of these priority areas will lead to destructive competition among diseases, with some very worthy issue areas being left out because their constituencies lack the resources of other groups.
- The mission focus areas would also need to be structured in a manner that did not result in them becoming too broad, which would do little to address criticisms over current NIH funding models.
- We reiterate that NIH funding should be based on identifying the best science, and this objective should be paramount in the creation of any new structure or strategic planning initiative.
- The development of definable metrics, which should include input from the research community, may be ultimately helpful in determining what fits the description of the best science and could potential move NIH to recognizing more holistic goals with respect to disease.

#### Section 4002:

- Similar committees and working groups to address related issues have been tried on numerous occasions and have not yielded the intended results.
- Instead, we recommend the following practical changes, solicited from leaders in the Parkinson’s research community, to the reporting burdens of researchers:
  - Decrease the number of pages in grant applications by not forcing applicants to continually resubmit biographical and administrative information. That information should be submitted once, with additional application requirements serving to describe the research plan.
  - Consolidate the number of types of available grants.
  - Only collect information that is needed for application evaluation. Administrative information should be left for when an award has been made.

Section 4003:

- PAN supports efforts to ease travel restrictions to provide additional opportunities for NIH staff and leadership to meet and share knowledge face to face with colleagues in the research community.

Section 4004:

- PAN shares the goal of ensuring that NIH has the best possible caliber of leaders and decision makers guiding the various research Centers and Institutes.
- Setting term limits for director positions, with the possibility of reappointment, promotes accountability to mission and provides the NIH Director with greater ability to remove ineffective Institute and Center directors from their posts and appoint innovative and transformative leadership in critical areas.

Section 4007:

- PAN supports additional funding for the Common Fund to promote and advance collaborative efforts among NIH research Institutes and Centers.
- No additional funding provided to the Common Fund should be allocated for other priorities described in the preceding or proceeding titles and subtitles of this draft. Rather, new priorities should receive their own independent authorizing funding.

Section 4008:

- PAN supports additional funding for the BRAIN Initiative, particularly given that government agencies have been asked to shoulder a higher cost burden in the project's initial stages.
- The Initiative aims to revolutionize our understanding of the human brain by bringing together NIH, the Defense Advanced Research Projects Agency (DARPA), and the National Science Foundation (NSF) as well as key private sector partners.
- We are hopeful that this cross-cutting and targeted effort can answer questions and create tools that will be directly applicable to people living with Parkinson's and the millions living with neurological diseases.

**Subtitle B – Advancing Research for Neurological Diseases**

PAN applauds the inclusion of the *Advancing Research for Neurological Diseases Act*. We thank the Committee for including a top priority of the Parkinson's community in the discussion draft.

- Data collection would help us understand who actually makes up the population with neurological diseases. It has long been assumed that Parkinson's, for example, primarily affects older white men and that MS is most prevalent among white women. Recent research suggests that up to 15 percent of people with Parkinson's are under the age of 50 and that prevalence of MS among African American women could actually be higher than among white women.
- Having accurate data on the age, sex, race, ethnicity, geographic location, and family history of the individuals affected by any disease of the brain could be a 'game changer' for researchers, medical professionals, drug companies, and patient groups.
- We look forward to working with the Committee to ensure passage of this important provision.

### **Subtitle D – Reagan Udall Improvements**

PAN supports the proposed modifications to the current Regan-Udall Foundation structure, including limiting the number of voting board members who are representatives of industry and making necessary adjustments to the compensation of the executive director. Additionally, we agree with allowing federal employees to serve on the board as a way to help increase the board’s professional competency.

### **Subtitle E – FDA Hiring, Travel and Training**

PAN supports efforts to recruit, train, and provide professional development opportunities for highly qualified applicants and staff at FDA.

### **Subtitle F – FDA Succession Planning**

Section 4121:

- PAN encourages implementing policies that will better enable FDA staff to participate in meaningful professional development opportunities, including conferences and trainings, to increase institutional competency and diversity of experiences that informs the work of FDA.

Section 4122:

- We support the concept of formal succession planning for management positions within FDA.
- It is important to maintain continuity with key development and oversight functions as new therapies and devices are moved through the pipeline.

### **Subtitle I – Telemedicine**

PAN previously submitted comments on the draft *Advancing Telehealth Opportunities in Medicare Act* to the legislation’s primary co-sponsors. A copy of those comments is attached as an addendum to this response letter.

### **Subtitle K – Lowering Medicare Patients’ OOP Costs**

Section 4221:

- PAN supports the creation of a searchable website that allows Part A and Part B Medicare beneficiaries to compare the rate of payment and the maximum out-of-pocket costs for various items and services furnished by different providers in different settings within a payment area or Medicare Advantage plan.
- We recommend changing the description of Subtitle K to “Increasing Transparency in Medicare Patients’ OOP Costs” to better reflect the practical use of the web portal for consumers.

### **Subtitle P – Medicare and Pharma Technology Ombudsman**

Section 4321:

- The establishment of a centralized office within CMS to address inquiries and requests from manufacturers regarding coverage, coding, and payment would be invaluable in streamlining responses to medical device coverage decisions and appeals.
- The newly proposed office should be structured to coordinate with corresponding offices in CMS that issue regulations and determinations with respect to medical products and devices to encourage the flow and sharing of critical information.

**Conclusion**

Thank you again for the opportunity to comment on the draft *21<sup>st</sup> Century Cures Act* and for including the *Advancing Research for Neurological Diseases Act*. Please contact Jennifer Sheridan Palute, PAN's director of policy, with any questions about our comments at 202-638-4101 ext. 112 or [jpalute@parkinsonsaction.org](mailto:jpalute@parkinsonsaction.org).

Sincerely,



**Ted Thompson, J.D.**  
Chief Executive Officer

**PIPC Comments on the 21<sup>st</sup> Century Cures Discussion Draft  
February 10, 2015**

The Partnership to Improve Patient Care (PIPC) supports the goals of the 21<sup>st</sup> Century Cures Initiative of accelerating discovery, development and delivery of innovative treatments for many diseases that do not currently have treatment options. We applaud the House Energy and Commerce Committee for starting this discussion, and urge Chairman Fred Upton and Congresswoman Diana DeGette to work toward expanded innovation and access in a bipartisan manner.

Since its founding, the Partnership to Improve Patient Care (PIPC) has been at the forefront of patient-centeredness in comparative effectiveness research (CER) – both its generation at the Patient-Centered Outcomes Research Institute (PCORI), and its translation into patient care. Having driven the concept of patient-centeredness in the conduct of research, PIPC looks forward to bringing the patient voice to the discussion of how to advance patient-centered principles throughout an evolving health care system.

We are very pleased to see the Committee’s focus on incorporating patient perspectives into the regulatory process and to help address their unmet medical needs as part of building the foundation for 21<sup>st</sup> Century medicine. We would also urge the Committee to more explicitly recognize as a goal of its work the need to ensure health care decisions are made based on the principles of shared decision-making. This means arming patients and providers with the evidence and tools necessary to make informed decisions based on the needs, preferences, and circumstances of the individual patient. It also means establishing policies that incentivize providers and empower patients to make informed treatment decisions within new payment models. We agree with the Committee’s analogy that “[t]he discovery, development, and delivery process is a cycle, meaning that data captured and analyzed on the delivery side informs new discoveries and better, more targeted solutions for patients.” On the upswing of that cycle, if being implemented in compliance with principles of patient-centeredness, is an informed and empowered patient being treated by providers with the tools to deliver personalized care. Our comments will therefore focus on the need to develop policies that ensure patient engagement and capture patient preferences to support the discovery, development, and delivery of innovative new medicines.

**Expanding the Patient Engagement Infrastructure Beyond FDA**

We applaud the Committee for explicitly requiring patient participation in the development of regulations to implement various components of the discussion draft. First, we agree that patients will be a vital voice in any workshop convened by the Department of Health and Human Services (HHS) to obtain input regarding methodologies for developing the guidance on patient experience data, which will facilitate the translation of this work to also support shared decision-making and the delivery of personalized medicine.<sup>1</sup> Second, we agree that patients are essential

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<sup>1</sup> See page 13 of discussion draft, as it amends Section 505(y)(3)(B)(i) of the FDCA

in the development of evidentiary standards related to surrogate endpoints and the approval of breakthrough therapies.<sup>2</sup> Third, we are pleased to see patients represented on the proposed Expanded Access Task Force and Innovative Cures Consortium.<sup>3</sup>

PIPC also acknowledges that meaningful patient engagement requires that the patient voice not just be heard, but that it actually informs decision-making. We urge that the Committee consider how it can ensure that patient participation is meaningful, and does not represent what we would call “token” engagement where the patient voice is heard but later dismissed. As an example, PCORI could provide the Committee with some insights gained as it has gone through a long process, in its first five years of implementation, to create policies that give the patient voice meaning in the development of patient-centered outcomes research.<sup>4</sup>

The Committee’s discussion draft clearly seeks to build on the existing momentum to engage patients at the Food and Drug Administration (FDA). Yet, the Committee also includes “delivery of innovative treatments” as a goal of the discussion draft. Therefore, we believe that an opportunity exists to utilize and improve upon the FDA’s Patient-Focused Drug Development initiative as a model for patient engagement throughout HHS and its agencies to ensure the development and implementation of patient-centered policies that affect the delivery of health care innovations.

For example, there is a rare opportunity for HHS to work collaboratively with groups of patients and providers to identify outcomes that matter to patients, turn those outcomes into rigorously developed measures, apply those measures to research, and use those measures as the basis for assessing the impact of new delivery models on patients and patient care as they are being promoted by the Centers for Medicare and Medicaid (CMS). This work will not happen effectively with only a notice and comment period in the Federal Register. It requires a more proactive posture within government agencies to welcome the meaningful and timely input of patients. It requires a more proactive posture within government agencies to welcome the meaningful and timely input of patients—which is the goal of the FDA initiative—accompanied by the effective translation of the patient perspective into the delivery of public health programs.

Therefore, PIPC urges the Committee to require HHS to develop an infrastructure for meaningful patient engagement in all of its agencies, and to demonstrate to Congress how its engagement activities are making a difference in the management of its programs.

### **An Infrastructure for Measuring Value to the Patient**

The need for a stronger and more effective infrastructure for patient engagement is apparent in the recent announcement by HHS Secretary Sylvia Burwell (Secretary) calling for new measurable goals intended to move the Medicare program further toward value-driven health

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<sup>2</sup> See page 22 of discussion draft as it amends Section 507A(b)(2)(B)(III)(iii) of the FFDCA

<sup>3</sup> See page 87 of the discussion draft, Section 1124(b)(1)(C) (iii) and (iv) and (b)(1)(D)(iii) and (iv)

<sup>4</sup> Example at <http://www.pcori.org/assets/2014/02/PCORI-Patient-and-Family-Engagement-Rubric.pdf>

care – “the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models [APMs] and value-based payments.”<sup>5</sup> Parallel to this announcement, the Secretary unveiled the launch of a newly-established “Health Care Payment Learning and Action Network [Network],” which she indicated will help “[t]o make these goals scalable beyond Medicare” and thus applicable to states (and state Medicaid programs) and consumers, as well as private partners – such as payers, employers, and providers.<sup>6</sup> The first meeting of the Network convenes sometime in March 2015.

HHS sets out to have “85% of all Medicare fee-for-service [FFS] payments tied to quality or value by 2016, and 90% by 2018” – with a further goal of “tying 30% of [FFS] Medicare payments to quality or value through [APMs], such as Accountable Care Organizations [ACOs] or bundled payments by the end of 2016, and tying 50% of payments to these models by the end of 2018.”<sup>7</sup> Regarding the former, HHS notes the role of the ongoing Hospital Value-Based Purchasing (VBP) and Hospital Readmissions Reduction programs as leverage in meeting these ambitious targets.

PIPC recognizes that policymakers want to shift from health care payment based on volume to “value-based” models. As the Secretary seeks to develop and test new payment models, we also urge consideration of the significant implications these models will have on the transition to increasingly patient-centered healthcare, and the related issues of patient access and the physician-patient relationship. As part of our ongoing commitment to patient-centeredness in health care, PIPC recently developed a white paper to highlight some of the most important opportunities and issues that must be addressed in translating principles of patient-centeredness into value-based payment.<sup>8</sup> It will be imperative for the newly created Network to include the patient voice so that value *for the patient* is prioritized.

Without a strong infrastructure at HHS (particularly within CMS) for patients to engage in defining value, an opportunity will be lost to ensure the effective incorporation of the patient perspective by all federal agencies—not just FDA—that are involved in the innovation cycle, particularly related to the identification and measurement of healthcare outcomes that matter to patients. We urge the Committee to recognize that the patient experience is also a valid consideration for the *delivery* of innovation, especially as access is potentially limited by new payment and delivery models that do not necessarily prioritize or even measure value *to the patient*.

Therefore, we urge the Committee to require patient participation on the newly created Health Care Payment Learning and Action Network. We also urge the Committee to require CMS to engage patients in determining the appropriate measures that should be applied as the basis for determining value and quality in its work to shift from health care payment based on volume to “value-based” models.

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<sup>5</sup> see <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>

<sup>6</sup> *id*

<sup>7</sup> see <http://www.nejm.org/doi/full/10.1056/NEJMp1500445>

<sup>8</sup> see <http://www.pipcpatients.org/PIPC-APM-White-Paper.pdf>

## **Patient Experience Data**

PIPC strongly supports the development and use of patient experience data to enhance structured risk-benefit assessment frameworks at the FDA. As the Committee works through the complexities and details of these policies, we urge continued engagement of patients and providers, with an explicit goal of facilitating effective shared decision-making.

We are pleased that the discussion draft articulates the need for methodologies, standards, and potential experimental designs for patient-reported outcomes. Based on our experience in CER and the work of PCORI, we have noted the challenges of capturing outcomes that matter to patients in research due to the lack of existing rigorous methods for measuring those outcomes. Such challenges also seem to translate to capturing patient experiences in health care delivery. We recently participated in a dialogue with Avalere Health, related to the development and use of patient-reported outcome (PRO) measures. We would urge the Committee to consider the following recommendations from that dialogue:

- Supplement existing PRO-related efforts by establishing a national measure development research agenda that reflects patient experience and patient engagement
- Continue to identify clinical areas where PRO measures can support high-quality, patient-centered care
- Refine and prioritize existing measures to establish their clinical practicality via testing and evaluation
- Invest in openly accessible tools that providers, payers, and patients can build into health information technology and clinical practice
- Create an interoperable, data-sharing mechanism that allows PRO data to be entered, used, and interpreted by every level of a care team (e.g., patient, caregiver, physician, nurse, physician's assistant, post-acute care/long-term care provider)
- Support workforce development, training, and education to advance best practices for PRO data collection, interpretation, use, and evaluation
- Provisionally adopt PRO-based performance measures in pay-for-reporting and accreditation programs
- Gradually integrate PRO-based performance measures into provider practice transformation initiatives such as pay-for-performance, then into new payment and

delivery models<sup>9</sup>

In closing, thank you for this opportunity to submit our comments on the 21<sup>st</sup> Century Cures Discussion Document. We look forward to working with the committee and staff to advance a patient-centered health system.



Tony Coelho  
Chairman, PIPC

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<sup>9</sup> see <http://198.101.157.179/expertise/life-sciences/insights/avalere-white-paper-facilitating-a-transition-to-using-pros-to-measure-perf>



February 19, 2015

The Honorable Fred Upton  
The Honorable Diana DeGette  
Committee on Energy and Commerce  
United States House of Representatives  
2125 Rayburn House Office Building  
Washington, DC 20515

Dear Representatives Upton and DeGette:

The Patient-Centered Outcomes Research Institute (PCORI) applauds the efforts of the House Energy and Commerce Committee to forge a bi-partisan approach to speeding development of effective new therapies and to involving patients in the process. PCORI has proven that involving patients leads to better research questions and better research post-approval. We agree that engaging patients will improve technology development research and PCORI stands ready to help. I am pleased to respond to your request to comment on the Discussion Document entitled the “21<sup>st</sup> Century Cures Act,” released on January 26, 2015. As you know, PCORI is a nonprofit organization that funds research to improve the quality and relevance of evidence available to help clinical decision makers — patients, caregivers, clinicians, employers, insurers, and policy makers — make better-informed health care decisions.

PCORI’s legislatively mandated mission is to support research to determine which therapies work best for individual patients across a wide range of illnesses and conditions. Specifically, we fund research that can identify instances where a treatment works for some patients but not others and we can then study those in whom it does not work, looking at both genetic and non-genetic factors such as age, gender, race-ethnicity and concurrent illnesses. The results of our research can help identify novel disease mechanisms and pathways that can lead other entities to develop new, more effective therapies. At the other end of the development cycle, PCORI-funded comparative effectiveness research (CER) evaluates how new precision medicines work and for whom they work better than current approaches.

We understand that the Discussion Document is a first draft that is meant to spur discussion and that many changes and additions may be made along the way. Below are our thoughts and observations on the document that is presently available. Our comments are in *italics*:

**TITLE I**  
**Putting Patients First by Incorporating their Perspectives into the Regular Process and Addressing Unmet Needs**

### **Sec. 1001. Development and use of Patient Experience Data to Enhance Structured Risk-Benefit Assessment Framework**

The goal of this section is ensure greater involvement by patients in the drug development process. Specifically, the section requires the Secretary to establish a process to involve “patient experience” data in the risk-benefit assessment. In addition, the section requires the Secretary to develop guidance on “collection and methodological” consideration for patient experience data, among other things.

*Although PCORI is not involved in the phase of research related to drug development, the core of our mission is to include patients and other stakeholders in the healthcare system in our research so that it is useful, attentive to patient preferences and circumstances, and rapidly disseminated to improve practice. Since our inception, we have funded 50 pilot projects to determine the most effective ways to engage patients and stakeholders in research, we continually monitor and evaluate how patients and stakeholders are involved in our research programs, and we produced a Methodology Report and standards that provide baseline requirements and a framework for most effective practices in the planning, design, and conduct of patient-centered outcomes research. Our [National Patient-Centered Clinical Research Network](#) (PCORnet), initiated in 2014, is comprised of 29 constituent networks, 18 of which are Patient-Powered Research Networks (PPRNs), which are operated and governed by patient-led groups. All 29 networks involve patients in governance of network activities. Patients help to generate research questions and approve participation of their network within each multi-network study. In addition, patient partners work with health systems, researchers and other patients in addressing issues of patient privacy in the use of stored electronic clinical data. PCORI’s previous efforts and experience in this area should be helpful in guiding the collection and methodological work around gathering patient data, and we are very happy to be a resource in any way we can, for example, through our PCORnet patient community.*

### **Subtitle C – Approval of Breakthrough Therapies**

#### **Sec. 1041. Approval of Breakthrough Therapies**

The purpose of this section is to outline the process for approving breakthrough therapies that may include “early stage clinical safety and effectiveness data that provide sufficient evidence for approval...” The section permits the Secretary to “make approval of a drug under this subsection subject to a requirement that the sponsor will assess the safety and effectiveness of the drug through a post-market assessment plan.” This plan may include clinical trials or studies other than randomized clinical trials.

*Although the focus of the section is on the approval of individual drugs, we note that it will increasingly be useful to perform comparative clinical studies, or sometimes comparative observational or big data studies. CER studies, for example of two or more treatments for the same indication, are the kind of information patients and clinicians will need ultimately. We believe PCORI is the appropriate entity to support CER studies after medications have been approved. Indeed, this exactly the type of research PCORI was established to support.*

**Subtitle E – Priority Review for Breakthrough Devices**

The purpose of this section is similar to Subtitle C, above, in that it outlines a process for breakthrough therapies that hold promise for reducing the risk for hospitalization and improve quality of life, among other qualities.

*As noted above, PCORI's mandate is to support research that determines which therapy works best for which patient. As a result, we believe that PCORI's role in the process is to support CER studies after devices and therapies, including breakthrough devices and therapies, have been approved. The comparators may be other devices or alternative treatments such as surgery or intense medical management.*

**Subtitle F – Accelerated Approval for Breakthrough Devices****Sec. 1101. Accelerated Approval for Breakthrough Devices**

The purpose of this section is to allow the Secretary to approve a device that appears to predict clinical benefit. It also notes that this approval “may be subject to a requirement that the sponsor of the device conduct appropriate post-approval studies to verify clinical benefit or effectiveness.”

*PCORI was created to support these kinds of post-approval studies. Our goal is to position PCORnet within the research framework to do this consistently and efficiently. PCORnet, a logical venue in which to place these trials, is built to support rapid identification and recruitment of a sizable population of patients through EHRs, who may have received the therapy/device, and assess their experience. PCORnet is working closely with the FDA and industry in this area and strongly supports routine collection in the EHR of unique device identifiers (UDIs) to help conduct outcomes research more efficiently and accurately.*

**TITLE II****Subtitle F – Building a 21<sup>st</sup> Century Data Sharing Framework****Part 1 – Improving Clinical Trial Data Opportunities for Patients**

In short, the purpose of many of the sections in this Title is to ensure that data in various locations can be standardized and used in research.

*We applaud the committee members for recognizing the immense potential value of these data. In this regard, 21<sup>st</sup> Century Cures aligns precisely with the primary goal of PCORnet – to gain access to and harmonize data. Currently, PCORnet has access to data on more than 25 million patients, with data on more than 6 million of these patients harmonized and ready for research. Having invested more than \$250 million in this infrastructure, we and PCORI's Board of Governors hope that new efforts recognize what has been accomplished and seize the opportunity to build on this foundation.*

**Sec. 2081. Standardization of Data in Clinical Trial Registry Data Bank on Eligibility for Clinical Trials**

The purpose of this section is to require the Director of NIH to ensure that information in the clinical trial registry data bank is standardized, can be compared and integrated into electronic health records, among other purposes.

*PCORI has developed, posted for public comment and is revising its policy on [Peer Review of Primary Research and Public Release of Research Findings](#). It is a more expansive set of requirements than the policy NIH currently has posted for public comment. It is aligned with NIH's proposed requirement for posting a standardized results table on ClinicalTrials.gov within 12 months of study completion and inclusion of that table in the final report PCORI-funded research submit to us; peer review of PCORI-funded research findings to assure scientific integrity and alignment with Methodology Standards for CER; and posting of an entire final report on PCORI's website within one year of completion of the study. Additionally, per our legislation, we require two abstracts or summaries written for critical end-users of research: medical professionals and patients/consumers. Again, we feel our work in this important area could help inform your work on this issue as part of the 21<sup>st</sup> Century Cures initiative.*

### **Sec. 2012. Clinical Trial Data System**

The goal of this section is to establish a Clinical Trial Data System Agreement under the Director of NIH and the Commissioner of the FDA, which will “implement a system to make de-identified clinical trial data from qualified clinical trials available for purposes of conducting further research.” Moreover, applicants to this system may not be involved in other clinician trials or collaborating with others, must indicate how they will put their data into standardized formats, allow users to access clinical trial data and “ensure dissemination on the results of the research to interested parties to serve as a guide to future medical produce development or scientific research,” among other activities.

*PCORI is developing a process for “open science,” which will require and support placement of a data set and study protocol on PCORI's website for reproduction of study findings and the conduct of additional analyses. We agree with and will implement the recommendations of the Institute of Medicine's recent report on this topic.*

## **Part 2 – Improving Clinical Outcomes for Patients and Program Integrity through CMS Data**

### **Sec. 2085. Expanding Availability of Medicare Data**

The goal of this section is to allow qualified entities to conduct non-public research on Medicare data so that providers, suppliers, employers, insurers, medical societies or hospital associations can “develop and participate in quality and patient care improvement activities, including developing new models of care.” Privacy and security of the data must be assured.

*PCORnet is currently piloting the linkage of EHR data from PCORnet partners with CMS data, using CMS's virtual data warehouse, to obtain clinical outcomes. Again, we believe our experience with PCORnet could be helpful in informing your work on expanding availability of*

*Medicare data in the 21<sup>st</sup> Century Cures initiative and would be happy to provide additional information about our pilot.*

### **Part 3 – Building a 21<sup>st</sup> Century Clinical Data Sharing System**

#### **Sec. 2091. Commission on Data Sharing for Research and Development**

This section establishes a “Commission on Data Sharing for Research and Development” that will develop methods to allow data from public programs (e.g., Medicare, CHIP, the Exchanges, etc.) to be shared with qualified entities.

#### **Sec. 2092. Recommendations for Development and Use of Clinical Data Registries**

This section requires the Secretary to make recommendations for “use of clinical data registries that are integrated with clinical practice guidelines and best practices or standards of care...” Specifically, the section requires the Secretary to establish standards to “allow for the bidirectional, interoperable exchange of information between the electronic health records of the reporting clinicians and such registries. Further, the goal of the section is to recommend how registries can be used to “evaluate various care models and methods, including clinical care coordination, and the impact of such models and methods on the management of diseases as measured by appropriate care parameters based on clinical practice guidelines and best practices.” Moreover, the registries must record and report post-market data to achieve a number of goals, including “better defining appropriate clinical use of evidence development for the Medicare program.” The data then may be used to inform clinicians as to how best to prevent diseases, such as diabetes, and to promote preventive health benefits to reduce the risk of chronic diseases such as obesity, osteoporosis, cardiovascular disease, cancer, and diabetes.

#### **Subtitle G Utilizing Real-World Evidence**

##### **Sec. 2101. Utilizing Real-World Evidence**

This Section requires the Secretary to establish a program allowing sponsors to submit “real-world” evidence for a number of purposes, including “satisfying post-approval study requirements.” Real-world evidence is defined as “data about the usage, benefits, or risks of a drug derived from sources other than randomized clinical trials, including from observational studies and registries, used to establish safety or effectiveness.”

#### **Subtitle M – Accessing, Sharing and Using Health Data for Research Purposes**

##### **Sec. 13442. Treating Disclosures of Protected Health Information for Research Similarly to Disclosures of Such Information for Public Health Purposes**

This section allows protected health information for research purposes and includes comparative effectiveness research activities.

*PCORI believes that many of the sections above could be coordinated with and could build upon the data infrastructure and culture of collaboration created by PCORnet. PCORI has committed more than \$250 million in the development of PCORnet, which is a large, highly representative, national coalition of networks that will support the conduct of clinical outcomes research. From the beginning, we have worked with all relevant agencies, including*

*the NIH, FDA, CMS and ONC. We believe that by increasing the amount of rigorously collected information available to healthcare decision makers and the speed at which it is generated, PCORnet will be a resource of clinical data gathered in “real-time” and in “real-world” settings, ranging from safety net clinics to academic health systems. Data will be collected and stored in harmonized, interoperable formats under rigorous security protocols, and data use across the network will be accomplished using a variety of methods that ensure patient privacy and confidentiality.*

*Currently, PCORnet includes 11 Clinical Data Research Networks (CDRNs), which are health system-based networks that will securely collect health information during the routine course of patient care for more than 25 million persons; and 18 Patient-Powered Research Networks (PPRNs), which are focused on a particular condition and operated by groups of patients and their partners. Among the conditions represented by PPRNs are diseases such as mental illness, breast cancer, diabetes, Crohn’s disease, COPD, multiple sclerosis, epilepsy, arthritis, muscular dystrophy, heart disease, diabetes, sleep apnea, sickle cell disease, and ALS (Lou Gehrig’s disease). Finally, 50 percent of the PPRNs (9 of the 18) are focused on rare diseases. Many of the 29 constituent networks are multi-state, as well.*

*The goal of PCORnet is to create a secure national research resource that will enable teams of health researchers, patients, and their partners to work together, leveraging multiple rich data sources to support research, such as electronic health records, insurance claims data, and data reported directly by patients. Patients, clinicians and health system leaders will be involved throughout and the networks will support observational and interventional research studies that compare how well different treatment options work for different people. The ability to perform more representative research and generate generalizable evidence, and also discern what works for particular subgroups, is a key attribute of PCORnet.*

*Although electronic health records are a valuable source of information, true interoperability of EHR data remains elusive. PCORnet presents an opportunity to leverage our nation’s sizable investment in electronic health records by making EHR data interoperable on the back end through the application of the Common Data Model.*

*At present, electronic health data is not plug-and-play ready for many uses, including research. This data requires significant curation, harmonization and transformation. Once that is done, however, the start-up time for the conduct of new research projects is reduced significantly. This step, data aggregation, is a significant hurdle in any research project. This hurdle is surmountable through PCORnet, enabling the use of harmonized data through a broad national health data “fabric” to support faster, more efficient clinical trials.*

*The Common Data Model is PCORnet’s specific approach to producing comparable, interoperable “research ready” data from each of the CDRNs and PPRNs, by defining common data elements (e.g., birthdate, diagnosis of diabetes). These data tables will include basic information about demographic characteristics, diagnoses, medications, procedures, and events. Importantly, the Common Data Model uses existing standards for coding electronic*



*health data, such as ICD, LOINC, CPT, and others. We would underscore that PCORnet is not creating or re-creating standards, rather it is mapping existing data to a common format that will make data aggregation and analysis easier and more efficient.*

*By way of example, a date of a given event (for example, a visit to a physician) is a critically important variable in many research studies. In a health system's EHR, this field may be electronically captured number of ways ("DOB," "Date of Birth," "Birth-DT"). By employing a Common Data Model, recognizing and reconciling the various ways different systems capture this important variable can be done once ("Birthdate"). Additionally, PCORnet incorporates existing, commonly-used data formats, such as CPT codes for procedures, into the Common Data Model. PCORnet does not seek to create or recreate health information exchange standards.*

*Our PCORnet Common Data Model builds on prior work in other health data networks, including the FDA Sentinel Initiative and many disease-specific networks funded through NIH (Cancer Research Network, Cardiovascular Disease Research Network) and AHRQ (Centers for Education and Research on Therapeutics).*

*Finally, our goal is to enable external partners to collaborate with PCORI-funded networks. Due to our shared interest in creating a health information infrastructure, we would be pleased to work together with you on the goals of building a 21<sup>st</sup> Century clinical data sharing system.*

### **Title III**

#### **Subtitle B – Broader Application of Bayesian Statistics and Adaptive Trial Designs**

##### **Sec. 3021. Clinical Trial Modernization**

This section calls for the Secretary to develop a process through which sponsors of drugs, biological products, or devices may submit to the Secretary a proposal for the incorporation of adaptive trial designs, Bayesian methods, or other alternative statistical methods into proposed clinical protocols and marketing applications for drugs, biological products, or devices.

*With extensive investments in this area, PCORI can be of great service to the goals of this section. Among PCORI's charges is the responsibility to develop and improve the science and methods of comparative clinical effectiveness research. To that end, our Methodology Committee produced The PCORI Methodology Report which includes 47 standards for the conduct of patient-centered outcomes research (PCOR). Although specific to PCOR, we believe this document serves as a helpful resource across health services research. Of particular interest to Section 3021 are standards developed for adaptive and Bayesian trial designs.*

*To build on this work, PCORI funds research to support the conduct of methodologically robust CER that is responsive to the needs of patients and other stakeholders. Our CER methods program is building a research portfolio, currently 58 projects, to address the gaps in patient-centered CER identified in the Methodology Report. Additionally, as mentioned above, PCORI*



*funded 50 pilot projects in 2012 to test the most effective way to engage patients and stakeholders in research, including in Bayesian trials.*

*We also would note that the first trial PCORI is funding for PCORnet, Optimal Maintenance Aspirin Dose for Patients with Coronary Artery Disease, will explore many of the aspects of modernizing clinical trials addressed under this title, including reducing administrative inefficiency and regulatory burden through the use of a centralized institutional review board, collecting minimum necessary data, using an online portal and leveraging EHRs to support finding eligible patients more rapidly.*

*Finally, we would note the work of PCORI's Advisory Panel on Clinical Trials. We convened this group of external experts in clinical trials methods to provide advice and guidance on the research question involved and the research design or protocol, including important patient subgroups and other parameters of the research. The panel advises PCORI on, among other aspects, the methodological standards in the design and conduct in clinical trials supported by PCORI; the development of new, or refinement of existing, methods for clinical trials; human subjects issues related to recruitment and informed consent in such trials; strategies for designing clinical trials to maximize internal validity, efficiency, and generalizability and patient centeredness; and approaches to data analysis.*

*PCORI believes our investments in advancing the modernization of clinical trials can be leveraged effectively to the goals of 21<sup>st</sup> Century Cures. We look forward to continuing our collaboration on these efforts with our Federal partners, patients, academia, private research entities and the life sciences industry.*

Many thanks for giving PCORI an opportunity to comment on the discussion draft. We would be happy to answer any questions, clarify any of our comments, or provide additional information as your work on the 21<sup>st</sup> Century Cures draft evolves.

Sincerely,



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## **Comments from Members of Patient, Consumer and Public Health Coalition Selected Provisions on Drugs**

### **TITLE 1: PUTTING PATIENTS FIRST BY INCORPORATING THEIR PERSPECTIVES INTO THE REGULATORY PROCESS AND ADDRESSING UNMET NEEDS**

#### **SUBTITLE B. SURROGATE ENDPOINT QUALIFICATIONS AND UTILIZATION**

**This section shows a lack of respect for the need for scientific validation of surrogate endpoints and should be deleted. We will send a thorough analysis as a separate document.**

#### **SEC. 1041. APPROVAL OF BREAKTHROUGH THERAPIES.**

**Approval of Breakthrough Therapies** (pg 29-34) allows therapies to enter the market after only Phase 2 trials if they are meant for certain serious or life-threatening diseases or conditions, contingent on post-market studies. Of course, we want to help patients who are facing imminent death or serious disability from a disease or condition. However, unproven treatments have the possibility of causing an earlier or more painful death or disability. That is why it is essential to have as much information as possible before approving ineffective drugs or those with dangerous side-effects.

As currently written, this section would put many patients at great risk. This section needs to be greatly revised or deleted to preserve the balance between speed and safety.

The vagueness of the term “serious or life-threatening disease or condition” means it could be interpreted broadly and end up being used for conditions that are eventually life-threatening, but not eminently so. And a “serious disease or condition” could be interpreted even more broadly. As worded, the FDA would lower standards for drugs for patients who have many other safer and more effective treatments available. This would harm more patients than it helps, and put patients’ lives at risk.

Many of these diseases and conditions for which unmet medical needs exist have small populations of people with the disease. Because of this, Phase 2 trials are quite small, making true determination of safety and efficiency difficult. Allowing these therapies to skip Phase 3 trials in favor of post-market studies would be dangerous for several reasons. Also, it has been shown that there are major delays in the submission of post-market study data; in fact, a substantial number are never completed in a way that provides meaningful information about patients. For example, when more than 40% of patients in a study drop out before the study is completed, experts agree that it is impossible to determine how safe or effective a drug is. Although the Act theoretically gives the Secretary the right to withdraw approval for the therapy, in practice this happens extremely rarely.

Any consultation requirements regarding guidance or anything else should explicitly include public health and/or consumer advocacy organizations. While this section does include patient advocacy

groups, some patient groups lack the scientific expertise to fully participate in these efforts and many patient organizations have very substantial financial conflicts of interest with industry.

It is very disturbing that the need to study patients that reflect the diversity of our country is not mentioned anywhere in this bill. This is an important issue that would be undermined by the provisions in this section. Diversity is essential because research tells us that some naturally occurring genetic variations may influence the way certain drugs are metabolized and work in certain racial and ethnic groups. Biological differences can also affect how drugs are metabolized in women compared to men, and patients over 65 compared to younger adults. Children also respond to drugs differently depending on their age. Patients deserve to know if a new drug is likely to be safe and effective for them. A drug that is safe and effective for a White woman under 65, for example, may not be safe or effective for a Black man over 65. Racial and ethnic minorities are rarely included in sufficient numbers in clinical trials used as the basis of FDA approval of drugs. And yet, these are the medical products that all patients -- including millions of men and women over 65, and millions of men and women of color of all ages-- rely on. It is not always possible to predict how different major subgroups might respond differently to a drug and for that reason is it essential that each group be analyzed to determine if the product is safe and effective for them.

Lowering safety and effectiveness standards and conducting smaller trials to expedite approval exacerbates the main challenge in conducting subgroup analyses: the sample sizes are too small, and become minuscule when age, race, and sex are all considered.

Pushing the burden for confirming safety and effectiveness for different groups (whether women, men, people of color, or people over 65) from pre-market to post-market studies is unfair to patients because research shows that a decade is likely to go by before post-market studies are completed<sup>1</sup>. Moreover, despite requirements to do so, post-approval studies rarely do better with regard to diversity; companies have no incentive to ensure diversity once their drug/device has already been approved for the general population.

Ultimately, accelerated approval of medical products does an enormous disservice to patients if those products are approved on small numbers of patients. Small clinical trials increase the likelihood of insufficient numbers of demographic subgroups, and the ability to conduct subgroup analyses. Information on a trial's demographic makeup and whether subgroup analyses were conducted is essential for patients in order to make well-informed medical decisions.

#### **SUBTITLE D: ANTIBIOTIC DRUG DEVELOPMENT**

The proposed Antibiotic Drug Development legislation is likely to do more harm than good as it is written. There are too many loopholes and not enough safeguards for patients. Fortunately, however, it could be greatly improved:

1. **Intended patient population must be clearly defined.** In sec. 1061, page 34, line 21, "limited population of patients" should be changed to "well-defined population of patients" every place

it occurs in the document. Safe use and effective stewardship of new antibiotics relies on prescribing only to patients who will have a favorable risk/benefit profile. The intended population should be clinically identifiable, and their characteristics and the methods to identify them should be included in the prescribing information.

2. **“Unmet medical need” must be clearly defined.** In sec. 1061, page 35, line 18 and every place it appears in the document, a new drug to meet such an “unmet medical need” should be defined as a drug that has improved efficacy or decreased harms over available therapies as demonstrated in adequate, well-controlled studies.
3. **Antifungal drugs should not be included.** In sec. 1061, page 35, line 4 “antifungal” should be removed every place it occurs in the document. Anti-fungal drugs are often well-reimbursed drugs with long treatment durations and there is absolutely no reason to include them in this legislation other than to benefit companies who would do well without these provisions.
4. **There should be no direct-to-consumer advertising for drugs intended only for a well-defined patient population.** In sec. 1061, page 40, subparagraph (4) “Promotional Materials” should be removed in its entirety. Due to the limited evidence that these drugs are safe or effective for any but a small minority of patients, there should be no direct-to-consumer advertising. This will help ensure appropriate prescribing only to the intended patient population, which is critical for both patient safety and antibiotic stewardship.
5. **Prominent visual element on packaging should be required.** Previous drafts of legislative language required a prominent symbol or visual element to appear on the drug packaging to indicate the limited approval. The symbol has now been replaced by a simple warning statement in the prescribing information (sec. 1061, page 39, subparagraph (C)). Physicians and patients rarely read labels. A prominent symbol would increase appropriate use by physicians and some patients. Appropriate prescribing is critical to patient safety and to antibiotic stewardship. Such a symbol would also increase transparency and educate patients about potential risks, who may not recognize the significance of a general written statement. It would harm patients to discard this critical safeguard.
6. **Third party organizations should not establish breakpoints.** Allowing susceptibility test interpretive criteria standards to be established by a “nationally or internationally recognized standard development organization” (sec. 511, page 45, lines 20-22) opens the process to bias, as these organizations do not have the same conflict-of-interest protections that the FDA does. These organizations may have direct financial relationships with pharmaceutical companies, which conflict-of-interest “procedures” (sec. 511, page 46, line 24) may not sufficiently address. As lower breakpoints can significantly alter antibiotic prescribing, these organizations should not be allowed to establish breakpoints. The section “Voluntary use of non-adopted criteria” (Sec. 511, page 53, subparagraph (5)) should be removed in its entirety. Sponsors should use the currently accepted breakpoints.
7. **The Secretary should update breakpoints as needed based on evidence, not pre-established timelines.** In sec. 511, page 50, subparagraph (c), lines 18-19, the Secretary is required to update breakpoints “every 6 months”. This stipulation should be removed and replaced with “as needed based on evidence of changes in patient outcomes in relation to susceptibility criteria”. On page 51, subparagraph (iii), line 12, the phrase “and explaining the reason for so declining” should be removed. The Secretary should not be obligated to explain their reasoning for declining to alter a breakpoint.

8. **Conveyance of exclusivity privileges should not be allowed.** The purpose of a limited population approval is to address a specific unmet medical need. The provision to convey 12 months of the 5-year extension of exclusivity period for a qualified infection disease product to “one or more other drugs”, which may not be fulfilling such a requirement, is completely inappropriate. For example, it could be enormously costly to Medicare and healthcare when used for extremely expensive specialty drugs.
9. **Authority to revoke new microbial drug designation should be designated.** As these drugs are expected to have significant post-market study obligations, it is in patients’ best interest that the FDA have the authority to withdraw this designation at any time as new data is submitted.
10. **Standards of safety and efficacy should be strengthened.** Evidence such as “alternative endpoints,” “datasets of limited size” and “data from phase 2 clinical studies” (sec. 1061, page 38-39) are not acceptable grounds for approval. Moreover, this section is misleading because it claims that the standards of substantial evidence “including whether a drug is safe and effective” (sec. 1061, page 41, lines 20-21) are unchanged. These parameters be replaced with patient-centered and clinically meaningful outcomes such as mortality and irreversible morbidity. “Alternative endpoints” should be replaced with “valid surrogate endpoints that reflect mortality or irreversible morbidity” every place it occurs in the document.
11. **Risk evaluation and mitigation strategies (REMS) should be required.** Approval under this mechanism should be contingent on any strategies, including REMS and post-market studies, deemed necessary to ensure safe use of the new drug.
12. **Rule of construction on “practice of health care” should be removed.** In sec. 1062, page 59, subparagraph (e) should be removed in its entirety. This section introduces unnecessary confusion, as physicians should be aware of the limited nature of the evidence supporting these new drugs, and should adjust their prescribing practices accordingly. Appropriate use of these new drugs is essential to both patient safety and good antibiotic stewardship practices.
13. **60 Day Requirement for Secretary to consider designation should be removed.** This section (sec. 1064, page 70, subparagraph (iv)(I)) requires the Secretary to make a determination as to whether a drug is a “new antimicrobial drug” within 60 days of a request from a sponsor. This timeframe is too short for the Secretary to adequately judge the sponsor’s submission and will place undue burdens on the FDA.

#### **SEC. 1161. DISSEMINATION OF INFORMATION ABOUT MEDICAL PRODUCTS USING THE INTERNET.**

Section 1161 (pg 92-94) deregulates the use of internet and social media platforms for communicating about medical products. The FDA recently released draft guidance regarding this issue, entitled “Internet/Social Media Platforms with Character Space Limitations— Presenting Risk and Benefit Information for Prescription Drugs and Medical Devices.” The FDA draft guidance provides a very weak regulation, but this provision in 21<sup>st</sup> Century Cures weakens those efforts further. This section should be deleted, and the FDA should continue the process they already started, which has ample opportunity for public comment regarding regulating social media.

Patients and consumers increasingly rely on social media and the internet as sources of health and medical information that influence their decisions to seek medical care. As the draft guidance states, “Truthful, accurate, non-misleading, and balanced product promotion best serves the public health.” The FDA recognizes throughout the draft guidance the inherent difficulty in communicating adequate

risk and benefit information through platforms that have very tight space limitations. The draft guidance states, “For some products, particularly those with complex indications or extensive serious risks, character space limitations imposed by platform providers may not enable meaningful presentations of both benefit and risk.”

The discussion draft ignores this difficulty, and it explicitly allows companies to only present the benefits (approved uses) in character-limited applications and hide the risks with hyperlinks. This could harm millions of patients.

It is well known among social media experts that consumers are less likely to obtain information that requires more “clicks.” Many may not even realize that the link provides crucial, potentially life-saving information. Allowing all risk information to be hidden via subsequent links clearly increases the chances that consumers will not see the risk information that is crucial for them.

Marketing studies suggest that most consumers and patients will not follow links to additional information. When social media are used to promote the use of medical products, they might not even realize that there are possible risks.

The FDA draft guidance, although very lenient, required that industry present the “most serious risks,” and then, rather than delineating all the risk information, it could instead provide a link to the full risk information. We have urged the agency to define what they mean by “most serious” since individual patients and consumers may have different views about what risks they find acceptable. Are the most serious risks the ones that are common and harm quality of life, such as nausea or dizziness, or the ones that might be rare but life-threatening, such as renal failure or potentially fatal blood clots?

It is difficult if not impossible to think of many examples that could effectively communicate risks and benefits within strict space limitations without removing substantial amounts of risk information and relying heavily on links, given the complexity of risk and benefit information for most medical products.

To safeguard patients, the amount of space should be comparable for risks and benefits and the reliance on links should be identical for risks and benefits when advertising on any internet or social media platform. If the proposed legislation overrules the FDA guidance, it should do so to protect patients who rely on social media, not to provide biased information to them.

## **TITLE II: BUILDING THE FOUNDATION FOR 21<sup>ST</sup> CENTURY MEDICINE INCLUDING HELPING YOUNG SCIENTISTS**

### **SEC. 2001. INNOVATIVE CURES CONSORTIUM**

Section 2001 does not have adequate conflicts-of-interest safeguards. The stated purpose of this section is “to accelerate the discovery, development, and delivery in the United States of innovative cures, treatments, and preventive measures for patients.”

This private/public partnership is too heavily tilted to favor industry's position. There are many perspectives on this issue, and as written those other perspectives are under-represented. Industry representatives would have the ability to use its influence on the consortium to steer not only private

dollars but also public dollars to research projects it favors. Of the 22 members on the consortium, industry would have more than one-third of the representatives (8 members).

This is too much power. Industry representatives have a duty to their employers to represent their interests. Maximizing industry profits often does not align with our nation's public health needs.

#### **SEC. 2021. MEDICAL PRODUCT INNOVATION ADVISORY COMMISSION.**

Section 2021 should be deleted. As written, it states specifically that the National Institutes of Health, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services should focus on "discovery, development, and delivery of **new** medical products" (p 141). The emphasis on new, with no mention of safe or effective products is misguided. Patients want and deserve medical products that would improve patient outcomes.

Although this section mentions conflicts-of-interest, it does not prevent conflicted individuals from serving on the advisory commission and does not state if the meetings will be open to the public. It also bypasses the experts at NIH and the National Science Foundation and allows the Comptroller General to appoint members to the commission. These are all major problems. That is why this section should be deleted and completely redrafted.

#### **MEDICAL AND HEALTH SOFTWARE DEFINED.**

**Section 2061 and 2062** (pg 154-162) defines "medical software" and "health software", and removes regulatory authority from the FDA for "health software". There are several major problems with this; most importantly, the intent is to exclude many types of potentially life-saving or life-threatening software from FDA regulation. This puts millions of Americans at risk, as described below.

Medical Software is defined in this section as software intended to "analyze patient-specific information and other information to recommend to health care professionals a single treatment or course of action" while health software is defined as "intended for use to analyze patient-specific information or other information for purposes of presenting patient-specific recommended treatments or courses of action to inform healthcare professionals' decisions". The major difference seems to be simply the number of recommendations the software makes to the health professional after an analysis is performed. The discussion draft itself makes note of the difficulty in appropriate regulation in light of these definitions.

**In summary, the definition of health software explicitly includes software with known risks to patients and yet exempts them from all regulation.**

On page 155, health software includes "electronic health records" and software "intended for use for aggregation, conversion, storage, management, retrieval, or transmission of data from a device or other thing." All healthcare-related software used in hospital and office settings should be regulated by the FDA. Electronic medical records are not merely a storage system; they are used to advise physicians about treatment decisions. For that reason, the accuracy of information stored in them and other software used to advise health professionals about treatment based on those records, are critical to

healthcare decision-making and patient care. For example, a health insurance company described a case study in which two patients had their imaging scans mixed up in the patients' electronic records. This led to one of the patients having unneeded surgery to remove a kidney<sup>ii</sup>. In a federal survey in Fall 2014, 15% of 10,000 doctors responding said electronic records had led them to choose the wrong medication or lab order. The hospital rating organization Leapfrog Group, found that physician order entry systems in many EHRs fail to alert doctors about a third of the time to medication allergies and other important factors – and hospitals sometimes remove double-checking mechanisms<sup>iii</sup>. The removal of double-checking mechanisms is an example of another reason health software used in healthcare settings needs regulation by the FDA – to ensure that it works with the real-life routines of the end users. This was a lesson learned during the regulatory history of software used in blood banks<sup>iv</sup>.

In a short 9-week study of only 36 hospitals, the ECRI Institute's Patient Safety Organization found 171 health information technology malfunctions and disconnects that caused or could have caused patient harm. This included computer programs that truncated medication dosage fields, leading to a respiratory arrest; computer systems that didn't talk to each other, leading to a patient dying of organ rejection; and an electronic systems' misinterpretation of "midnight" so that an infant received antibiotics a day too late. Overall, 53% of the incidents involved a medication management system, 25% involved a computerized order entry system, 15% involved an electronic medication administration record, 17% were caused by clinical documentation systems, 13% were caused by Lab information systems and 8% were caused by radiology or diagnostic imaging systems<sup>v</sup>. All of these systems could easily fit under the definition of health software above.

Electronic Health records only work when healthcare workers and patients can trust them to be accurate at all times – trust that can only be justified with rigorous and regulated validation and testing. This type of software is critical to patients' lives and safety, and must be regulated as such.

### **TITLE III: MODERNIZING CLINICAL TRIALS**

#### **SEC 3031. POSTAPPROVAL STUDIES AND CLINICAL TRIALS**

Section 3031 (pg 235-237) allows the Secretary to reevaluate whether a post approval study or clinical trial should be continued. A study or trial can be deemed unnecessary because the study is no longer scientifically warranted, changes in the standard of care, or renegotiation of the timelines for the post approval study.

In our experience, the FDA already has latitude about no longer requiring a post-approval study if a product is no longer on the market. Most post-market studies are delayed and the FDA rarely enforces those requirements. This provision therefore seems unnecessary but may provide a loophole without safeguards for patients. This provision should be deleted or revised so that any changes of the requirements for a post approval study or clinical trial should require a new Advisory Committee meeting for adequate review by experts in the field to evaluate the safety and efficacy data.

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<sup>i</sup> Moore Thomas, Furberg Curt. Development times, clinical testing, postmarket follow-up, and safety risks for the new drugs approved by the US Food and Drug Administration. JAMA Intern Med 2013; DOI: 10.1001/jamainternmed.2013.11813

<sup>ii</sup> NORCAL Mutual Insurance Company. Electronic Health Records: Recognizing and Managing the Risks. Claims Rx. October 2009.

<sup>iii</sup> Ungar, Laura, and Jayne O'Donnell. "Feds Move into Digital Medicine, Face Doctor Backlash." USA TODAY 1 Feb. 2015: <http://www.usatoday.com/story/news/nation/2015/02/01/backlash-against-electronic-medical-records/21693669/>

<sup>iv</sup> December 3, 2014: Blood Products Advisory Committee Meeting FDA Executive Summary <http://www.fda.gov/AdvisoryCommittees/CommitteesMeetingMaterials/BloodVaccinesandOtherBiologics/BloodProductsAdvisoryCommittee/ucm424819.htm#G>

<sup>v</sup> ECRI Institute PSO. PSO Deep Dive. January 2013. <https://eshop.ecri.org/p-140-pso-deep-dive-health-information-technology.aspx>

## **Comments from Members of the Patient, Consumer, and Public Health Coalition Medical Device Comments**

Approximately 99% of all regulated medical devices are cleared by the Food and Drug Administration (FDA) through the 510(k) process, and the FDA reviews 90% of 510(k) applications within 90 days.<sup>1</sup> Only 1% of devices are approved by the FDA's more rigorous Premarket Approval (PMA) process, which is comparable in work load to a drug review but provides only about 10% the user fees as a new drug application. Most PMAs are supplemental PMAs and also reviewed very quickly.

In light of these facts, there is no medical or public health justification for expediting medical devices as described in Title 1, Subtitle E (Priority Review for Breakthrough Devices) or Subtitle F (Accelerated Approval for Breakthrough Devices). From our patient, consumer, and public health perspective, the micromanagement of FDA prescribed in these sections is for the benefit of industry, not the benefit of patients or consumers.

It is deeply disappointing that safety and effectiveness of medical devices are hardly mentioned in this discussion draft. Patients want safe and effective devices cleared in a timely matter—not the fastest device out of the lab. Safety is not mentioned once in Subtitles E, F, and I (Combination Products) and is mentioned only twice in Subtitle D—Medical Device Reforms.

FDA has a lifesaving role as a regulatory agency, and yet the sections on medical devices repeatedly put industry in the position of dictating to the FDA, rather than being regulated by the FDA. While improved communication between industry and the agency is a laudable goal, these provisions tip the balance in ways that would require enormous additional resources at CDRH – resources that neither Congress nor the device industry has been willing to provide in appropriations or user fees.

### **Micromanaging CDRH with Vague Goals, Loopholes, and Burdensome Requirements**

It is ironic that the same document that requires FDA to reduce the burden on the medical device industry adds enormous additional burdens on CDRH, a Center with limited resources from Appropriations and even less from user fees.

Sec. 515B (p 72), states that the Secretary shall establish a program for priority review for devices that have “ the potential to, compared to existing approved alternatives, reduce or eliminate the need for hospitalization, improve patient quality of life...” (p 73).

This is a reasonable goal but one could argue that any new device has the potential to be better than what is currently on the market. This priority status would require a judgment in the absence of any objective research to determine which devices offer statistically significant advantages – or any advantages. It is only after data are collected and reviewed by the FDA that a determination can be made that a new device has significant advantages over other devices. Unfortunately, the goal of this section is to provide priority review earlier in the process. Most companies will claim that their product offers significant advantages, despite the absence of objective evidence to support those claims. This entire micromanaged process would therefore add an enormous burden to the FDA, adding another step to the approval process that inevitably would slow the process down for all medical devices under review.

The micromanagement reflected in “Review” (p 74), “Actions” (p 76), “Additional Actions” (p 77), and the “Priority Review Guidance” (p 78) sections reflect the opinion that Congress should tell the FDA how to conduct scientific reviews, and to require a burdensome process to do so. It also pushes the FDA to lower the standards in the premarket review process and shift scientific evidence of safety and effectiveness to the post-market phase. The track record of post-market studies required by FDA shows that the companies lack the incentive to conduct post-market studies appropriately or in a timely manner. Instead, these studies are often delayed for years,<sup>2</sup> and with up to 95% of patients lost to follow-up.<sup>3</sup>

Regarding the “withdrawal” section (p75), it states that the “Secretary may not withdraw the designation” **based on the criteria no longer being met** because of the clearance or approval of another device that was previously approved for such designation. This is a loophole that will allow non-qualifying devices to use paths supposedly designed for breakthrough devices.

For decades, Congress left specific scientific decisions to federal public health agencies, rather than prescribing those decisions in legislation. There is good reason for this approach. The FDA should determine the appropriate staff to review a request for priority review or assign staff to facilitate the development of devices, or determine what evidence is needed to establish a device’s safety and effectiveness. It is particularly misguided to legislate “shorter or smaller clinical trials, the application of surrogate endpoints and Bayesian statistics.” Scientific decisions should be left to scientists, rather than dictated by legislation.

The section on “clinical protocols” (p 78) puts the Secretary in a subservient role to industry. It states that clinical protocols will be “binding on the Secretary, subject to changes agreed to by the sponsor.” Who is regulating whom?

### **Breakthrough Devices**

Sec. 1101 on breakthrough devices (page 82) lowers safety and effectiveness standards to accommodate accelerated approval of devices. It would allow the use of a surrogate endpoint that is “reasonably likely to predict clinical benefit.” Reasonably likely is not defined, and as spelled out in our analysis of the Surrogate Marker section of our comments (Title 1, Subtitle B), surrogate endpoints often do not correlate with patient health outcomes of importance to patients, such as survival, good health, or hospitalization. This section also would rely on post-approval studies to “verify clinical benefit or effectiveness” years after a product is on the market. This is unfair to patients, who pay for devices that are unproven and may be dangerous. The experience of patients with metal on metal hips shows that removing a poorly tested device is not a simple matter; revision surgery is often more dangerous and less effective than the surgery to put in a first implanted device. Patients should not be used as unwitting guinea pigs to determine the safety and effectiveness of unproven devices for years while we wait for post-market studies to be complete. Devices should be studied before they are marketed to establish if they are beneficial.

### **Combination Products**

**Subtitle I** (Combination Products, p 198) also reflects excessive and unjustifiable micromanagement. It specifies that for combination products, the FDA agency center with primary jurisdiction “be the sole point of contact for the sponsor of the product.” This is potentially harmful to patients. It is in the interest of patient safety and accurate communication that the center without primary jurisdiction should also be able to contact the sponsor if there are questions regarding safety and effectiveness.

Sec. 2142 (p 201), the request for a GAO Report on FDA regulation of combination products, is basically a performance report on the FDA. If such a report is needed, it should be part of the user fee negotiations.

## **Subtitle D Medical Device Reforms**

### **Safety and Effectiveness Provisions Weakened**

Sec 5061 on third party reviews (524B, page 352) is dangerous because it would rely on third parties to assess device facilities. It ignores the inherent conflict of interest that occurs when a device maker can choose the company who will assess its facilities from a list provided by the Secretary (p 354). Device makers will soon determine which third party entities are the most lenient reviewers are and choose them. Companies that lose business because of their reputation as having higher standards will go out of business or need to lower their standards to stay in business. Use of third parties to make these essential decisions would be like parents hiring a third party to determine whether their child is to be admitted to Harvard, instead of Harvard making the decision. In the past, it was found that FDA efforts to monitor the third parties used so many resources that it made more sense to do the reviews inside the agency rather than monitor outside entities. Before including this provision, it is important to determine if it is cost effective to use third parties that are carefully monitored. If so, the "Accredited Person Selection" section should be changed to state that the reviewers on the list will be randomly assigned (rather than chosen by the manufacturer).

Sec. 5062 weakens the definition of "valid scientific evidence" (p. 356) by including case histories and relies on vague terms such as "well-documented," "acceptable protocol," and peer-reviewed journals that are "internationally recognized as authoritative sources of information." Who determines if a journal is an authoritative source, what is acceptable protocol, and what is well-documented? Particularly dangerous is the provision that if data are in a peer-reviewed journal they should be presumed to be valid (p. 356). Peer reviewers do not see the original data for a journal article and are in no position to judge whether the data are valid. Peer reviewers can only judge the information provided to them in a journal article, and try to determine whether information is missing. They are not able to determine if data presented are fraudulent or inaccurate. The wording that "the Secretary may not require submission of the data for the Secretary's review" inappropriately limits the authority of the agency to scrutinize data.

Absence of valid scientific evidence is already a major problem with 510(k) submissions. A recent study found that despite the law requiring publicly available scientific evidence of substantial equivalence, the vast majority of more than 1100 implantable medical devices did not provide such information to the public.<sup>4</sup> This means that doctors, patients and manufacturers (who may want to improve on a current device) lack this critical information. This proposed legislation limits the FDA's ability to carefully scrutinize data that nobody else other than the manufacturer is likely to have access to. While the FDA approval process is basically an honor system that relies on the integrity of the applications it receives, the agency must have the authority to ask for more information when necessary to make an appropriate decision regarding an application.

### **Reducing Burdens on Industry and Increasing Burdens on the FDA and Patients**

Sec. 5063 (p 357) mandates that FDA employees and supervisors receive training on the least burdensome concept and that they receive retraining annually (without an option to test out). This would have a chilling effect on FDA reviewers who seek safety and effectiveness information regarding

devices they are reviewing. Moreover, FDA has limited resources that should not be spent on unnecessary annual training. The idea that all FDA staff need annual training is also quite insulting: when is the last time Congress required annual training for other scientists? Sec. 5063 also pressures FDA staff with an “ombudsman audit” that reviews an FDA’s device unit based on a “representative sample of persons from industry.” An ombudsman is supposed to be an objective third party; industry is not objective about the work of the FDA. If industry is to have an ombudsman, then public health researchers and consumer advocates should also have an ombudsman. The FDA is a regulatory agency that should not be forced to spend its limited resources cajoling the companies it regulates.

Sec. 5065, the “Notification of Marketing of Certain Class I Devices” (p 360) gives the Secretary only 5 business days to determine if the device conforms with requirements before the device is marketed. Clearing devices too quickly (even on low-risk class I devices) will lead to unsafe devices reaching the market. Research has shown that even Class I devices have been subject to high-risk recalls when patients or consumers were killed or permanently harmed by a faulty Class I device.<sup>5</sup> These have included heating pads that caused severe burns. This section should be deleted because rushing these judgments would harm patients.

Sec. 5066 ties the FDA’s hands by restricting what the FDA may request regarding 510(k) applications. Despite the requirement of substantial equivalence for 510(k) clearance, the FDA is already much too flexible in implementing the law. For example, in recent years a spinal implant was cleared as substantially equivalent to a predicate spinal implant that was cleared as substantially equivalent to a dental implant made of a different material, with a different shape, and a very different purpose. The current language ties the Secretary’s hands regarding indication for use statements and or data regarding an indication other than proposed indication. This language (p 361 lines 14-19) should be deleted. Since the 510(k) process is intended to clear devices that are safe and effective, despite rarely requiring clinical trials, the agency must have the power to request information that may affect the safety and effectiveness of devices.

### **Reducing the Independence of FDA Advisory Panels and the Objectivity of Panel Meetings**

Proposals regarding Advisory Panel meetings would make those meetings even more industry-centric than they already are. Advisory Panels are supposed to provide outside expertise independent of the sponsors. The sponsor (manufacturer) spends hours at these meetings presenting their data and answering any questions from the FDA or Advisory panel members. They already control the content of the meetings by virtue of having more time to present their views and information than the FDA and everyone else combined. If industry has the opportunity to recommend external experts for advisory committees as well (Pp 76 & 77), then public health advocates should have that same opportunity. Similarly, Sec. 5066 states that the FDA must consult with the device applicant regarding the expertise needed on advisory panels (p 354) and it micromanages FDA on how many voting members should be on the panels. The proposed legislation provides a less objective and more biased situation regarding the order of testimony and how often industry is allowed to testify. It states that the meetings “shall encourage free and open participation by all interested persons;” this sounds reasonable, but most of those in the room will be from industry. The general public does not read the Federal Register and therefore rarely know when FDA meetings take place. And, since industry representatives are paid to attend FDA Advisory Committee meetings and often pay patients to attend as well, and since the only public health, patient, or consumer representatives must pay their own way, most of those at Advisory Committee meetings are from industry. These misguided provisions would give the sponsor a greater say in the proceedings.

### Priority Review Criteria

The “Designation Process” section includes a 60 calendar day deadline after the FDA receives a request to determine if a product meets the priority review criteria. But if a device maker submits a request that is lacking critical scientific evidence, 60 calendar days (43 working days in months without holidays) may not be enough time. A request for reconsideration is even tighter—30 days. Also, Sec. 5064 of the discussion draft states that new FDA device reviewers must receive training on the use of standards to “facilitate” the review of devices within 30 days – thus taking overburdened staff away from their jobs to train them to be more productive. Unless the device user fees are substantially increased, FDA would not be able to reach these unrealistic timelines.

### Conclusions

The medical device sections of the discussion draft do nothing to ensure that medical devices are safe or effective. Patients do not want a device that was cleared or approved the fastest if that means it wasn’t reviewed carefully. They do not want a device that meets surrogate endpoints -- they want devices that improve their health or survival. The discussion draft would be very helpful to companies regulated by the FDA but would dangerously reduce the safeguards that are needed to ensure that devices are safe and effective. The unintended consequence would be to increase the number of high-risk and moderate-risk recalls, and make decisions about medical devices unduly burdensome to patients and their physicians as well as an already under-resourced CDRH staff.

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<sup>1</sup> Food and Drug Administration (2011). Analysis of Premarket Review Times Under the 510(k) Program. <http://www.fda.gov/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CDRH/CDRHReports/ucm263385.htm#a>

<sup>2</sup> Reynolds, et al. Assessing the Safety and Effectiveness of Devices After US Food and Drug Administration Approval FDA-Mandated Postapproval Studies. *JAMA Intern Med.* 2014;174(11):1773-1779.

<sup>3</sup> Zuckerman D, Booker N, Nagda S (December 2012). "Public health implications of differences in U.S. and European Union regulatory policies for breast implants". *Reproductive Health Matters* **20** (40): 102–11.

<sup>4</sup> Zuckerman et al. (2014). Lack of Publicly Available Scientific Evidence on the Safety and Effectiveness of Implanted Medical Devices. <http://archinte.jamanetwork.com/article.aspx?articleid=1910556>.

<sup>5</sup> Zuckerman et al. (2011). Medical Device Recalls and the FDA Approval Process. *Archives of Internal Medicine*. doi:10.1001/archinternmed.2011.30. <http://center4research.org/nrc-in-the-news/medical-journal-articles/medical-device-recalls-and-the-fda-approval-process/>.

## Comments of Members of the Patient, Consumer, and Public Health Coalition 21<sup>st</sup> Century Cures Surrogate Endpoints Section

### TITLE I—PUTTING PATIENTS FIRST BY INCORPORATING THEIR PERSPECTIVES INTO THE REGULATORY PROCESS AND ADDRESSING UNMET NEEDS

#### Subtitle B—Surrogate Endpoint Qualification and Utilization

**Sec. 1021. Evidentiary standards for the review of requests for the qualification of surrogate endpoints; Biomarkers partnership.**

**Sec. 1022. Enhancing the process for qualification of surrogate endpoints.**

**Sec. 1023. Transitional provisions for previous submissions for qualification of biomarkers as surrogate endpoints.**

**Sec. 1024. Biannual reports to Congress.**

**This section of the bill would endanger patients and should be struck in its entirety, for the reasons given below.**

Surrogate markers are laboratory measurements or physical signs intended to substitute for the measures of health that patients care most about, such as survival, good health, or days spent in the hospital.<sup>1</sup> Biomarkers are a type of surrogate marker that are laboratory measurements that reflect disease process activity.<sup>2</sup> Biomarkers are chosen because they seem likely to predict a health outcome, such as glucose levels correlating with days in the hospital for a patient with diabetes.<sup>1</sup> However, whether a surrogate marker will accurately predict a patient's health is uncertain.<sup>2</sup> Moreover, the mechanism of the treatment may not be fully understood, leading to unanticipated consequences.<sup>3</sup> That is why it is risky to rely on surrogate markers as primary measures of effectiveness of a medical product or procedure, instead of relying on health outcomes that are known to be "clinically meaningful," such as survival.<sup>2,4</sup>

In some cases a drug that has a significant impact on a surrogate marker has no real clinical benefit to patients, resulting in the approval of a worthless or even a harmful treatment.<sup>2</sup> For example, although high levels of HDL cholesterol ("good cholesterol") are correlated with fewer heart attacks and better heart health, when Pfizer tested torcetrapib, it increased HDL levels but the patients were more likely to die from cardiovascular causes. For that reason, the drug was never approved and lives were saved.<sup>5</sup> Other examples of this type of discrepancy include: the use of the CD4 cell count to evaluate AZT (zidovudine) for HIV/AIDS,<sup>6</sup> bone mineral density as a surrogate to evaluate the use of sodium fluoride for osteoporosis in postmenopausal women;<sup>7</sup> and left ventricular function as a surrogate for reduced mortality as a result of vasodilators.<sup>8</sup> All these drugs had a positive impact on these surrogate outcomes, but not on patient health. Urging the FDA to rely more on surrogate outcomes, in the absence of clear evidence of patients' improved health, will almost inevitably result in FDA approving more worthless or harmful treatments.<sup>2</sup>

Conversely, relying on surrogate markers also creates a risk of disregarding effective treatments. For example, when interferon- $\gamma$  was tested in clinical trials to treat chronic granulomatous disease in children, the surrogate outcomes were not affected by the treatment but children getting the treatment had fewer serious infections and spent less time in the hospital, which shows it was very effective.<sup>9</sup>

As the above examples indicate, the health consequences of reliance on such markers are potentially disastrous.

If the FDA relies on surrogate markers for drug approval decisions and then requires post-market studies to validate the marker or prove the safety and effectiveness of the drug, it may be many years before those post-market studies are completed. Detailed clinical and empirical evidence is needed to ensure that a surrogate marker is a valid measure that fully captures the net benefit of the drug or treatment.<sup>4</sup> This requires gaining an understanding of which identified pharmacologic actions contribute to a drug's clinical effect, as well as the mechanisms of the disease, which is a complicated and rare feat.<sup>2,4,8</sup> Choosing the right cancer biomarkers has been especially challenging; for example a chemotherapy drug that slows or stops the progression of cancer or reduces the chances of dying of cancer, can have such severe side effects that the patient lives a shorter life or one with a much poorer quality of life.<sup>10</sup> Thus, clinical-efficacy end points, which allow approval on the basis of a beneficial effect in adequate clinical trials, are more accurate, and strategically simpler.<sup>2,4</sup>

The main advantage of using surrogate markers is to speed up approvals, but shorter studies are less accurate at determining long-term risks.<sup>2</sup> Moreover, it creates statistical problems, by confounding the variables and introducing heterogeneous variance.<sup>8</sup>

To date, FDA has succeeded in striking an appropriate balance between the challenges with biomarkers and surrogate endpoints and their potential benefit in speeding up availability of treatments. This flexibility has decreased the new drug approval times substantially since the early 1990s.<sup>11</sup> Companies and the FDA often rely on surrogate markers for drugs reviewed in accelerated approval processes, to shorten the time frame needed to evaluate treatments for serious and life-threatening conditions.<sup>2</sup> Rather than conduct long-term studies to see how long a patient lives, surrogate markers are used in an effort to predict survival; if a drug or device has a positive impact on the surrogate marker, then the FDA requires post-market studies to conclusively demonstrate the link between the effect on the surrogate and the predicted clinical benefit.<sup>2</sup> As a result of FDA's regulatory expertise, the Agency alone is tasked with making such determinations.

During the 20<sup>th</sup> century, the FDA's drug approval standards were strengthened to require two adequate and well-controlled clinical trials using clinically meaningful outcomes, such as survival or improved health. Congress revised the law toward the end of the 20<sup>th</sup> century to encourage the FDA to waive those standards. Particularly in accelerated pathways, the FDA often relies on data from a single trial with a surrogate marker endpoint. As was mentioned above, when the pre-market results are not conclusive, the FDA requires the company to confirm safety and efficacy in post-market studies.<sup>12</sup> Unfortunately, 15 years after accelerated approval was established in 1992, only 38% of 1,682 post-market studies required to confirm clinical benefit had even been started.<sup>11</sup> As of 2013, 43.5% of trials required in 2011 have not yet begun.<sup>13</sup> Drugs approved more quickly often are found to have serious risks after the drugs have been widely used for years, thus requiring changes in risk information on their labels, including "black box" labeling restrictions.<sup>14,15</sup> But in the years before those post-market studies are completed, patients and their physicians lack information to make the best treatment decisions, and this could lead to unnecessary deaths and very serious complications.

The question is: are the changes regarding surrogate endpoints proposed in this section of 21<sup>st</sup> Century Cures more likely to benefit patients or harm them? As has been shown, the FDA already has procedures in place to allow the approval of new drugs for serious and life-threatening condition under the accelerated approval process using surrogate markers, with the requirement of post-marketing

studies to be conducted to confirm new agents' clinical benefits. However, companies by and large have not honored their commitments to conduct these crucial studies with serious consequences for patients and the public health.

The bill proposes to use surrogate markers more widely, without adequate safeguards. It would allow approval of drugs for diseases that already have safe and effective treatments; drugs should not be approved based on preliminary data unless they are urgently needed. Since surrogate markers may not accurately predict health outcomes important to patients, markers should be used only when they are likely to do the most good and the least harm: speeding access to new treatments for those who are very ill and who lack safe and effective alternatives. Instead, the proposed legislation would apply to all drugs, devices and biologics under the agency's purview. Moreover, the bill fails to address the fact that most companies fail to comply with requirements to conduct post-marketing studies in a timely manner. The FDA task of monitoring post-market studies would increase exponentially if more drugs relied on surrogate markers. This would use valuable FDA staff time and result in further delays, leaving patients and doctors without crucial information on the clinical effects of new drugs, thus endangering patients.

Given the difficulties and complexities of the use of surrogate markers described above, it is critical that the FDA continue to address the role of these biomarkers on a case-by-case basis in the context of the approval process. In addition, the agency requires discretion in the use of surrogate markers depending on the nature of the disease under consideration and the drug being considered for approval. Because surrogate markers can often provide misleading information, which may suggest clinical benefit when there is none or when a new product may be especially harmful for some patients, FDA decisions on the use of surrogate markers must be done with great care and with the most rigorous scientific scrutiny.

Instead, the bill proposes a new process for the approval of surrogate markers. First, it seeks the establishment of a generic framework for the approval of surrogate markers for all drugs, devices and biologics. As has been described above, the role of surrogate markers in predicting disease processes and drug effects is disease-specific and complex, and not amenable to a one-size-fits-all approach described in the bill. Second, there is no mention of the need for clinical validation of these surrogate markers in the bill or a mechanism to improve FDA enforcement so that companies complete required studies in a timely manner. Patients would pay the price for this legislation, literally and figuratively, by paying for unproven treatments that could put their lives at risk.

In addition to expanding the use of surrogate markers and instituting a generic template for validation of these biomarkers, the bill seeks to 1) establish fixed time frames for the evaluation of a surrogate marker based on a request by industry; 2) include industry experts as part of the evaluation process; 3) reduce FDA's authority under the guise of public-private partnerships where private entities have enormous clout; 4) institute an appeals process that is extremely burdensome to the FDA and has a chilling effect on FDA scientists' using their unbiased scientific judgment.

The proposed legislation would shift the balance of power in the regulation of the use of surrogate markers away from the FDA, and weaken the agency's ability to responsibly evaluate their use. Because of the complexity and difficulty in evaluating surrogate markers, creating fixed and short timelines for this process will stymie any rigorous investigation of specific biomarkers for given diseases. By making evaluation subject to industry request and including compulsory time limits, the legislation creates a situation where the agency could be flooded with requests, each requiring quick turn-around, which could lead to cursory and perfunctory review.

In summary, this section of the draft bill dangerously undermines the authority of the FDA, essentially privatizing a crucial regulatory function. By expanding the use of surrogate markers without adequate safeguards, it would put millions of patients at risk. By including industry experts in the evaluation of surrogate markers and offering a new appeals process when an industry request for approval of a surrogate marker is denied, it would greatly increase opportunities for bias stemming from financial conflicts of interest and political interference.

This section of the proposed bill should be deleted in its entirety.

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<sup>1</sup> Mark Rothman, "Surrogate Endpoints," FDA (April 2012),

<http://www.fda.gov/downloads/Drugs/NewsEvents/UCM300741.pdf>.

<sup>2</sup> Russel Katz, "Biomarkers and Surrogate Markers: An FDA Perspective," 1 *NeuroRx* (Apr. 2004).

<sup>3</sup> LJ Lesko and AJ Atkinson Jr, "Use of biomarkers and surrogate endpoints in drug development and regulatory decision making: criteria, validation, strategies," 41 *Annu Rev Pharmacol Toxicol* (2001).

<sup>4</sup> Thomas R. Fleming, "Surrogate endpoints and FDA's accelerated approval process," 24 *Health Affairs* (Jan. 2005)

<sup>5</sup> Avorn J. Torcetrapib and atorvastatin--should marketing drive the research agenda? *N Engl J Med*. 2005 Jun 23;352(25):2573-6.

<sup>6</sup> Fleming TR, DeMets DL. Surrogate end points in clinical trials: are we being misled? *Ann Intern Med*. Oct 1996;125(7):605-613.

<sup>7</sup> BL Riggs, et al., "Effect of fluoride treatment on the fracture rate in postmenopausal women with osteoporosis," 322 *NEJM* (Mar. 1990).

<sup>8</sup> J K Aronson, "Biomarkers and surrogate endpoints," 59 *British Journal of Clinical Pharmacology* (May 2005).

<sup>9</sup> A Controlled Trial of Interferon Gamma to Prevent Infection in Chronic Granulomatous Disease. *New England Journal of Medicine*. 1991;324(8):509-516.

<sup>10</sup> Charles L. Sawyers, "The cancer biomarker problem," 454 *Nature* (Apr. 2008).

<sup>11</sup> Carpenter, Daniel. Reputation and power: organizational image and pharmaceutical regulation at the FDA. Princeton University Press, 2014: 609

<sup>12</sup> Expedited approval of drugs for serious life-threatening diseases or conditions, 21 U.S.C 356(a)-(c).

<sup>13</sup> Fain, Kevin, Matthew Daubresse, and G. Caleb Alexander. "The food and drug administration amendments act and postmarketing commitments." *JAMA* 310, no. 2 (2013): 202-204

<sup>14</sup> Frank, Cassie, David U. Himmelstein, Steffie Woolhandler, David H. Bor, Sidney M. Wolfe, Orlaith Heymann, Leah Zallman, and Karen E. Lasser. "Era of faster FDA drug approval has also seen increased black-box warnings and market withdrawals." *Health Affairs* 33, no. 8 (2014): 1453-1459.

<sup>15</sup> Moore TJ, Furberg CD. Development times, clinical testing, postmarket follow-up, and safety risks for the new drugs approved by the US Food and Drug Administration: The class of 2008. *JAMA Intern Med*. 2014;174(1):90-95.



**PEAC**  
PATIENTS EQUAL  
ACCESS COALITION

February 10, 2015

The Honorable Fred Upton  
Chairman  
House Energy and Commerce Committee  
2125 Rayburn House Office Building  
Washington, DC 20515

The Honorable Diana DeGette  
Member  
House Energy and Commerce Committee  
2125 Rayburn House Office Building  
Washington, DC 20515

Sent via e-mail: [energyandcommerce.cures@mail.house.gov](mailto:energyandcommerce.cures@mail.house.gov)

Re: 21st Century Cures Discussion Document

Dear Chairman Upton and Representative DeGette:

The Patients Equal Access Coalition (PEAC) appreciates the opportunity to submit these comments in response to the request for information from the patient community as part of the Committee's 21<sup>st</sup> Century Cures Initiative. PEAC is a patient-focused coalition which works to ensure that cancer patients have appropriate access to all approved anti-cancer regimens including, but not limited to, oral and intravenous drugs, intramuscular injections, surgery, radiation, and transplantation.

We were very pleased to review the 21<sup>st</sup> Century Cures Discussion Document, which includes a number of proposals seeking to accelerate the discovery, development and delivery of treatments and cures for diseases including cancer. We are writing to respectfully request that you add in a provision from the Cancer Drug Coverage Parity Act to ensure that patients have access to innovative therapies once they are developed.

Cancer patients face barriers since insurance coverage has not kept pace with innovation in medicine and the growing trend towards orally and other patient-administered chemotherapy. Patient-administered chemotherapy has become more prevalent and is the standard of care for many types of cancer. Oral chemotherapy also accounts for approximately 35% of the oncology development pipeline. More importantly, many oral anti-cancer medications do not have intravenous (IV) or injected alternatives and are the only option for some cancer patients.

As these medications become more prevalent in cancer treatment, they must be as affordable as their IV counterparts. The traditional form of chemotherapy, IV, is covered under a health plan's medical benefit where the patient is only required to pay a small office visit co-pay. Patient-administered anti-cancer medications tend to be covered under the pharmacy benefit, which leaves many patients responsible for extremely high and unmanageable co-pays as high as hundreds or thousands of dollars per month. As a result, almost 10% of patients choose not to fill their initial prescriptions for oral anti-cancer medications due to the high rates of cost-sharing.<sup>1</sup> This disparate insurance coverage harms patients, who must pay exorbitant cost-sharing to access needed treatments, and hinders innovation since manufacturers cannot be certain that people will be able to access treatments if they're created.

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<sup>1</sup> Streeter SB, Schwartzberg L, Husain N, and Johnsrud M, Patient and Plan Characteristics Affecting Abandonment of Oral Oncolytic Prescriptions. *Journal of Oncology Practice*. Vol. 7, Issue 3S: 46s-51s, 2011.

To address this patient access challenge, PEAC supports the Cancer Drug Coverage Parity Act, which requires any private health plan that covers anticancer medications to cover self-administered anti-cancer medication at a cost no less favorable than the cost of IV, port administered, or injected anti-cancer medications. This legislation, which was supported by a bi-partisan group of ninety-two members in the last Congress, is not a mandate as it only applies to health plans that already cover chemotherapy. This bill ensures equality of access and insurance coverage for ALL anti-cancer regimens.

This federal legislation is building off of passage of similar laws in thirty-four states plus the District of Columbia, including Michigan and Colorado. Analysis of the implementation of these laws in various states indicates that the plans have been able to comply with the laws' requirements easily and that the impact on premiums has been negligible. Despite these successes, federal legislation is required to ensure that all individuals with private health insurance benefit from these protections.

We respectfully request that you include provisions from the Cancer Drug Coverage Parity Act in the final 21<sup>st</sup> Century Cures legislative package. Enhancing access to innovative therapies requires ensuring that patients can afford them once approved. Thank you very much for the opportunity to submit these comments. If you have any questions or would like additional information, please contact Meghan Buzby at [mbuzby@myeloma.org](mailto:mbuzby@myeloma.org) or 410.252.3457.

Sincerely,

AIM at Melanoma  
American Society of Hematology  
Aplastic Anemia & MDS International Foundation  
Association of Community Cancer Centers  
Cancer Support Community  
Fight Colorectal Cancer  
FORCE: Facing Our Risk of Cancer Empowered  
International Myeloma Foundation  
Leukemia and Lymphoma Society  
Lymphoma Research Foundation  
National Brain Tumor Society  
National Patient Advocate Foundation  
Ovarian Cancer National Alliance  
Roswell Park Cancer Institute  
Susan G. Komen

## **ADDENDUM: SUBTITLE N—21<sup>st</sup> CENTURY CURES ACT DISCUSSION DRAFT**

### **Subtitle N—Medicare Part D Patient Safety and Drug Abuse Prevention; Sec. 4281, Establishing PDP Safety Program to Prevent Fraud and Abuse in Medicare Prescription Drug Plans and Sec. 4284, Requiring E-Prescribing for Coverage of Covered Part D Controlled Substances**

**Section 4281, page 309, lines 18-21 and page 310, lines 1-2; Authorize the use of the PDP Safety Program in Part D and MA-PD plans rather than require use.** As proposed, plan sponsors would be required to implement these programs precisely as defined by the legislation and subsequent regulations issued by the Secretary. While there is a need for federal guidance to support the implementation of these programs and to provide a framework that defines beneficiary protections that would be required across all programs, a mandate would be too prescriptive and would inhibit development of innovative practices that could improve the effectiveness of PRRs. The Pew Charitable Trusts (Pew) has also sought feedback from plan sponsors about current use of PRRs in their private-payer and managed care Medicaid plans. In these discussions, plan sponsors have expressed strong interest in implementing programs in their Medicare plans that mirror existing PRRs that have demonstrated effectiveness, if granted the authority to do so.

**Section 4281; Provide plan sponsors with the option to restrict beneficiaries to a designated prescriber in addition to a designated pharmacy.** A recent review of state Medicaid programs found that most PRRs restrict beneficiaries to a single pharmacy and a single prescriber.<sup>1</sup> Inclusion of a prescriber component may improve the effectiveness of these programs by designating a single clinician to oversee the pain management needs of the patient. Medicare MA-PD plans are in an ideal position to implement effective prescriber- and pharmacy-based programs in light of their management of both medical and prescription benefits. While sponsors of Medicare Part D plans lack direct oversight of prescribers, plan sponsors with whom Pew has spoken described using prescriber outreach to increase awareness of potential overuse of opioids. One plan sponsor reported using prescriber letters and other correspondence to encourage communication among multiple prescribers who are providing care for a patient. As a result, the plan is often able to identify individual prescribers who agree to coordinate pain management care for these patients.

**Section 4281, page 310, lines 6-10; Revise requirements for the network of safe pharmacies that restrict participation to pre-approved contracted entities.** The proposed language limits participation in the PDP Safety Program to a network of contracted pharmacies. Pew is concerned that this approach could serve as a barrier to patient access to pain management therapies, especially in rural locations where the density of pharmacies is low compared with urban areas. Pew supports the reasonable access conditions described in the paragraph that follows (page 310, lines 11-20), which take into account the location of the beneficiary's residence(s), work site(s), mobility, and other relevant factors. While program structures differ, PRRs in state Medicaid and private payer plans often allow the beneficiary to submit preferences for a prescriber and pharmacy that are approved unless the plan sponsor has determined that the selected prescriber or pharmacy is contributing to the patient's misuse of controlled substances.

**Section 4282, page 313, lines 1-4, and section 4284, page 317, lines 1-3; Delink the requirement for electronic prescribing from the compulsory procedures defined for the PDP Safety Program to ensure sufficient time for adoption of this technology by prescribers and pharmacies.** The draft language includes a deadline of eight months following enactment of the legislation, after which time prescriptions for controlled substances for Medicare beneficiaries will be covered only if the prescription is transmitted electronically as described in Section 4284. Pew is concerned that this abbreviated timeframe could delay implementation of the PDP Safety Program, or result in substantial barriers to patient care if there is delayed or low uptake of this technology by prescribers and pharmacies in some geographic areas. Further, there are conflicting reports about the current state of readiness of prescribers to meet the requirements of electronic prescribing for controlled substances defined under the Drug Enforcement Agency's interim rule, Electronic Prescriptions for Controlled Substances, which became effective on June 1, 2010. For example, a software vendor has reported that prescribers in New York are ready to meet the state's e-prescribing requirement for controlled substances that goes into effect on March 27, 2015.<sup>ii</sup> However, state-based organizations representing prescribers and other stakeholders have asked for a one-year delay, citing a lack of readiness to meet required standards for transmitting these prescriptions.<sup>iii</sup> Additionally, in most states an average of just 70 percent of pharmacies are enabled to accept electronic prescriptions.<sup>iv</sup> Pew therefore encourages the Committee to delink the requirement for electronic prescribing to ensure timely implementation of the PDP Safety Program.

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<sup>i</sup> Roberts AW and Skinner AC. Assessing the present state and potential of Medicaid controlled substance lock-in programs. *J Manag Care Pharm.* 2014;20(5):439-46c. Available at <http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=18019>.

<sup>ii</sup> DrFirst BusinessWire. NY State ready to deploy new weapon in the battle against prescription drug abuse. Available at [http://www.businesswire.com/news/home/20150108005135/en/NY-State-Ready-Deploy-Weapon-Battle-Prescription#.VLq03y7\\_Eg8](http://www.businesswire.com/news/home/20150108005135/en/NY-State-Ready-Deploy-Weapon-Battle-Prescription#.VLq03y7_Eg8).

<sup>iii</sup> Medical Society of the State of New York (MSSNY). MSSNY urges governor and legislature to delay e-prescribing requirement; physician action needed. Available at [http://www.mssny.org/Documents/FOR%20ONLINE%20PDF%20URLS/NONY\\_feb2015-1-26low.pdf?hkey=66fe00f5-a7ee-4ad5-b8ae-ad2ff0737c75](http://www.mssny.org/Documents/FOR%20ONLINE%20PDF%20URLS/NONY_feb2015-1-26low.pdf?hkey=66fe00f5-a7ee-4ad5-b8ae-ad2ff0737c75).

<sup>iv</sup> SureScripts. E-prescribing of controlled substances. State regulatory status & pharmacy enablement. Available at <http://surescripts.com/products-and-services/e-prescribing-of-controlled-substances>.



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February 10, 2015

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Ranking Member Gene Green  
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Rep. Diana Degette  
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Dear Chairman Upton, Ranking Member Pallone, Chairman Pitts, Ranking Member Green, and Representative Degette,

On behalf of the Pew Charitable Trusts, thank you for the opportunity to provide comments on your 21<sup>st</sup> Century Cures initiative. Attached please find our comments on three areas: antibiotic development, medical device safety, and prescription drug abuse.

Sincerely,

Allan Coukell  
Senior Director, Health Programs  
The Pew Charitable Trusts

**1. Antibiotics: Section 1061 - Approval of Certain Drugs for Use in a Limited Population of Patients.**

Antibiotics are one of the greatest success stories in modern medicine. Without them, women would be more likely to die in childbirth, surgeries would be more dangerous, and cancer treatments would expose patients to untreatable infections. Evolving resistance continually chips away at our antibiotic supply, making a robust pipeline essential. However, because antibiotic

infections are opportunistic and often secondary to another illness, there is no cohesive patient advocacy coalition pushing for antibiotic drug discovery or calling for better cross-sector cooperation. There are no scheduled marches on Capitol Hill to compel members of Congress to make antibiotic drug discovery a national priority, thus it is important that Congress recognize and address this urgent public health need.

The problem of antibiotic resistance is real and growing. Drug-resistant bacteria are spreading in our hospitals and our communities. According to a 2013 report by the Centers for Disease Control and Prevention (CDC), more than 2 million people per year are sickened by drug-resistant infections, and more than 23,000 die as a result. In the past few years, pathogens resistant to multiple antibiotics—so-called “superbugs”—have emerged as an even greater public health concern. Doctors already face patients with untreatable infections, and threats such as carbapenem-resistant Enterobacteriaceae (CRE) —which the CDC calls a “nightmare bacteria” —hint at the potential of worse to come. CRE has spread rapidly across the nation, from one medical facility in one state in 2001 to medical facilities in 47 states as of February 2014. Nearly half of hospital patients who contract bloodstream infections from CRE will die as a result.

The pipeline of new antibiotics is running dry. The World Health Organization (WHO) recently concluded that we may be entering the very real possibility of a “post-antibiotic era,” in which the practice of medicine effectively returns to the time before the discovery of penicillin. Drug makers developed 13 new classes of antibiotics between 1935 and 1968, but only three new classes since that time. A Pew analysis finds 37 new antibiotics currently at some stage of clinical development, but few drugs that are likely to overcome resistance or target the most serious pathogens. It is clear that there are too few drugs in development to meet current and anticipated patient needs.

Section 1061 would help streamline the regulatory pathway for antibiotics and could address CRE and other dangerous pathogens. It directs the FDA to approve new antibiotics for specific, limited populations of patients with life-threatening infections where few or no treatment options currently exist.

This pathway was endorsed by the President’s Council of Advisors on Science and Technology (PCAST) in 2012 and 2014 reports. While the 2012 PCAST recommendation was broader than antibiotics, the report specifically called out antibiotics as appropriate for this pathway; the 2014 report was specific to antibiotics. PCAST explained the benefit of a limited population pathway:

For some drugs, clinical trials may be able to demonstrate the safety and efficacy of a drug in a specific subgroup of patients who have a serious, high-risk manifestation of a common condition (such as morbid obesity, or bacterial infection resistant to standard antibiotics) or who are at especially high risk (such as patients with auto-antibodies that point to high-risk for development of Type 1 diabetes) long before it is possible to determine the more complex benefit-risk

balance for broader groups with milder conditions or less risk (such as overweight or ordinary bacterial infection).

Currently, in order for the FDA to approve a new antibiotic, the agency generally requires extensive clinical trials in the larger population due to concerns about safety risks resulting from possible use in broader groups. It is desirable to have a pathway under which such drugs could rapidly reach high-need patients while reducing the risks of wider use. There are also clear public health benefits to limiting the use of new antibiotics effective against drug-resistant bacteria, thus staving off the emergence of drug-resistant strains.

Section 1061 would implement this recommendation by directing the FDA to create this pathway, allowing the FDA to approve antibiotics for use in limited populations.

PCAST recommended that the approval pathway be accompanied by a designation that would:

...send a clear and effective signal to patients, physicians, payors and malpractice insurers that the drug should be reserved for use in the specific subgroup of patients. The designation would not forbid off-label use, but would be intended to affect the likely usage by shifting responsibility to educated prescribers and payors. In doing so, it would shift the overall benefit-risk balance and allow the FDA to responsibly approve drugs intended for patients with the serious manifestation.

As PCAST points out, the intent of the designation is not to prohibit off-label use. Section 1061 appropriately includes language that makes it clear that this legislation would not limit the practice of medicine.

While Section 1061 does have a labeling provision, the language should be strengthened in order to fully achieve the goals laid out by PCAST. Specifically, antibiotics approved under this pathway should be clearly labeled with a visual element or other branding so that prescribers and dispensers can immediately understand that the risk/benefit calculation FDA made in approving the LPAD drugs was specific to a patient with no other options, and that the drug may not be appropriate for patients who have other treatment options. What the branding looks like is less important than that it appear wherever the brand name appears. Strong labeling is important both to support informed physician decision making and, importantly, to give reviewers at FDA comfort that if they approve drugs with more limited data, they have assurance that the preponderance of the use of those products will be in the intended population; if FDA reviewers do not have this comfort the pathway is unlikely to be utilized, even if it is authorized. The Pew Charitable Trusts, the Infectious Diseases Society of America, and a number of other prominent provider and public health groups are advocating that Section 1061 be amended to allow for this kind of designation so that the legislation will fully implement the intent of the pathway.

This provision also contains a number of process provisions that prescribe a series of meetings and agreements between the FDA and the sponsor. We are concerned that the legislation is too prescriptive, and that the process outlined could actually impede the more flexible evaluation of the drug the legislation intends. While we support company access to the FDA, and the intent that the pathway be voluntary, we urge the committee to consider a less prescriptive approach to make it easier for both the FDA and product sponsors to utilize the pathway.

With these alterations, Section 1061 would help to fill an urgent public health need by providing a pathway for the most essential new antibiotics to reach the patients who need them.

## 2. Devices

The development of promising new technologies often takes several years. In the interim, many patients with life-threatening or irreversibly debilitating conditions lack sufficient treatment options. Accepting the status quo is not a suitable answer for these patients. Part of the solution must include more efficient, faster, and cheaper ways to gather and analyze information on products that are expected to improve outcomes.

No less important are assurances that the devices used in care are not putting patients needlessly at risk. The development and implementation of robust postmarket monitoring systems and policies are essential to quickly identify unsafe or ineffective products and remove those technologies from the market.

Many of the provisions in the 21st Century Cures discussion draft recognize the importance of prompt patient access to new technologies, while also acknowledging that postmarket controls and data collection are essential to protect patients from faulty products. Improving the research infrastructure to more efficiently and quickly collect data on the performance of medical devices—both pre- and post-market—can achieve both of these goals.

As Congress considers these and other proposals to accelerate the delivery of innovative devices to patients, these efforts should embody the following principles:

- *Registries can support both innovation and postmarket surveillance*  
Registries—large databases that aggregate information on patient outcomes from many providers—can assess the real-world performance of medical devices that may not be detected in clinical trials. Hip implants, for example, are expected to last 15-20 years, but typically require only two years of clinical data for FDA approval. Registries can also facilitate device innovation by collecting data more efficiently than traditional clinical studies, which can save manufacturers considerable time and money—further spurring the development of new technologies to improve care. The discussion draft reinforces the importance of registries as an essential tool to efficiently collect data on product performance.

The Pew Charitable Trusts, the Blue Cross and Blue Shield Association, and the Medical Device Epidemiology Network Infrastructure Center at Weill Cornell Medical Network Infrastructure Center at Weill Cornell Medical College last year released the findings of a series of meetings that brought together medical device stakeholders—including manufacturers, FDA, clinical societies, payers, and patient groups—to better define the role of device registries in our healthcare system. We recommend that registry findings and reports should be released on a regular basis, and that the governance, operations, and financing should be made publicly available. The Centers for Medicare and Medicaid Services (CMS), the FDA, and other stakeholders should encourage the use of registries that meet these criteria.

In addition, the lack of interoperability among electronic health record (EHR) systems hinders the ability for registries to extract clinical and outcome data from them. Instead, registries must extract information from the EHR systems at each facility, or require manual entry from providers. Addressing this interoperability challenge should enhance the utility of registries to collect data. Finally, many registries have sought clarity on when their studies are considered research or quality improvement efforts. This confusion has slowed their use by hospitals and their ability to make a meaningful contribution.

- *Postmarket controls are essential when less data is collected premarket*

Several of the provisions in the discussion draft would accelerate patient access to new medical devices by relying on shorter clinical trials, surrogate endpoints, new statistical modeling techniques, and other methods. Under these provisions, the FDA may shift data typically collected premarket until after approval. That change would give the FDA less certainty on the full risks and benefits of particular products at the time new devices come to market.

The success of shifting data typically collected premarket to after approval relies on the prompt collection of postmarket data. The FDA must have the necessary tools to ensure that this information is quickly collected, potentially through mandatory postmarket studies or the use of registries. In addition, fulfillment of the FDA's national medical device postmarket surveillance plan—which outlines key steps to improve device safety—will help ensure that the necessary infrastructure exists to collect the necessary information.

Congress should evaluate whether the FDA has sufficient authorities to promptly withdraw product approvals if the necessary information is not promptly collected or suggests that the product benefits do not outweigh the risks. Should the FDA lack these authorities, Congress should provide the agency with enhanced abilities to protect the public when postmarket responsibilities are not fulfilled.

- *Gaps in claims data hinder its utility for medical devices*

Finally, the discussion draft emphasizes the value of claims data so that patients, clinicians, and regulators will have more and better information on medical interventions. Several provisions would make claims data more publicly available or enhance the use of this information to understand the safety and effectiveness of medical products.

Unlike some other forms of health data, claims provide long-term information on patient outcomes and span providers. For example, a patient that undergoes a cardiac procedure from one provider may, several years later, seek emergency care for chest pain at another provider. Given that health plans reimburse for both encounters, claims contain information on outcomes that may be unavailable elsewhere. Electronic health records,

for example, contain more detailed clinical information but are not interoperable, meaning that the data is not easily aggregated across providers to conduct detailed longitudinal analyses.

Claims however, only document the procedure—such as a stent insertion or hip implant—not the specific product used. If added to claims, the new unique device identifier (UDI) system—which provides each medical device with a code corresponding to its manufacturer and model type—could provide the necessary details on what product is implanted in the patient. Documenting UDIs would make claims data valuable for analyses of product performance, and would increase transparency on the products used in care.

UDI data in claims could also enable the FDA’s Sentinel Initiative—a postmarket surveillance monitoring program—to evaluate the safety of devices. Congress instructed the FDA to create the Sentinel program in 2007, and it has since been used both to identify safety concerns with products and to disprove suspected problems. Given Sentinel’s successes, Congress instructed the FDA in 2012 to expand this system to devices. However, due to Sentinel’s reliance on data derived from health insurance claims that currently lack information on the devices used in care, this system cannot efficiently assess device performance until claims include UDI data.

Given that the claims form is standard across payers, the creation of a new field would also enable the collection of UDI data by private health plans, such as Aetna, that have expressed an interest in obtaining this information.

While there is an administrative process to update claims standards to include a field for UDI, congressional action may be necessary to ensure that claims can contain this critical data and that Medicare utilizes the information to improve care.

We look forward to working with the Committee to refine proposals in the discussion draft to reflect these principles and facilitate more efficient data collection to spur innovation while ensuring the safety and quality of medical devices.

### **3. Prescription Drug Abuse: Section 4281 - Medicare Part D Patient Safety and Drug Abuse Prevention**

Pew supports the inclusion of provisions in the 21st Century Cures Act discussion draft that aim to decrease abuse of prescription opioids and other controlled substances among high-risk Medicare beneficiaries. The proposed Prescription Drug Plan (PDP) Safety Program is an important step toward addressing potentially inappropriate opioid use in this patient population. These programs, which have also been called patient review and restriction programs (PRRs), would require patients at risk of drug abuse to utilize a designated pharmacy to obtain all prescriptions for opioids and other controlled substances. These programs also improve continuity of care among at-risk patients by providing improved drug therapy management. Use of these programs by sponsors of Medicare Part D and Medicare Advantage Prescription Drug (MA-PD) would expand the number of tools that plans have available to combat prescription drug abuse. Similar policies have been included in legislation proposed by members of Congress from both parties, as well as in the President's FY 2016 Budget request. The broad bipartisan support for this policy reflects the shared interest in advancing these programs as a means to address the nation's prescription drug abuse epidemic.

More than 16,000 Americans die each year from overdoses of opioids, also known as narcotic pain relievers. According to the CDC, such deaths quadrupled between 1999 and 2010, consistent with an increase in prescribing rates for these drugs. Among the elderly population, data from the Substance Abuse and Mental Health Services Administration indicate that the number of seniors who reported misusing a pain reliever during the past year increased 155 percent between 2002 and 2012. Prescription opioids provide medical benefit to patients with pain. However, research conducted by the Agency for Healthcare Research and Quality has concluded that there is limited evidence supporting the effectiveness of these therapies for the treatment of chronic non-cancer pain. In addition, other studies have found that elderly patients who are prescribed opioids are up to five times more likely to experience a fall or fracture than patients who receive non-opioid therapies for osteoarthritis. This data highlights the need to ensure appropriate use of opioid therapies to prevent the morbidity that extends beyond the direct harms associated with misuse, abuse, and addiction.

There is growing concern about potential overuse of opioids among Medicare Part D beneficiaries. In 2011, nearly 9 million—28 percent—of Medicare Part D beneficiaries were prescribed opioids for non-cancer, non-hospice-related care. Analyses conducted by CMS and the Government Accountability Office (GAO) have sought to quantify the extent of opioid overuse in this population. In an evaluation conducted by CMS investigators used quantity thresholds for opioid dispensing, as well as an assessment of the dosage and duration of therapy to assess prescribing for 8.8 million beneficiaries who received opioids according to 2011 claims data. Beneficiaries with cancer and patients receiving hospice care were excluded from the analysis. Potentially unsafe opioid use, which was defined as doses that exceeded 120 mg daily morphine-equivalent dose (MED) for 90 or more consecutive days, was found in approximately 225,000 beneficiaries. Among the 225,000 beneficiaries defined as having potentially unsafe

opioid use, 28.3 percent obtained prescriptions from four or more prescribers and nearly 18 percent used four or more pharmacies. When the number of prescribers, number of pharmacies, and the dose and duration were analyzed together, a subset of 22,000 Part D beneficiaries was found to have received doses that exceeded 120 mg daily MED for 90 or more consecutive days from four or more prescribers and four or more pharmacies. A GAO evaluation of 2008 claims data that also excluded individuals with cancer and patients receiving hospice care identified 170,000 Part D beneficiaries who visited at least five and as many as 87 medical professionals in a year to obtain prescriptions for opioids or other drugs from 14 classes of abusable drugs.

These studies highlight the need to ensure the safe and appropriate use of opioids in the Medicare population. Sponsors of Medicare Part D and MA-PD plans are limited in their ability to curtail drug overuse and abuse, however. Current law prevents these plans from implementing PRRs, despite the fact that officials from CMS and other government agencies have indicated a willingness to explore the use of these programs. Meanwhile, the effectiveness of PRRs has led to their broad adoption in the public and private sector. Medicaid programs in 46 states and the District of Columbia have implemented a PRR. An evaluation performed by a CDC expert panel found that PRRs used in state Medicaid programs have generated savings and reduced narcotic prescriptions, abuse, and visits to multiple doctors and emergency rooms. Another CDC report that provided a detailed analysis of outcomes from six state Medicaid PRR programs reported favorable outcomes, including significant decreases in the average number of billing claims for narcotics, number of pharmacies and prescribers used, and emergency department visits. Reductions in medical and prescription drug costs were also realized.

While the discussion draft establishes these programs through a PDP Safety Program, Pew recommends refining portions of subtitle N to maximize the impact of PRRs, including changes to section 4281, "Establishing PDP Safety Program to Prevent Fraud and Abuse in Medicare Prescription Drug Plans," and section 4284, "Requiring E-Prescribing for Coverage of Covered Part D Controlled Substances." Pew's recommended changes can be found in the attached addendum.

Pew appreciates the opportunity to comment on the discussion draft and encourages the Committee to refine the legislation with the proposed changes. These changes will be key to ensuring the program works as intended. Pew looks forward to working with Congress to advance this important public health proposal.



PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

February 11, 2015

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Dear Chairman Upton and Representative DeGette:

We at the Pharmaceutical Care Management Association (PCMA) thank you for the opportunity to comment on the 21<sup>st</sup> Century Cures legislative discussion draft released January 27, 2015. PCMA is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans and operate specialty pharmacies for more than 216 million Americans with health coverage through Fortune 500 companies, health insurers, labor unions, Medicare, Medicaid, the Federal Employees Health Benefits Program, and the exchanges established by the Affordable Care Act. Our industry works to make access to prescription drugs more affordable for those with health coverage by negotiating price concessions with pharmacies and drug manufacturers.

To offer timely, meaningful feedback within the short timeframe that we understand has been set out by the committee, we offer this brief discussion of our top concerns and observations on the discussion draft. This letter follows written comments we sent in response to "21<sup>st</sup> Century Cures: A Call to Action," dated November 25, 2014. We intend to submit, shortly, a more detailed discussion of the draft bill's many provisions. We look forward to working with the Committee on how best to encourage development of new treatments for diseases while also considering how to make those advances in care affordable and accessible to Americans.

We have significant concerns with a number of provisions in the 21<sup>st</sup> Century Cures draft. While there are some provisions that we would strongly support, including those to stem fraud and abuse in Medicare, we believe that many other provisions could seriously damage the Medicare Part D program by harming competition and straining the financial sustainability of Medicare and prescription drug benefits generally.

As the industry responsible for facilitating access to needed pharmaceutical therapies, we appreciate the goal of getting new therapies into development and delivered to the patients who need them. As these new treatments and therapies come to market, however, it is increasingly apparent that the pricing of these drugs is not sustainable and that competition is needed. As we have seen with the recent example of new therapies to treat Hepatitis C, market competition is necessary to bring drug prices down. The growing backlog of generic drug applications and the absence of approved competitors to name-brand drugs is creating a situation where dollars that



## PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

could be used to pay for increasingly expensive new therapies are locked up due to backlogs and lengthy exclusivity periods. As the Committee further considers 21<sup>st</sup> Century Cures, we strongly recommend that consideration be given and provisions be added to speed competing therapies to market.

Recent launches of high-cost medications are already testing the sustainability of Medicare Part D and private insurance coverage, even without additional exclusivity periods for their development. This proposal includes a number of provisions, including Secs. 1063, 1222, 1241, and 1261, that would increase the market exclusivity periods for various types of drugs. We strongly oppose these provisions, particularly in light of similar, recently enacted provisions to establish or lengthen market exclusivity that have not yet shown their merit. In short, we do not see a compelling policy basis for such additional exclusivities beyond those currently in effect. Further, for similar reasons, we oppose provisions to increase Medicare payment under Part B for various types of drugs.

In addition, the draft contains provisions to expand the transfer and use of Medicare data by third-party researchers, registries, and other organizations. We support use of data to assess quality of care, but believe that these provisions as drafted could allow confidential, proprietary drug-pricing and discount data to be widely released and circulated, potentially among marketplace competitors and suppliers. Even if it were inadvertent, giving competitors and suppliers access to competitive pricing data could lead to tacit collusion and would seriously weaken negotiations as well as the competitive bidding paradigm on which Part D was designed. We believe that this possibility is unintended and suggest that, to avoid harm to the marketplace, safeguards be added to ensure that proprietary pricing information is not included in the data widely released to qualified entities, qualified clinical data registries, and other entities designated by the Secretary to receive data, especially under Secs. 2085 and 2086.

We also believe there could be an unintended consequence of certain proposed changes to the HIPAA privacy rule under Sec. 2221, which as drafted appears to bar providers, pharmacies, pharmacy benefit managers and plan sponsors from contacting patients for such things as refill reminders, questions about prescriptions, appointments, or billing, even when directed by CMS. We are working with the Confidentiality Coalition to devise an industry alternative that would facilitate research without introducing unwarranted impediments to patient contact by health care providers and those administering benefits.

Finally, we support Secs. 4281, 4282, 4283, and 4284 to stem fraud and abuse in Medicare through more careful handling and distribution of controlled substances.

We will have additional comments on these and other sections of the draft, but wanted to alert the Committee to our key concerns. As we noted at the outset, we appreciate the opportunity to review the discussion draft and will be submitting more detailed comments in the coming days.



PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

We thank the Committee for its extensive work on 21<sup>st</sup> Century Cures and for the opportunity to share our thoughts. We look forward to working with you on these important issues. If there are any questions about our comments, please contact me at [kbass@pcmanet.org](mailto:kbass@pcmanet.org).

Sincerely,

Sincerely yours,



Kristin Bass  
Senior Vice President, Federal Affairs and Policy



PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

February 20, 2015

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The Honorable Diana DeGette  
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Dear Chairman Upton and Representative DeGette:

We at the Pharmaceutical Care Management Association (PCMA) again thank you for the opportunity to comment on the 21<sup>st</sup> Century Cures legislative discussion draft released January 27, 2015. PCMA is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans and operate specialty pharmacies for more than 216 million Americans with health coverage through Fortune 500 companies, health insurers, labor unions, Medicare, Medicaid, the Federal Employees Health Benefits Program, and the exchanges established by the Affordable Care Act. Our industry works to make access to prescription drugs more affordable for those with health coverage by negotiating price concessions with pharmacies and drug manufacturers.

As we noted in our earlier, short comment letter, we wanted to provide more in-depth comments on the various provisions in the 21<sup>st</sup> Century Cures discussion draft, and this letter should be considered an addendum to our initial response.

### **Comments**

As we stated in our February 12 letter, we have significant concerns with a number of provisions in the 21st Century Cures draft. While there are some provisions that we would strongly support, including those addressing fraud and abuse in Medicare, we believe that many other provisions could seriously damage the Medicare Part D program by harming competition and straining the financial sustainability of Medicare and prescription drug benefits generally.

As we also stated in our previous two letters, as the industry responsible for facilitating access to needed pharmaceutical therapies, we appreciate the goal of getting new therapies into development and delivered to the patients who need them. As these new treatments and therapies come to market, however, it is increasingly apparent that the pricing of these drugs is not sustainable and that competition is needed. To free up resources to pay for new innovations, as well as to encourage those developing drugs

even when they are not the first in class to market, we encourage the committee to address the growing backlog of generic and new drug applications at the FDA. While there are a number of provisions in the draft designed to hasten the approval of innovative drugs, as the Committee further considers 21st Century Cures, we strongly recommend that consideration be given and provisions be added specifically to speed competing therapies to market.

Following is a commentary on selected sections of the 21<sup>st</sup> Century Cures legislative discussion draft. It is our hope that this document can be used to facilitate a constructive dialog between us to further our shared goals of helping those who suffer from diseases and debilitating conditions.

**Section 1041: Approval of Breakthrough Therapies (p. 29):** We believe that the current FDA protocol with four phases of new drug approval has worked well and balances the need to bring new drugs to market while protecting patient safety. This provision would allow certain drugs under development to skip Phase III of clinical trials, which tests the effectiveness and side effects of the drug in a larger population. We believe this could present undue risks if a drug were marketed before such data were gathered and facts were known. Additionally, we fear it could leave the evidence record lacking for subsequent analyses of the drug's effectiveness. For these reasons, we urge the Committee to strike this provision.

**Section 1063: Election to Convey a Portion of Extended Exclusivity Period Applicable to Qualified Infectious Disease Products (p. 59):** This and other sections of the draft contain provisions that would increase or facilitate the sale of market exclusivity period for a variety of kinds of drugs. We oppose all such provisions in the draft. These proposals come before the effects are known of recent legislation to establish or increase market exclusivity, such as for the establishment of the 12-year exclusivity period for biologics in the Biologics Price Competition and Innovation Act (BPCIA) and, specific to infectious disease drugs addressed in this section, the five-year added exclusivity period for drugs to treat infectious disease under the GAIN Act. We believe the effects of these laws should be observed before enacting additional provisions to increase or sell market exclusivity.

In the absence of evidence that needed cures would not come to market without extending already lucrative drug marketing exclusivities, we believe such proposals are premature. Today, there seems to be little reluctance from the pharmaceutical industry to invest in new drug discovery. According to their most recent data, a trade association for the branded drug industry reports that its member companies invested \$51.1 billion in research and development (R&D) activities in 2013—an all-time high and up over \$2 billion from the previous two years.<sup>1</sup> Thus, there does not appear to be a demonstrated need for additional exclusivity to bring capital into drug R&D.

Providing additional market exclusivities could exacerbate the current alarmingly high specialty drug spending trend with no clear benefit for patients. A number of recently approved drug and biologic therapies have entered the market with historically high

prices. While many of these drugs represent needed breakthroughs to fight devastating and debilitating illness, their cost can be a barrier to access for the patients who need these medicines and strains health budgets in both the public and private sectors. Since 2006, the annual increase in spending for specialty drugs has been above 14 percent every year.<sup>ii</sup> Additionally, current projections show that drug spending is poised to increase dramatically, driven by the use of high-cost drugs.<sup>iii</sup> Where specialty drug spending in the U.S. (reimbursed through both the pharmacy and medical benefits) was estimated to be \$87 billion in 2012, it is projected to reach \$402 billion by 2020.<sup>iv</sup> Moreover, by 2023, all health spending in the U.S. is expected to account for over 19% of GDP, driven in part by “an expected rising trend of expensive specialty drugs,” according to Medicare’s actuaries.<sup>v</sup> We believe these projected trends will be difficult, if not impossible, to sustain in the long term, even under current law. Adding additional exclusivity could further strain health budgets while bringing no certain benefits.

We therefore urge the Committee to reconsider and strike this provision and others in the draft adding or extending market exclusivity, such as Section 1222 for dormant therapies; Section 1241 for certain new drug applications and abbreviated new drug applications; and Section 1261 for a drug approved for a new indication for a rare disease or condition.

**Sections 1201-1202: Cures Acceleration Network (p. 99):** We support this provision allowing the existing Cures Acceleration Network flexible research authority and directing it to award grants and contracts for R&D on high-need cures using approved drugs and biologics for which all exclusivity periods have expired.

**Sections 1221-1223: Dormant Therapies (p. 101):** Similar to comments for Section 1063, we oppose increased exclusivity for what the draft defines as dormant therapies. We believe increased exclusivity—in this case, awarding as much as 15 years—would raise costs without assuring that a given drug would not have come to the market without additional years of protected sales revenue. Further, as drafted, the definition of dormant therapy would allow additional exclusivity to a product is intended to treat a disease for which there is “one or more unmet need.” We believe the “one or more unmet need” standard is imprecise and could apply to many, if not most new drugs approved by FDA. Additionally, the absence of protections against “evergreening” (whereby brand manufacturers are able to make relatively minor changes to their products to receive additional exclusivity) means that the new exclusivity would likely extend beyond 15 years. For these reasons, we urge the Committee to strike these sections.

**Section 1241: Extended Exclusivity Period for Certain New Drug Applications and Abbreviated New Drug Applications (p. 118):** As noted earlier, because it would increase costs for uncertain or unknown benefits, we oppose increasing current market exclusivity periods. In particular, this provision could award up to two additional years of exclusivity for a drug if the manufacturer gets approval for a new indication or use or if the drug has been reformulated to promote greater adherence, reduce side effects, “promote systemic benefits to the health care system,” or “provide other patient benefits.”

These justifications are worded overly broadly and could reward manufactures handsomely for making only minor improvements in a drug. We urge the Committee to strike this provision.

**Section 1261: Extension of Exclusivity Periods for a Drug Approved for a New Indication for a Rare Disease or Condition (p. 123):** We oppose this overly broad provision to add six months of additional market exclusivity for an existing drug that is subsequently approved for a rare disease indication. Because this provision is not explicitly targeted as an extension for orphan indications only, it appears to permit added exclusivity for drugs that are broadly used for tens of millions of people as long as the manufacturer sought and was granted an orphan indication. This could cost consumers using the drug for non-orphan indications and taxpayers billions of dollars. Moreover, the proposed extension would be in addition to any other eligible incentive, such as for pediatric products and there appears to be no limit to the number of six-month extensions for which a product is eligible. We urge the Committee to strike this provision.

**Section 2001: Innovative Cures Consortium (p. 131):** While we support the stated goal of the consortium to “accelerate the discovery, development, and delivery...of innovative cures, treatments, and preventive measures for patients,” we are concerned that the composition of the consortium would vest a large portion of its decision-making authority in representatives from the drug and device industries, seemingly to the exclusion of other stakeholders. Thus, we need to understand more about the consortium before offering a position on it.

**Section 2021: Medical Product Innovation Advisory Commission (p. 140):** Similar to our comments on Section 2001, we would prefer to understand more about this MedPAC-like commission’s intended purpose and the currently unmet needs it is designed to fulfill before offering a position on it.

**Section 2085: Expanding Availability of Medicare Data (p. 168):** As we stated in our previous letters addressing the “Call to Action,” and in our initial comments on the draft, we share the Committee’s goal to unlock make appropriate data available to support research into effective treatments and to improve dissemination of evidence on the effectiveness and cost of new and existing therapies. However, there are provisions in Section 2085 that we fear could seriously harm competition in the Medicare Part D program and elsewhere because they could be interpreted to allow the sharing of confidential drug pricing and discount information, which is currently protected by the Uniform Trade Secrets Act.

Section 2085 would allow researchers and other entities broader access to “claims data under the Medicare program.” Claims data in Part D are the prescription drug event (PDE) data files. These include amounts that Part D sponsors reimburse pharmacies for filling prescriptions—data which has long been recognized by public officials and Part D stakeholders as competitively sensitive, confidential, and protected. To date, CMS has shared this data with relatively few academic, nonprofit researchers under strict data-use agreements.

To maintain competition in Part D and the prescription drug benefit market generally, it is critical that these data remain confidential and proprietary in accordance with the Uniform Trade Secrets Act. Allowing the release of these data would harm competition by allowing tacit collusion among competitors who would have learned other businesses' negotiated agreements with suppliers and purchasers of their goods and services. As the Federal Trade Commission recently stated with respect to confidential pharmacy reimbursement rates in Medicare Part D, disclosure of such information, "may impair, rather than enhance, the ability of plan sponsors to negotiate lower prices."<sup>vi</sup> This would hurt competition and raise costs for the government and beneficiaries alike.

To facilitate the broader sharing and use of Medicare data for research while assuring that confidential pricing and discount data are not divulged, we suggest language be added to the legislation in this and other sections on data sharing provisions to assure that current confidentiality protections are maintained. We note that Section 2201 of the draft, governing release of NIH data, has such a provision, limiting the Secretary from sharing "any trade secret or commercial or financial information that is privileged or confidential." We would be happy to work with the Committee to help construct such language.

Finally, this section sets forth a number of restrictions on certain entities for sharing data, including that, "analyses may not be sold or provided to a health insurance issuer unless the issuer is providing the entity with Medicare data." We do not understand the basis for such a restriction and suggest that entities and stakeholders be put on a level playing field for sharing data absent a clear and compelling reason to do otherwise.

**Section 2086: Empowering Patient Research and Better Outcomes through CMS Data (p. 180):** This section would permit CMS to release data for research to an even broader set of potential recipients than Section 2085, including "researchers" that could be employed by suppliers and competitors to Medicare Part D plans. This sets up a potential opportunity to access proprietary pricing information. While the draft includes "minimum necessary" and other safeguards for individuals, there are insufficient safeguards for proprietary information being shared, and, once divulged, such information cannot be unlearned even if it were divulged for a different purpose. Similar to our comments on Section 2085, we could support this provision if proprietary, confidential pricing and discount data can be protected by adding language to that effect and would be happy to work with the committee on appropriate language. Without such language being added, we have serious misgivings about the provision due to the significant harm it could cause to Medicare Part D.

**Section 2087: Allowing Clinical Data Registries to Comply with HIPAA Privacy and Security Law in Lieu of Complying with the Privacy and Security Provisions of the Common Rule (p. 183):** In general, we believe provisions of HIPAA, the Common Rule, and FDA law could be harmonized to better facilitate research. We are currently working with the Confidentiality Coalition on policy in this area and will work through the coalition to provide feedback on this issue through the coalition.

**Section 2088: Access to CMS Claims Data for Purposes of Fraud Analytics (p. 184):** Similar to our previous comments in this document on sharing Medicare data, we urge the Committee to add language to protect confidential business data protected by the Uniform Trade Secrets Act. With respect to this particular provision, while we support the concept of improving fraud analytics, it is unclear to us the scope and volume of data that are intended to be made available. Given existing systems and security requirements, we do not believe that it is possible in real-time for entities beyond pharmacies and PBMs to access data. We believe such a requirement would entail significant changes in electronic systems and security and believe there would be considerable concomitant costs needed for such a change. We would therefore encourage an analysis of current processing, reporting, and security capabilities of the claims data system to gauge the feasibility of such a requirement.

**Section 2121: Coverage with Evidence Development (p. 196):** This provision would create a new Medicare entitlement by adding a new coverage category in Section 1861 of the Social Security Act for a “coverage with evidence development” (CED) item or service. We oppose and urge the committee to strike this provision, which we believe would essentially require Medicare to pay for clinical trials the Secretary determines are needed to approve a device under development. This would be an unprecedented and inappropriate subsidy of drug developers by taxpayers and Medicare beneficiaries.

**Section 2201: Sharing of Data Generated through NIH-funded Research: (p. 206):** We support this provision to empower NIH to require grant recipients to share with the public data generated through such research. In particular, as noted in our comments on Section 2085, we strongly support the provision in this section that explicitly protects “any trade secret or commercial or financial information that is privileged or confidential” and suggest that language to that effect be added to several other sections of this draft governing sharing and transfer of data.

**Section 2221: Accessing, Sharing, and Using Health Data for Research Purposes (p. 207):** We support efforts to make appropriate data available to support research into effective treatments and to improve dissemination of evidence on the effectiveness and cost of new and existing therapies. At the same time, we believe that any changes to rules governing disclosure and dissemination of data must maintain long-standing privacy protections for patients and strict confidentiality of proprietary business data, as we have mentioned in previous comments above.

HIPAA was expressly developed in light of electronic data exchange, and its underlying construct has worked well. Until now, that and other rules governing use of the Medicare and Medicaid databases have struck an appropriate balance between the need for confidentiality on the one hand, and the need to access necessary data on the other. We urge the Committee to maintain that current balance as it contemplates changes to existing policies or creation of new policies to governing use and disclosure of personally

identifiable health information. We are also engaged with the Confidentiality Coalition on these issues and will contribute further thoughts on confidentiality and privacy through the coalition.

We also wish to flag for the committee what we believe is an important, unintended consequence of Section 2221, which would be to prevent entities holding data received for research purposes from contacting individuals whose data they hold, even for other normal business purposes. Specifically, where the draft proposes to add Section 13445 to HIPAA, the text reads that no person may:

“(A) knowingly identify or contact, or attempt to identify or contact, individuals whose data are included in the limited data set or de-identified health information; or

“(B) knowingly permit or authorize a third party to knowingly identify or contact, or attempt to identify or contact, individuals whose data are included in the limited data set or de-identified health information.”

This language as drafted appears to bar providers, pharmacies, and pharmacy benefit managers and plan sponsors from contacting patients for such things as refill reminders, questions about prescriptions, appointments, or billing, even when directed by CMS. A physician group conducting research could not call a patient about tests or to schedule an appointment, if the patient were one whose data were also included in that acquired by the physician group. A pharmacy could not send refill reminders or call a patient about a drug recall if the pharmacy were undertaking research and acquired data on its customer base. A PBM could not conduct medication therapy management as required by CMS in Part D if it were undertaking research on the effectiveness of its communications and had, say, acquired data from a hospital on admissions. While admirably attempting to forestall improper attempts by researchers to contact subjects of research, Section 2221 could inadvertently discourage legitimate research based on the problems described above, or actually criminalize normal business activities of a broad range of participants in the health care market who might undertake research to improve care.

We are working with the Confidentiality Coalition to devise an alternative that would facilitate research without introducing unwarranted impediments to patient contact by health care providers and those administering benefits.

**Section 4062: Encouraging Health Plans to Establish Programs to Increase Adult Immunization (p. 275):** We support this provision to encourage programs to increase adult immunization in Medicare Advantage and Part D Plans. We note in particular our support for the recognition of the costs of these programs as quality-improving activities in the calculation of medical loss ratios.

**Section 4201: Coding and Reimbursement Reforms (p. 299):** Similar to our comments addressing Section 1064, this provision would instruct the Secretary to replace HCPCS Level II codes with NDC codes for drugs and biologics billed under Part B. We believe the effect of this policy would be to prevent generic versions of Part B drugs from

figuring into the average sales price calculations for identical brand drugs, resulting in a significant potential increase in Part B drug spending. We urge the Committee to strike this proposal.

**Section 4221: Medicare Site-Of-Service Price Transparency (p. 304):** We believe this provision could provide Medicare beneficiaries with useful information, enabling them to seek care in the most economical settings. However, similar to previous comments above on Medicare data, we urge that it protect confidentiality of proprietary business under the Uniform Trade Secrets Act, such as through a rule of construction which we urge the committee to add. Otherwise, it risks undermining the very competition it seeks to foster.

**Section 4281: Establishing PDP Safety Program to Prevent Fraud and Abuse in Medicare Prescription Drug Plans (p. 309):** We strongly support this provision to stem fraud and abuse of controlled substances in Medicare by establishing safe pharmacy networks to dispense prescription opioids to at-risk individuals. Already used in 46 state Medicaid programs, the creation of such a program in Medicare Part D allows plans and beneficiaries to choose a pharmacy that safely dispenses controlled substances. The policy maintains beneficiary access to needed medications, but prevents “drugstore shopping” to obtain untimely access to, or inappropriate quantities of, controlled substances. We thank the Committee for including this provision in the draft.

**Section 4282: Part D Suspension of Claims Payment (p. 313):** We support this provision, which permits a PDP sponsor to suspend payments pending an investigation of credible allegations of fraud by pharmacies. We believe this could be a valuable tool in improving the inefficient “pay and chase” model of combating fraud.

**Section 4283: Improving Activities of Medicare Drug Integrity Contractors (MEDICS) (p. 314):** We similarly support this provision, as included in this draft applying to contracts between CMS and PDPs, to further combat fraud and abuse in Medicare. We believe it can foster better and closer working relationships between MEDICS and Part D plans.

**Section 4284: Requiring e-Prescribing for Coverage of Covered Part D Controlled Substances (p. 316):** We also strongly support this provision to require e-prescribing for controlled substances. The practice is recommended as a key way to reduce fraud and diversion. We note, however, that the draft lists the implementation date as January 1, 2015. Presumably a new effective date will be added in the next version.

**Section 4321: Medicare Pharmaceutical and Technology Ombudsman (p. 322):** Similar to our comments above on Sec 2001, we are reluctant to support this provision at this time. We would prefer to understand more about its intended purpose and which unmet needs it is designed to fulfill. Moreover, we fear it might create an unlevel playing field in favor of pharmaceutical and device manufacturers within CMS where no such advocate exists for other federal partners, including payers, at FDA or CMS.

## **Conclusion**

We thank the Committee for its extensive work on 21<sup>st</sup> Century Cures and for the opportunity to share our thoughts. We look forward to working with you on these important issues. If there are any questions about our comments, please contact me at kbass@pcmanet.org

Sincerely,



Kristin Bass  
Senior Vice President, Federal Affairs and Policy

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<sup>i</sup> PhRMA, “2014 Profile: Biopharmaceutical Research,” April 2014.

[http://www.phrma.org/sites/default/files/pdf/2014\\_PhRMA\\_PROFILE.pdf](http://www.phrma.org/sites/default/files/pdf/2014_PhRMA_PROFILE.pdf)

<sup>ii</sup> Express Scripts, “The 2013 Drug Trend Report,” April 2014. <http://lab.express-scripts.com/~media/pdfs/drug%20trend%20report/express%20scripts%202013%20drug%20trend%20report.ashx>

<sup>iii</sup> See, e.g., CVS Health, “Specialty Trend Management: Where to Go Next,” 2013.

<http://info.cvscaremark.com/sites/default/files/Insights%202013.pdf>

<sup>iv</sup> Ibid.

<sup>v</sup> CMS Office of the Actuary, “National Health Expenditure Projections 2013-2023” <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2013.pdf>



**PRIVILEGED AND CONFIDENTIAL DRAFT**

February 19, 2015

Via Electronic Mail

The Honorable Fred Upton  
Chairman  
House Energy & Commerce Committee  
U.S. House of Representatives  
2125 Rayburn House Office Building  
Washington, D.C. 20515  
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Dear Chairman Upton:

The undersigned members of the Physician Clinical Registry Coalition applaud the Energy and Commerce Committee for issuing the 21<sup>st</sup> Century Cures discussion document (the Discussion Document or Document) to advance public discussion about the pace of cures in the United States. We are particularly pleased with the Document's focus on ways to encourage and facilitate the development and effectiveness of clinical data registries.

The Physician Clinical Registry Coalition (Coalition) represents 21 national medical specialty societies and other physician-led groups that sponsor clinical data registries that collect and analyze clinical outcomes data to identify best practices and improve patient care. Many of the members of the Coalition have been approved by the Centers for Medicaid and Medicare Services (CMS) as Qualified Clinical Data Registries (QCDRs) or Qualified Registries, or are in the process of seeking such approval, under the Physician Quality Reporting System (PQRS) program. We, therefore, appreciate the opportunity to submit these comments on the provisions of the Discussion Document that affect the development or operation of clinical data registries.

We are attaching a copy of the Coalition's recently-released *Guidance on Legal Challenges and Regulatory Obligations for Clinical Data Registry* ("Legal Challenges Guidance"). We hope this

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paper provides useful background information for the Committee's work to identify ways that Congress can help to alleviate unnecessary burdens and facilitate medical innovation.

The Discussion Document includes several provisions that relate to clinical data registries; yet, as the document indicates, there is currently no statutory definition of a clinical data registry outside of the Medicare program's definition of a QCDR. We suggest the Committee consider adopting the following definition of clinical data registries, loosely based on the definition set forth in the registries user guide published by the Agency for Health and Research Quality (AHRQ)<sup>1</sup>:

*A clinical data registry is an organized data collection system operated by or affiliated with a medical society, hospital association, or other health care association, that collects uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes, including but not limited to describing the natural history of disease; determining clinical effectiveness or cost effectiveness of health care products and services; measuring or monitoring safety and harm; and/or measuring quality of care.*

We are aware that there may be other definitions and are happy to work with the Committee and other groups to refine this definition.

The remainder of this letter provides our specific comments on the sections of the Discussion Document that most directly affect clinical data registries.

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<sup>1</sup> Gliklich R, Dreyer N, Leavy M, eds., *Registries for Evaluating Patient Outcomes: A User's Guide*. Third edition. Two volumes. (Prepared by the Outcome DEcIDE Center [Outcome Sciences, Inc., a Quintiles company] under Contract No. 290 2005 00351 TO7.) AHRQ Publication No. 13(14)-EHC111. Rockville, MD: Agency for Healthcare Research and Quality. April 2014, Vol. 1, p. 1. <http://effectivehealthcare.ahrq.gov/ehc/products/420/1897/registries-guide-3rd-edition-vol-1-140430.pdf>.

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1. EXPANDING USES OF MEDICARE DATA BY QUALIFIED ENTITIES—Section 2085(a)

The Coalition supports the provisions of Section 2085(a)(2)(A)(ii) that allow qualified entities to share Medicare data with individual health care providers and medical societies for quality of care improvement purposes and at no cost to such authorized users. These data may only be shared for nonpublic uses. We encourage the Committee to make this section even stronger by *requiring* qualified entities to share these data with providers and medical societies, rather than making data sharing discretionary. We also ask that the Committee clarify the meaning of “nonpublic use” and the preclusion in subparagraph (3)(C) on use of data provided by qualified entities for marketing purposes. We would like to make sure these restrictions would not prevent medical societies from sharing data with their participants or other parties for purposes of quality improvement or research, or from posting analyses on the society’s website to promote public awareness of the registry’s work.

In addition, we urge the Committee to require the Secretary to include verification of life status as part of the claims data provided by CMS to qualified entities under 42 U.S.C. § 1395kk(e) and by qualified entities to medical societies and other authorized users under this section. Utilizing clinical data, combined with claims information and death status would allow many medical society clinical data registries to provide long-term information on patient treatment outcomes and estimate patient survival rates. Physicians, hospitals, and other clinical registry participants can use this information to evaluate their respective outcomes against national standards or benchmarks. Outcomes data linked with death status data also help physicians, patients, and their families make informed treatment decisions. Clinical data registries and their participants can also use this information to facilitate research comparing the long-term effectiveness of alternative treatment strategies based on patient demographics.<sup>2</sup>

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<sup>2</sup> We understand that the current statutory framework (*i.e.*, Section 205(r) of the Social Security Act, 42 U.S.C. § 405(r)) presents some challenges to the Secretary’s ability to share state death data from the Social Security Death Master File, but are confident that this data sharing/linking could be accomplished under Section 205(r)(9), 42 U.S.C. §405(r)(9), of that Act.

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## 2. ACCESS TO MEDICARE DATA BY QCDRS—SECTION 2085(b)

We strongly support the proposal to require the HHS Secretary to make Medicare, Medicaid, and CHIP claims data available to QCDRs and would urge the Committee to make these data available to clinical data registries generally. While many organizations that operate clinical data registries have obtained QCDR status for one or more of their databases, many registries have not obtained QCDR status. Indeed, some medical societies have one database that has qualified as a QCDR, but others that have not. It is imperative for many clinical data registries, and not just QCDRs, to have access to Medicare, Medicaid, and CHIP claims data to enhance their ability to track patients over time and therefore better analyze outcomes from surgical and other medical procedures.

We urge the Committee to require the Secretary to include verification of life status as part of the claims data provided under this section for the same reasons stated in our comments on Section 2085(a) above.

We also do not believe that registries should be required to pay for access to these data. Most registries are sponsored by nonprofit organizations and many have limited budgets. Moreover, the studies that clinical registries conduct using federal program data are typically used to support public purposes and specific public policies, including CMS reimbursement and coverage policies, Food and Drug Administration pre- and post-market surveillance programs, and other government initiatives. Allowing the Secretary to charge clinical data registries a fee for access to program data is inconsistent with the language of Section 2085(a)(2)(C), which precludes qualified entities from charging authorized users a fee for supplying them with Medicare data. We ask that the Committee remove the fee requirement or at least give the Secretary the discretion to reduce or waive the fee if the data are being used to support public purposes/policies.

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### 3. HIPAA COMMON RULE EXCEPTION—Section 2087

The Coalition strongly supports the inclusion of language requiring the Secretary to establish an exception to the Common Rule that allows clinical data registries to comply with the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 instead of comparable provisions of the Common Rule. The need for this exception is discussed in our *Legal Challenges Guidance* (at pp. 7-8).

The Common Rule applies to entities involved in human subjects research that receive federal funding and/or engage in federally-regulated activities, including most teaching hospitals and academic medical centers—the prime participants in most clinical data registries. The Common Rule’s requirements for the use and disclosure of patient data are generally also covered by HIPAA rules that are far more protective of patient privacy. Uncertainty over the applicability of the Common Rule and duplicative requirements are imposing unnecessary burdens among hospitals and other current and prospective registry participants.

We would suggest that the Discussion Document be more specific and give the Secretary more direction on the nature and scope of this exception. Specifically, we recommend that, at a minimum, the exception apply in situations where clinical data registries are collecting identifiable patient information, but are not engaged in direct human subjects intervention or interaction for research purposes (*e.g.*, clinical studies), and are following all the applicable requirements of the HIPAA regulations with respect to protecting the privacy and security of such information. These are the situations where the Common Rule’s duplicative and burdensome requirements create the most confusion and other problems for registries and their participants. The exception would not apply to registries, participants, or other entities conducting research that involves direct interaction with patients for purposes of such research, rather than simply for purposes of clinical care or quality improvement.

To implement this recommendation, we suggest you replace Section 13431(2) (p. 183, lines 23-26 through p. 184, lines 1-3) with the following two new paragraphs:

(2) establish an exception to the provisions cited in paragraphs (1)(A) and (B) for clinical data registries that are collecting individually identifiable health information, as defined by 42 C.F.R. 160.103, but are not engaged in direct intervention or interaction with human subjects for research purposes and are following all the applicable requirements of the privacy and security rules issued under the Health Insurance Portability and Accountability Act of 1996, as amended, [Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified at 42 U.S.C. § 1320d *et seq.*)], with respect to such information.

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(3) issue guidance on the remaining applications of the provisions cited in paragraphs (1)(A) and (B) to clinical data registries within one year after the date of enactment of this section.

4. COMMISSION ON DATA SHARING FOR RESEARCH AND DEVELOPMENT—Section 2091

The Commission on Data Sharing for Research and Development created under this section is charged with establishing various standards, processes, procedures, and best practices for the collection and dissemination of clinical data by clinical data registries. We strongly support the identification and promotion of best practices for clinical data registries. Such efforts are critical to ensuring the integrity and effectiveness of registry processes. We also generally support the specific registry practices identified in this section as being among those that are worthy of review and guidance.

The development of best practices should emanate from the clinical data registry community rather than the federal government. The government's role should be to recognize and promote innovative practices by clinical data registries and ensure that the technological and legal infrastructures support those efforts.

Although the Discussion Document does not give the Commission power to enforce the standards it sets, the language describing the Commission's charge seems prescriptive, rather than advisory, and the Commission actions could easily be given the force of law through regulations issued by various agencies within HHS. We would encourage the Committee to revise this section to form a true advisory body that is selected in a non-partisan fashion and that includes a wide range of stakeholders from and nominated by the clinical data registry community. The mission of the advisory body should be to highlight best practices by clinical data registries and be a source for the Secretary's recommendations in Section 2092. Together, the Secretary and the registry advisory body can work to identify and promote best practices, establish the infrastructure for registry data collection and sharing (*e.g.*, interoperability with EHRs), safeguard patient privacy and security, and protect registry data from legal discovery.

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5. RECOMMENDATIONS FOR DEVELOPMENT AND USE OF CLINICAL REGISTRIES—Section 2092

This section directs the Secretary to make recommendations for the development and use of clinical data registries and their integration with clinical practice guidelines and best practices or standards of care. The Coalition supports this provision, particularly to the extent that it addresses the promotion of bidirectional, interoperable exchange of information between electronic health records (EHRs) of reporting clinicians and registries. Extraction of clinical data from EHRs is the most efficient method of collecting data. But, the lack of interoperability between EHRs and clinical data registries is a serious impediment to this data collection method. Indeed, we would favor even stronger language requiring the Secretary to adopt and issue interoperability standards, implementation specifications, and/or certification criteria to ensure meaningful and timely exchange of information between certified EHRs and clinical data registries. In addition, meeting these interoperability standards should be a condition of certification for EHR technology for “Meaningful Use” purposes.

We are also concerned that the recommendations for interoperability are conditioned on adoption by clinical data registries. In fact, the principal impediment to integration of EHR data into clinical data registries is that some EHR companies refuse to share their data with registries or are charging their customers or registries excessive fees for this data exchange. As noted above, these standards need to be mandated by the Secretary for adoption by EHR companies as a condition of certification for EHR technology. EHR companies also should not be able to charge their customers or clinical data registries for sharing their customers’ data with registries.

We strongly support the requirement in subparagraph (c) that the Secretary consult with national medical societies when developing these recommendations. We encourage the Committee also to require the Secretary to consult with clinical data registries directly since many such registries are not tied to a particular medical society or are managed separately from such societies.

6. SUGGESTED ADDITIONAL ISSUES

a. Protection from Legal Discovery

We would urge the Committee to add a section to the Discussion Document protecting clinical data registry data from legal discovery, particularly data that identifies or could identify specific patients, providers, or facilities. There is currently no adequate federal protection for such data from subpoenas or other litigation-related discovery requests. The risk that such data may be

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subject to forced disclosure creates a chilling effect on the ability of clinical data registries to recruit data sources. Patient and provider-identifiable data collected by clinical data registries should be afforded the same or similar protections/privilege as “patient safety work product” submitted to Patient Safety Organizations (PSOs) under Section 922 of the Patient Safety and Quality Improvement Act.<sup>3</sup> Clinical data registries generally don’t fall within the definition of a PSO under this Act or the implementing regulations issued by AHRQ. Even when they do, clinical data registries should not need to be reconfigured to become PSOs and subject themselves to the multitude of PSO rules and regulations simply to protect their data from legal discovery. This issue is discussed in detail in our *Legal Challenges Guidance* (at pp. 12-18). We would be happy to work with Committee staff in developing the language for this privilege.

b. Group Practice Option for QCDR Reporting

Section 601(b)(1) of the American Taxpayer Relief Action of 2012<sup>4</sup> directed the Secretary to create an option for eligible professionals to satisfy the Physician Quality Reporting System (PQRS) incentive payment and penalty-avoidance requirements by reporting through a QCDR. CMS has interpreted the reference to “eligible professional” to preclude it from providing a PQRS QCDR group practice option. CMS permits several other options for group practice reporting, so there is no reason for not providing a QCDR group reporting option except for the apparent limitation of the authorizing statute. Accordingly, we urge the Committee to add language to the Discussion Document that would amend the QCDR authorizing legislation to permit group reporting by QCDRs. The following revisions to subparagraph D of the QCDR legislation would accomplish this purpose:

(D) SATISFACTORY REPORTING MEASURES THROUGH PARTICIPATION IN A QUALIFIED CLINICAL DATA REGISTRY.—For 2014 and subsequent years, the Secretary shall treat an eligible professional and group practices (as that term is defined by the Secretary) as satisfactorily submitting data on quality measures under subparagraph (A) if, in lieu of reporting measures under subsection (k)(2)(C), the eligible professional or group practice is satisfactorily participating, as determined by the Secretary, in a qualified clinical data registry (as described in subparagraph (E)) for the year.

\*\*\*\*\*

<sup>3</sup> Pub. L. No. 109-41, Section 922 (codified at 42 USC § 299b-22).

<sup>4</sup> Pub. L. No. 112-40, Title VI, Subtitle A, Section 601(b)(1) (codified at 42 U.S.C. 1395w-4(m)(3)).

The Honorable Fred Upton  
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We appreciate the opportunity to submit these comments and would be happy to meet with Committee staff to discuss any of the sections of the Discussion Document that affect clinical data registries and/or QCDRs. If you have questions or would like to arrange a meeting, please contact Rob Portman of Powers Pyles Sutter & Verville at 202-872-6756 or [rob.portman@ppsv.com](mailto:rob.portman@ppsv.com).

Sincerely,

AMERICAN ACADEMY OF DERMATOLOGY ASSOCIATION  
AMERICAN ACADEMY OF NEUROLOGY  
AMERICAN ACADEMY OF OPHTHALMOLOGY  
AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION  
AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS  
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS  
AMERICAN COLLEGE OF SURGEONS  
AMERICAN GASTROENTEROLOGICAL ASSOCIATION  
AMERICAN JOINT REPLACEMENT REGISTRY  
AMERICAN SOCIETY FOR RADIATION ONCOLOGY  
AMERICAN SOCIETY OF CLINICAL ONCOLOGY  
AMERICAN SOCIETY OF NUCLEAR CARDIOLOGY  
AMERICAN SOCIETY OF PLASTIC SURGEONS  
AMERICAN UROLOGICAL ASSOCIATION  
ANESTHESIA QUALITY INSTITUTE/AMERICAN SOCIETY OF ANESTHESIOLOGISTS  
GIQUIC/ AMERICAN COLLEGE OF GASTROENTEROLOGY  
NATIONAL ASSOCIATION OF SPINE SPECIALISTS  
SOCIETY OF INTERVENTIONAL RADIOLOGY  
SOCIETY FOR VASCULAR SURGERY  
SOCIETY OF NEUROINTERVENTIONAL SURGERY  
THE SOCIETY OF THORACIC SURGEONS

**P • C • R • C**

**PHYSICIAN CLINICAL REGISTRY COALITION**

# **GUIDANCE ON LEGAL CHALLENGES AND REGULATORY OBLIGATIONS FOR CLINICAL DATA REGISTRIES**

FEBRUARY 2015

American Academy of Dermatology Association ♦ American Academy of Neurology ♦ American Academy of Ophthalmology ♦  
American Academy of Physical Medicine and Rehabilitation ♦ American Association of Neurological Surgeons ♦  
American College of Emergency Physicians ♦ American College of Surgeons ♦ American Gastroenterological Association ♦  
American Joint Replacement Registry ♦ American Society for Radiation Oncology ♦ American Society of Clinical Oncology ♦  
American Society of Nuclear Cardiology ♦ American Society of Plastic Surgeons ♦ American Urological Association ♦ Anesthesia  
Quality Institute/American Society of Anesthesiologists ♦ GIQuIC/ American College of Gastroenterology ♦  
National Association of Spine Specialists ♦ Society for Vascular Surgery ♦ Society of Interventional Radiology ♦  
Society of Neurointerventional Surgery ♦ The Society of Thoracic Surgeons

# PHYSICIAN CLINICAL REGISTRY COALITION MEMBERS

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AMERICAN ACADEMY OF DERMATOLOGY ASSOCIATION

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THE SOCIETY OF THORACIC SURGEONS

## DISCLAIMER:

This Guidance document is provided for informational and educational purposes only. It is not intended to provide and should not be treated as legal advice. Registries should consult with their own counsel in making determinations about legal and regulatory issues affecting their operations.

## FOR FURTHER INFORMATION:

This Guidance was prepared for the Coalition by its legal counsel, Powers Pyles Sutter & Verville PC. Questions about the document can be addressed to Rob Portman at [rob.portman@ppsv.com](mailto:rob.portman@ppsv.com). Samantha Marshall, Amita Sanghvi, and Sarah Imhoff also made substantial contributions to the drafting of this Guidance.

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## EXECUTIVE SUMMARY

Clinical data registries or repositories (“Registries”) collect and analyze data on treatment outcomes submitted by physicians, hospitals and other types of health care providers related to a wide variety of medical procedures, diagnostic tests, and/or clinical conditions. Registries are often sponsored by national medical societies or their affiliates, universities, health insurers, or other entities. Their primary purpose is to produce benchmarks or metrics that their participating health care providers (“Participants”) can use to improve the quality of care they provide their patients. Registries also engage in research projects to enhance general knowledge about the safety and effectiveness of various medical procedures, diagnostic tests, treatments, and health care products. Other registries, such as public health databases, collect data on various population health events that may or may not involve medical treatment.

The federal government, health care products manufacturers, and state and local governments have increasingly come to rely on Registries for a wide variety of purposes. For instance, the Food and Drug Administration (“FDA”) has been encouraging drug and device manufacturers to work with Registries to conduct investigational and post-approval surveillance studies to ensure that both unapproved and approved drugs and devices are safe and effective. The Centers for Medicare & Medicaid Services (“CMS”) has required participation in Registries as a condition of reimbursement for certain medical procedures that involve investigational or off-label (i.e., unapproved) uses of drugs or devices. Similarly, the Centers for Disease Control and Prevention (“CDC”) and state and local governments are relying on other kinds of

data registries to track public health crises and responses.

At a time when the need for Registries is growing, so too are the legal challenges and regulatory burdens. Registries are subject to overlapping and duplicative federal rules governing the privacy and security of their data. They incur potential liability risk to patients, manufacturers, and others when they publish data and issue reports evaluating the efficacy of medical procedures or health care products. Registry data are also potentially subject to burdensome and costly legal discovery or subpoenas that threaten to drain Registry resources and discourage participation by health care providers.

The Physician Clinical Registry Coalition (“the Coalition”) is a group of more than twenty medical society-sponsored or physician-led Registries working for public policies to facilitate Registry development and to remove unnecessary legal and regulatory burdens on their operations. The Coalition is providing this Guidance to assist Registries in their understanding of several of these legal and regulatory challenges. This Guidance analyzes (i) the federal and state privacy issues facing Registries; (ii) ownership of Registry data; (iii) FDA medical device reporting requirements; (iv) liability risks associated with publishing benchmarks, analyses, or research studies on particular medical procedures, diagnostic tests, drugs, or devices using Registry data; and (v) available protections from legal discovery of Registry data under federal and state law.

We have focused on federal law in this Guidance. We cover state law more generally, but Registries should identify the specific rules

## EXECUTIVE SUMMARY

that apply to their operations in each state from which they collect or in which they maintain their data or a substantial business presence.

The guidance provided in this paper can be summarized as follows:

- I. **Privacy Issues**—Registries must comply with the regulations issued under the Health Information Portability and Accountability Act of 1996 (“HIPAA”)<sup>1</sup> and the Common Rule,<sup>2</sup> to the extent applicable, if they collect identifiable patient information from their Participants. The requirements of the HIPAA regulations and the Common Rule are complicated and overlapping. The Coalition is advocating for policy changes that would lessen these duplicative regulatory burdens without diminishing patient protection. Registries must also comply with state privacy laws, particularly in the states where the Registry has offices or holds data. Registries must adopt appropriate policies and procedures and purchase cyber security insurance to protect against the risk of data breaches and other privacy violations.
- II. **Data Ownership**—Ownership of Registry data is determined by state law and therefore varies based on the location of the Registry. Typically, Participants (not patients) own the medical records they create from patient encounters. Patients may or may not own the data in their medical records, but, in any case, they have a well-established right or interest in most states to review or seek modifications in their records. Registries own their aggregated data and databases. These distinctions need to be clearly articulated in Registry agreements with Participants (“Participation Agreements”). Registries should also understand and plan for the possibility that other stakeholders may also have (or at least claim) an ownership interest in Registry data. These stakeholders may include health insurers, government agencies, or device or drug manufacturers if they fund Registry data collection activities or contribute data to the Registry.
- III. **FDA Device Reporting**—FDA medical device reporting rules do not affect Registries directly, but Registries may need or wish to assist Participants and device manufacturers in meeting their obligations under these rules.
- IV. **Liability Risks**—Registries face liability risks in publishing their data or data analyses. Registries may have liability to Participants or patients if they publish erroneous data or data reports on the efficacy of certain procedures or health care products, and patients are harmed as a result. They may also have liability risk to drug or device manufacturers if they publish negative reports about the performance of particular health care products. Registries can best manage this risk by ensuring that the data and data reports they publish are current and accurate. Registries that are affiliated with national medical societies or other similar membership or multistakeholder organizations would also risk violating the antitrust laws if they were to use Registry data or reports to limit the ability of particular health care products companies or health care providers to compete in their particular markets.
- V. **Legal Discovery**—A fundamental concern in creating and operating a Registry is the risk that the information submitted to the

## EXECUTIVE SUMMARY

Registry by providers and manufacturers will be subject to legal discovery—for example, through a subpoena issued by a plaintiff in a malpractice action against a provider or a products liability suit against a device manufacturer or through a discovery request in direct litigation against a Registry. There is no general federal statutory protection against the discovery of Registry data in legal proceedings. The Federal Rules of Civil Procedure provide some protection against requests for Registry data, particularly in precluding disclosure of patient identifiable information. These rules may or may not protect against the disclosure of provider data, depending on the circumstances. The Patient Safety Organization (“PSO”) Act<sup>3</sup> and implementing rules<sup>4</sup> do provide some

protection against legal discovery, but that protection is subject to judicial interpretation and limitation; not all Registries can qualify as a PSO; and the PSO rules add significant regulatory burdens, potential penalties for noncompliance, and the risk of forfeiture of data if a Registry ceases to be a PSO. Many states have peer review and other laws that would protect against the discovery of Registry data in most circumstances, but these laws generally would not apply in a federal case based on federal law. The Coalition is advocating for broad federal legislation that would protect Registry data from legal discovery, whether through third-party subpoenas or direct litigation against Registries.

# GUIDANCE ON LEGAL CHALLENGES AND REGULATORY OBLIGATIONS FOR CLINICAL DATA REGISTRIES

The Coalition is providing this Guidance to assist Registries in their understanding of several legal and regulatory challenges that affect their ability to collect, protect, and analyze clinical data. The issues covered include: (i) the federal and state privacy issues facing Registries; (ii) ownership of Registry data; (iii) FDA medical device reporting requirements; (iii) liability risks associated with publishing benchmarks, analyses, or research studies on particular medical procedures, diagnostic tests, drugs, or devices using Registry data; and (iv) available protections from legal discovery of Registry data under federal and state law.

We focus on federal law, but Registries must also understand the state laws that affect their operations. This Guidance does not address all of the legal issues that Registries face; rather it focuses on those that are not only important, but also tend to raise policy issues that affect a Registry's prospects for success, many of which the Coalition is trying to address through its advocacy efforts.

## I. Privacy Issues

The Health Information Portability and Accountability Act of 1996 ("HIPAA")<sup>5</sup> and its implementing regulations are the primary federal law affecting the privacy of patient data collected by Registries. Most states also have their own laws that protect identifiable patient data. For the most part, Registries are safe in establishing procedures and processes for protecting their data that comply with HIPAA regulations. However, Registries should adopt strategies for complying with state data protection laws where they are more stringent than the HIPAA regulations.

### a. HIPAA

The rules issued under HIPAA establish a federal regulatory framework for the use and disclosure of protected health information ("PHI") by health care providers and other entities with which they share PHI. Specifically, the U.S. Department of Health and Human Services ("HHS") Office of Civil Rights ("OCR") has issued both Privacy and Security Rules (collectively, the "HIPAA Rules") to implement the statute.<sup>6</sup>

PHI is individually identifiable health information that requires patient authorization for use and disclosure unless such disclosure falls within one of many exceptions.<sup>7</sup> HIPAA applies to "covered entities," defined to include health care providers that transmit health information in electronic form, health plans, and health care clearinghouses, as well as "business associates," defined as entities that provide services for or perform functions on behalf of covered entities.<sup>8</sup>

The enactment of the American Recovery and Reinvestment Act ("ARRA") in 2009 extended HIPAA requirements and penalties to business associates.<sup>9</sup> Among other things, these changes subject business associates to the same penalties for unauthorized disclosure as covered entities and require business associates to notify individuals (or covered entities) and, in certain instances, the Secretary of Health and Human Services ("the Secretary"), in the event of a breach.<sup>10</sup> Business associates must also have appropriate policies and procedures to comply with the requirements of the Privacy and Security Rules.

The Privacy Rule allows for the disclosure of PHI by a covered entity without patient authorization for the purposes of treatment, payment, or health care operations.<sup>11</sup> Health care operations include, among other activities, quality assessment and improvement activities.<sup>12</sup> The Privacy Rule requires either a patient's authorization or a waiver of such authorization from an institutional review board ("IRB") or privacy board if PHI is being disclosed for research purposes.<sup>13</sup> "Research" means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.<sup>14</sup>

The extent to which HIPAA applies to the activities of a Registry will depend on the nature of the data being collected, the purpose of the collection, and whether that Registry is actually physically receiving the data. For example, a Registry would not be subject to HIPAA limitations when handling de-identified information, which is information that contains no personal identifiers or unique identifying numbers, characteristics, or codes.<sup>15</sup> Similarly, if a Registry collected "limited data sets," it would not need to obtain patient authorization or a waiver of such authorization from an IRB.<sup>16</sup> A limited data set is information that is partially de-identified by removing direct identifiers like name, address, phone number, and email address; but that retains certain PHI, such as an individual's gender, date of birth, or address containing only the city, state, or zip code.<sup>17</sup> The limited data set exception applies only to the use of data for research, health care operations, and certain public health purposes. This exception requires the covered entity to enter into a data use agreement with the limited data set recipient to preserve the confidentiality of the data and restrict its use. The Privacy Rule establishes specific requirements for such agreements.

The HIPAA Rules permit covered entities to share PHI with business associates for treatment, payment, or health care operations purposes if they enter into business associate agreements that meet regulatory requirements for protecting PHI.<sup>18</sup> Covered entities may only disclose to business associates the "minimum necessary" information for the business associate to perform its services or functions.<sup>19</sup>

Registries typically act as business associates of their participating physicians and hospitals, which are almost always covered entities under the HIPAA Rules. Registries usually perform data aggregation and related benchmarking analyses that support Participants' quality improvement efforts and other health operations. As such, Registries need to have a business associate agreement in place with each Participant prior to receiving the Participant's PHI.<sup>20</sup> If a Registry is subcontracting with a data management vendor for the collection, hosting, and/or analysis of Participants' PHI, a Registry must also have a sub-business associate agreement in place with the vendor. The same would be true for any other subcontractors with which the Registry wishes to share PHI.

Under the HIPAA Rules, the Registry's business associate status allows it to receive and analyze each site's data and report back aggregate results to all of its sites; but it cannot share the PHI of any one Participant with other Participants, except with the permission of all of the Participants whose data is being shared.<sup>21</sup> No patient authorization is necessary for Participants to send PHI to a Registry if the Registry has a HIPAA-compliant business associate agreement in place with each Participant and the disclosure is for health care operations and not research purposes.

The OCR has also indicated that no patient authorization is necessary if a Registry collects

data from Participants primarily for quality improvement/health care operations purposes, and then de-identifies the data and uses that for later research activities.<sup>22</sup> However, if a Registry wishes to **disclose** PHI to a third party for research purposes, a business associate agreement will not be sufficient to meet the HIPAA requirements for such disclosures, even if the primary purpose of collecting the data was for health care operations. Instead a Registry would need to obtain individual authorization or an IRB waiver of authorization for the disclosure of PHI,<sup>23</sup> as well as consent from the relevant Participants. For some types of research, it may be impracticable for researchers to obtain written authorization from individuals. For example, if a Registry is collecting retrospective data from Participants, it may be impossible and/or unduly burdensome to track down patients and get them to sign HIPAA authorizations. In such cases, Registries would need to seek an IRB waiver of the patient authorization requirement.

IRB waivers of the HIPAA patient authorization requirement are granted if the following conditions are met:<sup>24</sup>

1. The use or disclosure of PHI involves no more than a minimal risk to the privacy of individuals, based on, at least, the presence of the following elements:
  - a. an adequate plan to protect the identifiers from improper use/disclosure;
  - b. an adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining identifiers or such retention is otherwise required by law; and
  - c. adequate written assurances that PHI will not be reused/disclosed to any other person or entity, with certain exceptions.

2. The research could not practicably be conducted without an alteration or waiver.
3. The research could not practicably be conducted without access to and use of the PHI.

Registries collecting retrospective data can usually persuade an IRB to grant a waiver of authorization on grounds that it is impracticable and unduly expensive to obtain authorizations from the patients.

Importantly, OCR permits and encourages central IRB waivers of authorization—*i.e.*, waivers from a single IRB that apply to several covered entities participating in clinical trials or similar activities, including submitting data to Registries, and does not require the Participants to obtain separate waivers from their local IRBs.<sup>25</sup> Of course, Participants may still insist on obtaining local IRB approval and waivers to comply with their institutional policies.

The HIPAA Rules also permit a covered entity to disclose PHI to a public health authority<sup>26</sup> for certain public health activities and purposes, including “. . . preventing or controlling disease, injury, or disability, including but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions. . . .”<sup>27</sup> Thus, where a state or federal law authorizes a public health authority to collect certain public health-related PHI, for example, immunization data, a covered entity may share this information with a Registry operated by or on behalf of the public health authority without an individual’s consent. The HIPAA Rules do not specify what types of procedures a public health authority must take to protect the privacy and security of PHI it receives under the public health exception. Public health-related registries would be well-advised to follow the same rules that apply to covered entities and business associates for the protection of PHI.

## b. Common Rule

The Federal Policy for the Protection of Human Subjects or the “Common Rule” is codified in separate regulations by fifteen Federal departments and agencies, most of which are located in the Department of Health and Human Services (“HHS”). The Common Rule outlines the basic provisions for IRBs, informed consent, and “Assurances of Compliance” by institutions covered by the Common Rule. Human subject research conducted or supported by each federal department/agency is governed by the regulations of that department/agency.<sup>28</sup>

The Common Rule applies to research that is “conducted, supported or otherwise subject to regulation by any federal department or agency which takes appropriate administrative action to make the policy applicable to such research.”<sup>29</sup> In other words, the Common Rule applies to federally-funded research and research that is conducted pursuant to federal regulations. The Common Rule defines “research subject to regulation” as:

[R]esearch activities for which a federal department or agency has specific responsibility for regulating as a research activity, (for example, Investigational New Drug requirements administered by the Food and Drug Administration). It does not include research activities which are incidentally regulated by a federal department or agency solely as part of the department’s or agency’s broader responsibility to regulate certain types of activities whether research or non-research in nature (for example, Wage and Hour requirements administered by the Department of Labor).<sup>30</sup>

Where the Common Rule applies, it covers research involving human subjects, which includes the collection of identifiable patient

information.<sup>31</sup> The Common Rule generally does not apply to privately-funded research activities not otherwise subject to federal regulation.<sup>32</sup> Most Registries do not receive federal funding or conduct studies subject to federal regulation, and therefore are not subject to the Common Rule. However, many hospital Participants, particularly academic medical centers, are subject to the Common Rule because they receive federal research grants and other federal funding and/or participate in clinical trials regulated by the National Institutes of Health (“NIH”) or the FDA. Even if a particular research project is not federally funded or otherwise subject to federal regulation, many academic medical centers have signed “federalwide assurances” that require them to follow the Common Rule for any research they conduct.<sup>33</sup>

The Office for Human Research Protections (“OHRP”), the agency that administers the Common Rule for HHS, has clearly stated that entities that collect data in the course of clinical care and submit that data to external researchers are not engaged in human subjects research and therefore are not subject to the Common Rule with respect to such activities, even if they have signed federalwide assurances. Specifically, OHRP has issued guidance stating that “[i]nstitutions whose employees or agents release to investigators at another institution identifiable private information or identifiable biological specimens pertaining to the subjects of the research” are not engaged in human subjects research.<sup>34</sup> OHRP has further indicated that this guidance applies to hospitals, physician groups, and other covered entities that are otherwise covered by the Common Rule, but are only submitting data to Registries in the normal course of treating patients, and are not performing research themselves on that data.<sup>35</sup> This conclusion applies even if the covered entity is contacting the patient for information on how the patient’s condition is progressing, as long as such follow-

up activities are part of the normal treatment protocol.

In short, the Common Rule does not apply to hospitals and physician groups submitting data to Registries for health care operations or research purposes if they are simply submitting data to Registries collected in the normal course of clinical care and are not involved in the research themselves.

Even where the Common Rule does apply to entities that submit data to Registries, OHRP has clearly stated that data sources can rely on IRB waivers of the Common Rule consent requirements obtained by sponsors of clinical trials or other researchers, such as Registries.<sup>36</sup>

The Common Rule generally requires covered researchers to obtain informed consent from patients to participate in human subjects research and to implement safeguards for protecting the privacy and security of identifiable patient data collected for such efforts. Researchers are required to obtain informed consent or an IRB waiver of such consent, even if they are only collecting patient data from health care providers and not conducting clinical trials or otherwise interacting directly with patients. The Common Rule requirements for protecting patient data are generally less stringent than, but nonetheless duplicative of, the parallel requirements under the HIPAA Rules. To avoid these redundant regulatory burdens, the Coalition has asked OHRP to create an exception to the Common Rule for entities that are only collecting identifiable patient data (*i.e.*, and not interacting directly with patients) and that are in compliance with the relevant HIPAA Rules for protecting the privacy and security of patient data. OHRP is still considering this request.

### c. State Privacy and Breach Notification Statutes

The HIPAA Rules only preempt any state laws that provide less protection for patient privacy.<sup>37</sup> Many states have privacy and breach notification laws that impose more stringent privacy and security protections related to the use or disclosure of patient medical information.

For instance, California has a breach notification law that applies to licensed health facilities, clinics, home care agencies, and hospices in California.<sup>38</sup> The law requires these covered entities to report a breach of medical information to the California Department of Public Health and to affected individuals within five business days after a breach “has been detected.” By contrast, the HIPAA Rules require covered entities and business associates to report a breach of unsecured PHI within sixty calendar days of determining that such breach has occurred.<sup>39</sup> California law does not define “detected.” For instance, it is not clear whether the clock starts ticking on the five-business-day reporting obligation only when the covered institution learns of the breach or when one of its subcontractors, like a Registry, learns of the breach. Because of this uncertainty, it is common for California Participants to take a conservative approach and require its Registry partners to report any breach of PHI to the Participant within no more than five business days, and often less.

Access to medical records is another example of where state laws may be more stringent than HIPAA. In Virginia, a health care entity is required to provide patients access to their records with fifteen days of receiving a request.<sup>40</sup> By contrast, the HIPAA Rules require health care entities to provide this access within thirty days of a request.<sup>41</sup> Although the Virginia

law does not apply directly to Registries, a Virginia Participant may request that a Registry provide the Participant access to medical records managed by the Registry within the shorter time frame.

Compliance with states laws poses significant challenges for Registries that collect data from hospitals and/or physicians in many states. Registries should work with participating hospitals and physician groups in each state to identify local privacy and security rules that may be more stringent than the HIPAA Rules and that may require changes in a Registry's normal procedures for protecting patient data or reporting unauthorized uses or disclosures.<sup>42</sup>

#### **d. State Common Law**

Beyond federal and state privacy statutes, many states recognize a general, common law right to privacy and will hold entities and individuals legally responsible for violation of that right. The common law right of privacy will hold an individual liable for interfering with another's right to privacy by publicly disclosing personal facts.<sup>43</sup> Thus, the Registries should be aware that not only are they subject to state breach notification requirements, but they may also be liable for the negligent disclosure of PHI through state common law privacy claims. Most likely, these claims would arise in the form of demands for indemnification from a Participant that is sued for a Registry's wrongful disclosure of PHI. Likewise, such claims could also be brought against a Registry if the Participant has wrongfully submitted PHI to the Registry. Accordingly, most Registry participation and business associate agreements include mutual indemnification provisions identifying the circumstances under which Registries and their Participants will indemnify each other for wrongful acts or omissions that give rise to third-party liability claims.

As business associates covered by HIPAA and other privacy laws, Registries that have access to or control over PHI collected from Participants must have HIPAA-compliant policies and procedures in place before they start collecting data. They may also need policies to comply with the Common Rule and state privacy laws to the extent applicable to their activities. In addition, Registries should purchase sufficient cyber security insurance to protect against the risk of data breaches or other HIPAA/privacy violations.

## **II. Data Ownership**

Data ownership is determined by state law, either in the state where the data originated, where the data is held, or where the Registry's principal offices are located. The law in most states gives health care providers ownership over the medical records they keep from patient encounters. Patients have rights of access to or modification of their records to correct errors, but they may or may not own the data gathered by their health care provider.

Registries, by contrast, can and should own the compilation of data that they collect from Participants. This means Registries should own the aggregate data they create from Participants' raw data submissions, as well as the databases in which Participant's data is kept.

To avoid any doubt or controversies, Participation Agreements should clearly spell out these legal distinctions and state that (i) the Participant owns the raw data it submits (subject to any rights of patients), (ii) the Participant has the authority to submit the data to the Registry, (iii) the Registry owns its aggregate data and database(s), and (iv) the Registry is not required to return the data to the Participant upon termination or expiration of the Participation Agreement. The Participation

Agreement should also state that the Registry will continue to protect the Participant's data under HIPAA and other applicable laws as long as the Registry continues to possess the data.

Other Registry stakeholders may have or claim an ownership interest in Registry data. For instance, a manufacturer that funds the development of a data module within the Registry or a study of the effectiveness of the company's drug or device may claim that it owns the data in the module or the study data. The Registries' agreements with these other funders or data sources should clearly define who owns the data contributed or funded.

Registries should also consider whether to register their database, data reports, or other original works of authorship with the U.S. Copyright Office. The Registry's database would typically be subject to federal copyright protection as a compilation, provided that there is some originality to the development of the database.<sup>44</sup> The underlying data itself normally would not be covered by the copyright laws. Although registration is not required for copyright protection, a copyright holder can only sue for infringement under federal law and receive statutory damages after a work has been registered. However, Registry databases should have protection and the right to sue under state/common law copyright laws even if they do not register with the Copyright Office.

### III. FDA Medical Device Reporting

The FDA requires medical device manufacturers, importers, and user facilities to report medical device adverse events they become aware of to the FDA to address problems in a timely fashion.<sup>45</sup> A medical device distributor is defined as any person who "furthers the marketing of a device" but who "does not otherwise repackage or otherwise change the container, wrapper or labeling of the device or device package."<sup>46</sup> Distributors must

maintain records of reportable incidents but need not actually report them.<sup>47</sup>

A device user facility includes "a hospital, ambulatory surgical facility, nursing home, outpatient diagnostic facility, or outpatient treatment facility" but does not include school nurse offices or employee health units.<sup>48</sup> Device user facilities are required to report "deaths and serious injuries that a device has or may have caused or contributed to" to both the FDA and the manufacturer.<sup>49</sup> These facilities are also required to submit summary annual reports to the FDA and maintain adverse event files.<sup>50</sup>

Manufacturers are defined as persons (1) who actually make a device; (2) who otherwise repackage the container, packaging, or labeling of a device; or (3) who have another party make a device according to the manufacturer's specifications.<sup>51</sup> Manufacturers must submit reports of adverse events to the FDA within thirty calendar days of learning of the event. These adverse events include those that cause death or serious injury or malfunctions that if repeated could cause death or serious injury. Manufacturers also must report any event that "requires remedial action that presents unreasonable risk of substantial harm" or those for which the FDA requested a report be made within five working days of learning of the event. Manufacturers may also need to submit supplemental reports as necessary.<sup>52</sup>

Registries do not qualify as any of the entity types covered by the FDA medical device reporting requirements and therefore are not obligated to report adverse events to the FDA but could decide to do so voluntarily.<sup>53</sup> Registry Participants, however, may qualify as "user facilities" and must adhere to the Medical Device Reporting ("MDR") requirements.<sup>54</sup> If a Registry shares data with manufacturers on the performance of their devices, including data that suggests a device may have caused serious injuries to patients, that information could

obligate the manufacturer to report to the FDA.<sup>55</sup> Therefore, Registries may need to include provisions in their Participation Agreements with Participants or their data sharing agreements with manufacturers to address the Participants' or manufacturers' MDR requirements.

#### **IV. Liability Risks for Procedure or Product Evaluations**

A Registry could face liability risk based on its evaluation of the effectiveness of certain procedures, drugs or devices, or other health care products, and publish the results. This liability risk could arise if a Registry conducts its own studies or if it conducts studies on behalf of manufacturers. For instance, some Registries conduct FDA-regulated post-market surveillance, investigational device exemption ("IDE"), or investigational new drug ("IND") studies for manufacturers.

In theory, a Registry could be liable to patients if it published reports or studies finding that a particular procedure, drug, or device was effective when in fact it was later found to be ineffective or harmful. We are not aware of any case law in which such a claim has been brought against a Registry.<sup>56</sup> Registries generally would not be required to warn patients of product safety or effectiveness problems. However, if a Registry is publishing benchmarks on the performance of particular health care providers or health care products, it is possible that a court could find that the Registry has a duty of care in developing and disseminating those benchmarks. This would be similar to the duty of organizations that set standards or test consumer products.<sup>57</sup>

Likewise, if a Registry is conducting a study on behalf of a manufacturer, it could be treated as an extension of that manufacturer for liability purposes. It should, therefore, make sure that its study agreements with manufacturers

include appropriate indemnification provisions, liability releases, and other protections against third-party claims.

More generally, Registries that make a claim about the safety or effectiveness of a medical procedure, drug, or device based on Registry data should continue to update that claim based on additional or new data to avoid a possible lawsuit should a manufacturer, physician, or patient rely on it.

A Registry also could face liability risk if it publishes a negative evaluation of a manufacturer's product, and the manufacturer sues that Registry under a trade disparagement, antitrust, or similar legal theory.<sup>58</sup> Trade disparagement claims are based in state law and would allow a manufacturer of a drug or device to sue a Registry for making an allegedly false claim about the efficacy or safety of a particular drug or device when a Registry allegedly knew that the statement was false. Under federal law, a manufacturer could also bring a claim concerning false statements, misleading descriptions, or false or misleading representations of fact about a device under the Lanham Act, the United States trademark law, for devices that are protected under a trademark.<sup>59</sup>

Registries, as with other entities, generally cannot be held liable on a trade disparagement theory simply for making negative statements about a manufacturer's product. For example, an insurer's statement that a manufacturer's device had "no proven clinical utility . . . since it [was] considered to be investigational," without any evidence that the person or organization making the statement knew it to be false, was not enough to establish an insurer's liability to a device manufacturer on a trade disparagement theory.<sup>60</sup> Internal documentation that the insurer did in fact believe the device had no proven clinical use was useful in defending

against the trade disparagement claim in that case.<sup>61</sup>

In another case brought under both the Lanham Act and a state common law disparagement theory, the same manufacturer sued the American Association of Electrodiagnostic Medicine (“AAEM”)<sup>62</sup> over a literature review published in AAEM’s peer-reviewed journal that evaluated the manufacturer’s device. The literature review concluded that the evidence of the utility of the company’s medical device was inconclusive. The court held that AAEM was not liable in part because for a challenge to be brought under the Lanham Act, the speech at issue must be “commercial,” that is, related to a commercial transaction or the speaker’s economic interests.<sup>63</sup> Because the AAEM article only considered the usefulness of the device at issue and did not evaluate anything commercial in nature, the article did not violate the Lanham Act prohibition against disparaging speech. The court also noted that to “chill” the AAEM’s statements in this case would prevent “all debate about such subjects from entering the marketplace.”<sup>64</sup> So long as a Registry is not making statements or claims based on Registry data that are commercial in nature, it is unlikely to be held liable under the Lanham Act.

As to the state level disparagement or injurious falsehood claims, the court held that there was no liability under Maryland law for these claims where the statements were made without malice.<sup>65</sup> Whether malice is required for all state law disparagement claims or whether knowledge that the statements were false is sufficient to impose liability will vary from state to state. Registries and the organizations that support them therefore should be careful about making any statements about a drug or device that cannot be supported by objective scientific facts and data. They should also update any conclusions drawn on Registry data if a Registry becomes aware that the statements are no longer accurate.

For Registries that are sponsored by medical societies—and therefore are considered to be a combination of competitors—product evaluations can also lead to antitrust claims if a manufacturer alleges that a Registry disparaged one of the manufacturer’s devices or drugs to limit competition or to prevent the device from being purchased in the relevant market. Of course, if a manufacturer can show that a medical society engaged in *intentional* conduct to harm the competitive position of a particular manufacturer or group of manufacturers— e.g., by sharing data with some manufacturers and not others— the risk of antitrust liability would increase dramatically.<sup>66</sup>

Because of the risks of these lawsuits, if a Registry does decide to evaluate specific drugs or devices, it should make sure it has insurance that covers this activity. As noted above, if a manufacturer affirmatively asks or seeks to engage a Registry to evaluate the company’s product and publish its results, the Registry should insist that the manufacturer provide written indemnification provisions and liability releases for the Registry’s evaluation activities. The Registry should also ensure that any public statements that it makes about particular drugs or devices are accurate and not misleading. In addition, entities that create Registries might consider setting up a separately-incorporated subsidiary to house the Registry and thereby limit the parent organization’s liability risk. Generally, separate incorporation will prevent third parties from attacking the parent corporation’s assets based on actions of the subsidiary. The parent organization should weigh the cost and administrative burden of establishing and operating the Registry as a separate entity against the liability protection offered by separate incorporation.

## V. Data Protection Issues

A fundamental concern in creating and operating a Registry is the risk that the

information submitted to the registry by providers and manufacturers will be subject to legal discovery—for example, through a third-party subpoena<sup>67</sup> issued by a plaintiff in a malpractice action against a provider or a products liability suit against a device manufacturer or through a discovery request in direct litigation against a Registry. This section discusses the potential federal and state laws that might protect a Registry data from legal discovery and concludes there is a need for general federal legislation to protect Registries against discovery of identifiable Registry data.

### **a. Federal Rules of Civil Procedure**

Rule 45 of the Federal Rules of Civil Procedure (“FRCP”) applies to subpoenas issued in federal cases against third parties.<sup>68</sup> FRCP 45(d)(1) contains the provisions for protecting recipients of subpoenas from undue burden and expense. Attorneys issuing subpoenas have an affirmative obligation to avoid imposing such burdens, and courts are directed to enforce this duty and impose sanctions against a party or attorney who violates this prescription.

FRCP 45(d)(2)(B) allows a person who receives a third-party subpoena to file objections “to inspecting, copying, testing, or sampling any or all of the materials or to inspecting the premises—or to producing electronically stored information in the form or forms requested.” In the face of such objections, the person issuing the subpoena is then required to withdraw or modify its request or file a motion to compel production.

FRCP 45(d)(3) provides several grounds under which a reviewing court may quash or modify a subpoena, including if the subpoena requests disclosure of privileged or other protected matter (if no exception or waiver applies), or subjects a person to undue burden. The court is permitted, but not required, to quash or

modify a subpoena that asks for disclosure of a trade secret or confidential research, development, or commercial information. In making these assessments, courts typically will review some or all of the requested information in camera (*i.e.*, in private chambers), balance the competing interests, and then render a decision.<sup>69</sup>

For cases in which a Registry is a party to a lawsuit, the Registry would rely on FRCP 26(c) to protect its data from discovery requests. Discovery can take the form of requests for documents or data, oral or written depositions, or interrogatories for a Registry that can be addressed by a Registry as a whole.<sup>70</sup> FRCP 26(c) allows a court, “for good cause,” to “issue an order to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense.” This includes “forbidding the disclosure or discovery” or using other means to limit the discovery, including limiting it by time and place, prescribing other discovery methods that may be less invasive, limiting the scope of disclosure, or prohibiting or limiting how a trade secret or confidential research is revealed.<sup>71</sup> While FRCP 45(d) offers some protection to Registries concerning requests for information when they are not a party to a lawsuit, FRCP 26(c) offers comparable protections to the Registry once it becomes a party to a lawsuit.

In practice, federal courts have typically been very reluctant to disclose identifying information of patients or trade secrets of manufacturers unless the patient or company is a party to the suit. Instead, they will usually only permit discovery of aggregated, non-identifiable data, unless a compelling case is made for disclosing identifying information.<sup>72</sup> In some instances, the court will find that the sensitive nature of the information itself merits preservation of registry participants’ privacy and confidentiality.<sup>73</sup> Courts also are reluctant to admit evidence of

other bad acts to prove the liability of a defendant in a particular case arising out of a particular set of circumstances.<sup>74</sup> If a Registry were to receive a subpoena or discovery request seeking aggregated data, it could still object on grounds of undue burden or expense or lack of relevance of the data, but courts would be much less sympathetic to such arguments unless a significant actual burden could be demonstrated.

Two of the leading federal cases illustrating these principles are *Farnsworth v. Proctor & Gamble* and *Deitchman v. E.R. Squibb & Sons, Inc.*, both products liability cases in which manufacturers sought data from a registry.

In *Farnsworth vs. Proctor & Gamble*, P&G sought the names and addresses of women participating in a CDC study on Toxic Shock Syndrome (“TSS”) in an effort to discredit the study findings.<sup>75</sup> The plaintiffs sought to recover damages from P&G for TSS allegedly caused by “Rely” tampons manufactured by the company. Responding to P&G’s third-party subpoena, the CDC turned over virtually all of the documents relating to its study, except the names and addresses of the study subjects. It did turn over the names and addresses of patients who consented to have their information disclosed to P&G. Relying on FRCP 26(c) (even though this case involved a third-party subpoena), the *Farnsworth* court upheld the district court’s order that the privacy interests of the study participants outweighed the discovery interests of the manufacturer and denied disclosure of the patient names and addresses.

In *Deitchman v. E.R. Squibb & Sons, Inc.*, the court applied a similar balancing test in deciding whether to disclose patient registry records maintained by the University of Chicago (“U of C”).<sup>76</sup> The suit was filed against

Squibb and other drug companies seeking compensation for injuries allegedly caused by *in utero* exposure to the drug diethylstilbestrol (“DES”). As part of discovery, Squibb had asked the court to issue subpoenas for literally every document in U of C’s cancer registry. The U of C registry was the only central repository of data on the relationship between DES and clear cell adenocarcinoma of the genital tract, the principal disease at issue in *Deitchman*. The data in the registry were the primary basis for studies on the effect of DES in causing this form of cancer that were being used against Squibb in the case.

U of C filed a motion to quash under FRCP 45 (b), claiming its data were privileged and confidential. Here, the court acknowledged the need to protect the privacy of registry participants’ information, and indeed assumed for the sake of argument that the data were protected by a qualified privilege. But, the court also gave significant weight to Squibb’s need to defend itself and the importance of having access to the data on which studies showing the relationship between DES and genital tract cancer were based. As a result, the court held that the manufacturer was entitled to some limited discovery of registry data, while protecting the patients’ confidentiality and the interests of the registry. The court did not fashion a discovery order itself, but instructed the district court to do so in a way that would not require disclosure of patient identifying information and would otherwise protect patient confidentiality through the potential use of impartial third parties to review and report on the data. It concluded by stating, that the district court should work with the parties to develop an order that “allows Squibb the least necessary amount of information to avoid a miscarriage of justice without doing needless harm to . . . [a] Registry.”<sup>77</sup>

Other courts considering subpoenas of Registry data have similarly sought to balance the public interest in allowing the disclosure of necessary information for purposes of litigation or to expose research to critical inquiry and the need to protect the identity of study and Registry Participants. For example, a California District Court allowed production of raw data from a study on lung cancer in women exposed to secondhand smoke using data from a state-sponsored cancer registry so long as the identities of the individuals in the study who had not authorized the release of the data were kept confidential. In doing so, the court upheld a magistrate judge's decision to compel disclosure subject to certain confidentiality protections.<sup>78</sup>

*Farnsworth, Deitchman*, and other case law show that federal courts will look at all the facts and circumstances in determining whether to allow the discovery of Registry data. But, for the most part, courts are very unlikely to permit disclosure of patient identifying information. It is less clear whether the courts will permit data on specific providers or products to be disclosed. *Farnsworth* and *Deitchman* involved requests by manufacturers for data on their products. So they shed no light on how federal courts would resolve a discovery request by a plaintiff's attorney for Registry data on a specific manufacturer's product. But we do know the courts would balance the manufacturer's proprietary interests in preserving trade secrets and other confidential information against the discovering party's need for the data in the litigation.

We are not aware of any federal cases involving discovery requests for Registry data on a specific hospital's or physician's outcomes. However, as noted above, such requests might be denied on grounds that such data would not be relevant to prove poor performance in a particular case. Plus, if a Registry were

providing regular reports to a hospital or physician on their quality outcomes, the plaintiff could obtain the reports from the defendant hospital or physician.

## **b. HIPAA**

HIPAA regulations, while providing stringent confidentiality and security measures, have a relatively liberal exception for the disclosure of PHI in judicial and administrative proceedings. The exception allows for the disclosure of PHI in response to a court order or pursuant to subpoena, discovery request, or other lawful process so long as the covered entity receives "satisfactory assurance" that reasonable efforts have been made to give notice to the affected party or to obtain a protective order.<sup>79</sup> Given this broad, relatively accessible exception, it is fair to say that HIPAA provides no greater protection for the Registry data against a discovery request than would be generally available under the FRCP 26(c) or 45. Indeed, the HIPAA Rules actually provide less protection because they only safeguard PHI, not provider or manufacturer information.<sup>80</sup>

## **c. Patient Safety Organizations**

The formation of a Patient Safety Organization ("PSO") may provide a Registry with additional protections against discovery but also creates several new regulatory burdens and risks, including the risk of losing Registry information should the PSO status be revoked or relinquished. The Patient Safety Organization Act ("PSOA") protects against the legal discovery of identifiable patient safety work product ("PSWP") collected by a PSO.<sup>81</sup> This includes protection against federal, state, or local civil, criminal, or administrative subpoenas or discovery and protection against this work product being admitted as evidence in the same proceedings or admitted or accessible as part of a disciplinary proceeding against a provider,

subject to certain exceptions.<sup>82</sup> In order to obtain this protection, a Registry would have to qualify as and meet the ongoing requirements of a PSO and Registry data would have to constitute identifiable PSWP,<sup>83</sup> which is by no means a given. This protection is limited to identifiable data and is not self-enforcing.<sup>84</sup> Thus, a PSO could have to go to court to enforce the PSO discovery prohibition.

The downsides to forming a PSO, among other things, are that the Registry would be subject to government audits and potential sanctions for non-compliance with PSO rules.<sup>85</sup> The PSO confidentiality rules also significantly limit the ability of PSO Participants to make public statements about their performance in relation to benchmarks established by a PSO Registry because such information would be based on PSWP submitted by the Participants.<sup>86</sup> Most importantly, a Registry that voluntarily decides not to maintain its PSO status or is disqualified for noncompliance with the PSO rules would have to transfer its PSWP to another PSO, return the data to its source, or destroy the data.<sup>87</sup>

Importantly, the PSO privilege language is not self-enforcing—that is, the assertion of the privilege can be challenged in court—and is therefore subject to judicial interpretation and limitation. To date, PSOs attempting to protect information from discovery collected pursuant to state incident reporting requirements have had little success in court. In the 2014 case *Tibbs v. Bunnell*, the Supreme Court of Kentucky ruled that state-mandated incident reports held by a PSO are not privileged under the PSOA because the plain language of the Act does not protect “information collected, maintained, or developed separately, or existing separately from a patient safety evaluation system.”<sup>88</sup> Because Kentucky law mandates that “incident investigation reports” be “*established,*

*maintained and utilized* as necessary to guide the operation of [a] facility” and that facilities must have policies and procedures for recording such incidents,<sup>89</sup> the court held that they had been created separately from the system protected by the PSOA. The court further held that this information could be discovered only after an “in camera” review by the court to separate discoverable information from information that was privileged.<sup>90</sup>

In a second 2014 case, *Charles v. Southern Baptist Hospital of Florida*, a Florida Circuit Court similarly found that information held by a PSO that was collected “pursuant to a healthcare provider’s obligation to comply with federal, state, or local laws, or accrediting or licensing requirements [was] not privileged” under the PSOA, based on the same statutory language cited in *Tibbs*.<sup>91</sup> The *Charles* court held that this limitation applies to any information that is merely “collected” or “maintained” to comply with “external obligations” and not just information actually provided to the government.<sup>92</sup> Thus, in Florida, information collected under state record keeping requirements that can be reviewed on request by the state Agency for Health Care Administration is not privileged under the PSOA.<sup>93</sup> The holdings in both *Tibbs* and *Charles* are limited to their respective state jurisdictions. As of the date of this Guidance, the *Charles* case was being appealed to the Florida appeals court.

Thus, while PSO status provides the most direct federal protection of Registry data from legal discovery, the protection comes with significant regulatory risks and burdens, it is not self-enforcing, and it may be limited by judicial interpretation. Each Registry must balance the risks and limitations of the PSO discovery protections against the benefits.

#### d. AHRQ Protections

The Agency for Healthcare Research and Quality (“AHRQ”) may offer some protection for Registry data against legal discovery. This protection would be available only if a Registry received AHRQ funding or received data from an entity that has received AHRQ funding related to a Registry’s data.

AHRQ’s confidentiality statute, 42 U.S.C. § 299c-3(c), limits the use of information compiled in an AHRQ-sponsored study to the original purpose for which the information was supplied unless the person or establishment supplying the information has consented to its use for other purposes. AHRQ has broadly interpreted this provision to protect data against all forms of legal discovery and has concluded that such protection travels with the data, and therefore is not limited to the data of entities directly receiving funding. In addition, AHRQ has pledged to assist recipients of AHRQ funding in convincing courts to adopt AHRQ’s broad interpretation of § 299c-3(c).<sup>94</sup>

It is important to note that AHRQ’s position on its ability to protect AHRQ-funded data has not been tested in a court of law and the protections that it offers become weaker the more removed an entity is from the actual recipient of AHRQ funding. In another AHRQ-sponsored memorandum, the authors noted that the confidentiality protections offered through the AHRQ statute may become more attenuated where the AHRQ-sponsored organization is merely operating as a “repository” for patient safety data collected by a non-AHRQ sponsored entity and is not collecting the data itself.<sup>95</sup> Moreover, the language of § 299c-3(c) does not explicitly protect data from legal discovery. Without an explicit legislative protection, there is no guarantee that information provided to an AHRQ-funded Registry would be protected from disclosure.<sup>96</sup> Additionally, as with PSOs,

becoming a recipient or sub-recipient of AHRQ funding, or even just affiliating with such an entity, could result in the loss of at least some control over the data and subject the Registry to substantial additional federal regulatory requirements that apply to recipients of federal funding.

#### e. Certificates of Confidentiality

The NIH issues Certificates of Confidentiality to protect investigators and institutions from legal discovery of information that could be used to identify subjects within a research project.<sup>97</sup> Specifically, the authorizing statute covers “[p]ersons so authorized to protect the privacy of [research subjects from being] compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals,”<sup>98</sup> a statement that is confirmed by the NIH in its guidance documents.<sup>99</sup> Certificates of Confidentiality are issued to institutions or universities where the research is conducted and, according to the NIH, afford permanent protection to research subjects that participate in research projects covered by these certificates, even to those patients who may have submitted research data to the institution before the certificate was issued.<sup>100</sup> Certificates of Confidentiality only protect patient information, not providers or institutions.

Certificates of Confidentiality generally apply only to specific research projects, not to broad classes of research or data collection, such as would be the case for a Registry. They also only apply to certain types of sensitive research. NIH defines sensitive to mean “that disclosure of identifying information could have adverse consequences for subjects or damage their financial standing, employability, insurability, or reputation.”<sup>101</sup> Examples of such research include collecting “genetic information,” “information on psychological well-being,” sexual information, and information “on substance

abuse or other illegal risk behaviors.” It also includes “studies where subjects may be involved in litigation related to exposures under study.”<sup>102</sup> Given their narrow scope and applicability, it is unlikely that a Registry, or the research projects it sponsors or facilitates, would qualify for a Certificate of Confidentiality.

#### f. State Law

The lack of comprehensive federal statutory protection for Registry data from legal discovery suggests that a Registry may need to look to state law for protection, at least to fight subpoenas issued in state court proceedings or federal cases that involve state law claims. As a general rule, a plaintiff in a lawsuit filed in state court **outside** the state in which a Registry is located would have to ask a state court **within** the Registry’s home state to issue a third-party subpoena seeking Registry data. The court reviewing the subpoena would most likely apply its own state law rather than the law of the state in which the lawsuit was filed.

The general standards in most states for evaluating such subpoenas are similar to those set forth in the FRCP 26(c) and 45. However, some states have special statutes that would provide additional protection for Registry data if a Registry can show these laws apply to a particular subpoena.<sup>103</sup> Of course, these state statutory protections would not necessarily apply if the underlying lawsuit were filed in federal court and solely involved federal law claims, in which case FRCP 26(c) or 45 would likely govern.

A review of all of the potential state statutes that might protect Registry data is beyond the scope of this document. Registries should focus their review of state data protection laws in the state in which the bulk of Registry data collection activity takes place, the state where the data is stored, and the state in which the Registry or sponsoring organization is incorporated. These

are the most likely places where a subpoena would have to be issued to obtain Registry data, and, therefore, the most likely jurisdictions whose data protection laws would be applied.

#### g. Limited Research Privilege

There may also be some cases where a Federal court, relying on state law, will accord a “qualified privilege” to scholarly research to protect the public interest in promoting this research as part of the balancing test for admitting evidence applied under Rule 201 of the Federal Rules of Evidence.<sup>104</sup> State courts might also grant this qualified privilege under analogous state rules of evidence. Where available, this privilege could be used to protect research data beyond the confidentiality of patient information. For example, in *Dow Chemical Co. v. Allen*, the court barred discovery pursuant to an administrative subpoena of all working papers, notes, reports, and raw data of an unfinished animal toxicity study in part on the grounds that the risks of premature disclosure to the development of the research outweighed the value of the data to the litigation.<sup>106</sup> While the data in *Dow* received protection, this protection would not necessarily have extended to separate litigation that depended more heavily on the animal toxicity study data. The case indicates, however, that there may be some circumstances in which a court will exclude data from consideration in a case or investigation to protect the integrity of the research itself.

In addition, in *Cusumano v. Microsoft Corporation*, the court, applying FRCP 45, also denied production of two academicians’ research materials on the grounds that academicians are entitled to the same pre-publication privilege as journalists, subject to a balancing of the interests in disclosure against the interests in protection of the information.<sup>106</sup> In reaching this conclusion, the court cited case law from other federal appellate courts holding

that the medium by which an individual engages in investigative reporting does not change the amount of protection that the work receives.<sup>107</sup> It may also be possible to assert this privilege in state court, either through a balancing of interests, as in *Dow Chemical*, or by the assertion of a specific state law research privilege.<sup>108</sup> In addition to the protections that may be available for patient data, Registries with pre-publication data that are designated for a specific research purpose may be able to gain additional protections for this data pending publication.

In sum, other than those provided under the PSO laws, there are no specific federal statutory privilege protections for Registry data. The federal evidentiary rules do provide some protection for such data, particularly identifiable patient data. HIPAA provides some protection for PHI legal discovery, but it provides no protection for provider or manufacturer data. While the PSO Act contains a federal privilege for identifiable PSWP, the costs/risks of becoming a PSO must be balanced against the benefits of the statutory privilege. The affiliation

with a recipient of AHRQ funding may enhance the protection of Registry data, but could also create additional burdens and result in the possible loss of control of the data. Certificates of Confidentiality do protect against legal discovery, but most Registry research would likely not qualify for such a certificate.

Registry data likely will receive some privilege protections under state law, but Registries must review the laws in the states where they do business or are conducting their Registry activities to determine whether there are laws in place that would protect their data from discovery. In addition, in some rare cases a qualified privilege for pre-publication data may be available to Registries. But these state law protections may not always be available in federal court proceedings.

Based on this lack of clear federal protection of Registry data from legal discovery, the Coalition is working on developing federal legislative proposals that would provide such protection without the onerous conditions imposed by the PSO Act and rules.

## ADDITIONAL RESOURCES

For additional resources on registry legal and policy issues, please see the following:

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, UNITED STATES DEPT. OF HEALTH AND HUMAN SERVS., PUB. No. 13(14)-EHC111, REGISTRIES FOR EVALUATING PATIENT OUTCOMES: A USER'S GUIDE (Richard E. Gliklich et al. eds., 3rd Ed. 2014), *available at* <http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=1897&pageaction=displayproduct>

UNITED STATES GOV'T ACCOUNTABILITY OFFICE, CLINICAL DATA REGISTRIES: HHS COULD IMPROVE MEDICARE QUALITY AND EFFICIENCY THROUGH KEY REQUIREMENTS AND OVERSIGHT, PUB. No. GAO-14-75 (Dec. 2013), *available at* <http://www.gao.gov/assets/660/659701.pdf>

## END NOTES

1. Pub. L. No. 104-191, 110 Stat. 1936 (1996) ( codified at 42 U.S.C. § 1320d *et seq.*).
2. See United States Dep't of Health and Human Servs., *Federal Policy for the Protection of Human Subjects ('Common Rule')*, <http://www.hhs.gov/ohrp/humansubjects/commonrule/index.html> (last visited January 15, 2015).
3. Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. §§ 299b-2, 299b-26 (2014).
4. 42 C.F.R. Part 3 (2014).
5. 42 U.S.C. § 1320d *et seq.* (2014).
6. 45 C.F.R. pts. 160 and 164 (2014).
7. 45 C.F.R. § 164.502 (2014); 45 C.F.R. § 164.508 (2014); 45 C.F.R. § 160.103 (2014).
8. 45 C.F.R. § 160.103.
9. American Recovery and Reinvestment Act of 2009, 41 U.S.C. § 17934 (2014).
10. *Id.* at §§ 17934, 17937.
11. 45 C.F.R. § 164.506(c) (2014); 45 C.F.R. § 164.508(a)(2) (2014).
12. 45 C.F.R. § 164.501 (2014).
13. 45 C.F.R. § 164.512(i) (2014).
14. 45 C.F.R. § 164.501(i). The preamble to the Privacy Rule explicitly included within the definition of research the development (building and maintenance) of a repository or database for future research purposes. 67 Fed Reg 53,231, (Aug. 14, 2002).
15. 45 C.F.R. § 164.514 (2013).
16. 45 C.F.R. §§ 164.512(i); 164.514(e).
17. 45 C.F.R. § 164.514.
18. 45 C.F.R. § 164.502 (e).
19. 45 C.F.R. § 164.502(b).
20. See 45 C.F.R § 164.502.
21. See 45 C.F.R. § 164.504 (2013).
22. See United States Dep't of Health and Human Servs., *Frequently Asked Questions: Health Information Privacy* (Dec. 15, 2008), [http://www.hhs.gov/ocr/privacy/hipaa/faq/health\\_information\\_technology/544.html](http://www.hhs.gov/ocr/privacy/hipaa/faq/health_information_technology/544.html). The FAQ states:

May a health information organization (HIO), acting as a business associate of a HIPAA covered entity, de-identify information and then use it for its own purposes?

Answer:

A HIO, as a business associate, may only use or disclose protected health information (PHI) as authorized by its business associate agreement with the covered entity. See 45 C.F.R. § 164.504(e). The process of de-identifying PHI constitutes a use of PHI. Thus, a HIO may only de-identify PHI it has on behalf of a covered entity to the extent that the business associate agreement authorizes the HIO to do so. However, once PHI is de-identified in accordance with the HIPAA Privacy Rule, it is no longer PHI and, thus, may be used and disclosed by the covered entity or HIO for any purpose (subject to any other applicable laws).

The Coalition also had a meeting with OCR officials on August 7, 2013, in which the agency confirmed that patient authorization is **not** required if a Registry properly de-identifies PHI for research purposes as long as doing so is authorized by the Covered Entity that submitted the data. OCR re-iterated this position at a conference on registry issues sponsored by the American Medical Association's National Quality Registry Network on April 22, 2014 ("NQRN Conference").

23. 45 C.F.R. § 164.512(i).
24. *Id.*
25. United States Dep't of Health and Human Servs., *Health Services Research and the HIPAA Privacy Rule*, NAT'L INST. OF HEALTH (May 20, 2005), <http://privacyruleandresearch.nih.gov/healthservicesprivacy.asp>.
26. A "public health authority" is an agency or authority of the United States government, a State, a territory, a political subdivision of a State or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with, a public health agency. See 45 CFR 164.501.
27. 45 C.F.R. § 164.512(b)(i).
28. See United States Dep't of Health and Human Servs., *Federal Policy for the Protection of Human Subjects ('Common Rule')*, <http://www.hhs.gov/ohrp/humansubjects/commonrule/index.html> (last visited January 15, 2015).
29. 45 C.F.R. § 46.101(a) (2014).
30. 45 C.F.R. § 46.102(e) (2014).
31. 45 C.F.R. § 46.101(b).
32. See 45 C.F.R. § 46.101(a).

33. See United States Dep't of Health and Human Services Office for Human Research Protection, *Federalwide Assurance (FWA) for the Protection of Human Subjects*, <http://www.hhs.gov/ohrp/assurances/assurances/filasurt.html> (last updated June 17, 2011).
34. United States Dep't of Health and Human Services Office for Human Research Protection, *Guidance on Engagement of Institutions in Human Subjects Research*, Section III.B.6. (Oct. 16, 2008), <http://www.hhs.gov/ohrp/policy/engage08.html>.
35. See Letter from Ivor A. Pritchard, Ph.D., Senior Advisor to OHRP Director, to Anthony L. Asher, Director of National Neurosurgery Quality and Outcomes Database, (December 29, 2011), [http://www.hhs.gov/ohrp/policy/Correspondence/ohrp\\_12/29/2014\\_response\\_.html](http://www.hhs.gov/ohrp/policy/Correspondence/ohrp_12/29/2014_response_.html). OHRP confirmed these statements in a meeting with PCRC on August 7, 2013 and at the April 22, 2014 NQRN conference on registry issues. See *supra*, note 22.
36. Human Subjects Research Protections: Enhancing Protections for Research Subjects and Reducing Burden, Delay, and Ambiguity for Investigators, 76 Fed. Reg. 44,512, 44,521 (July 26, 2011). OHRP staff reiterated this position during the August 7, 2013 meeting with PCRC and at NQRN's April 22, 2014 conference.
37. 45 C.F.R. § 160.203 (2014).
38. CAL. HEALTH AND SAFETY CODE § 1280.15 (2014).
39. 45 C.F.R. §§ 164.404(b) and 164.410 (2014).
40. VA. CODE ANN. § 32.1-127.1:03(e) (2014).
41. 45 C.F.R. § 164.524(b) (2014).
42. The National Conference of State Legislatures has a resource tracking state statutes and regulations regarding breaches of personally identifiable information. Nat'l Conference of State Legislatures, *Security Breach Notification Laws*, <http://www.ncsl.org/research/telecommunications-and-information-technology/security-breach-notification-laws.aspx> (last updated Jan. 12, 2015).
43. Restatement (Second) of Torts § 652D (1977); see e.g., *Roe v. Craddock*, 555 N.E.2d 1155, 1157 (Ill. App. 3d 1990) (noting that the Supreme Court of Illinois has acknowledged the public disclosure of private facts as a valid claim under Illinois law).
44. 17 U.S.C. § 103(b). See also *Feist Publications, Inc., v. Rural Telephone Service, Co., Inc.*, 499 U.S. 340 (1991).
45. 21 C.F.R. § 803 *et seq.*
46. 21 C.F.R. § 803.3 (2014).
47. 21 C.F.R. § 803.1(a) (2014).
48. 21 C.F.R. § 803.3.
49. 21 C.F.R. §§ 803.1; 803.10 (2014).
50. 21 C.F.R. § 803.1.
51. 21 C.F.R. § 803.3.
52. 21 C.F.R. § 803.10(c); see also 21 C.F.R. § 803.50 (2014).
53. 21 C.F.R. § 803.3.
54. 21 C.F.R. §§ 803.1, 803.10, 803.30 (2014).
55. 21 C.F.R. §§ 803.1, 803.10, 803.40 (2014).
56. In fact, when registries have been mentioned in products liabilities cases, it is usually to chastise a manufacturer for either not using a registry as part of post-market surveillance or for ignoring the data submitted to a registry as part of post-market surveillance. See e.g., *Fraser v. Wyeth*, 857 F. Supp. 2d 244 (D. Conn. 2012); *Barrow v. Bristol Myers Squibb*, 1998 WL 812318 (M.D. Fl. Oct. 29, 1998).
57. See, e.g., *Hempstead v. General Fire Extinguisher Corp.*, 269 F. Supp. 109 (D. Del. 1967) (holding that an underwriters' Laboratories could be liable for negligent approval of fire extinguisher if its negligence was the proximate cause of an explosion that injured plaintiff); *Hanberry v. Hearst Corporation*, 276 Cal. App. 2d 680 (Cal. Ct. App. 1969) (holding that a defendant-publisher may be liable for negligent misrepresentation where a plaintiff purchased shoes that contained publisher's Good Housekeeping Seal of Approval but which contained defects that caused plaintiff's injury). See also *Snyder v. American Association of Blood Banks*, 144 N.J. 269 (1996) (finding a voluntary association of blood banks liable to a patient who contracted AIDS from transfused blood for negligently failing to adopt a particular test for HIV as part of the association's recommended standards). But see, *NNV v. American Association of Blood Banks*, 89 Cal. Rptr. 2d 885 (Cal. Ct. App. 1999) (holding that blood banks had no liability to injured third party based on failure to recommend appropriate HIV test and disagreeing with *Snyder*).
58. See 15 U.S.C. § 1 (2014).
59. 15 U.S.C. § 1125 (2014).
60. *Neurotron v. Med. Serv. Ass'n. of Pennsylvania.*, 254 F.3d 444, 452 (3d Cir. 2001).
61. *Id.*
62. Note that AAEM name has since been changed to the American Association of Electrodiagnostic and Neuromuscular Medicine.
63. *Neurotron v. Am. Ass'n of Electrodiagnostic Med.*, 48 Fed. Appx. 42, 44 (4th Cir. 2002) (citing *United States v. Edge Broadcasting Co.*, 509 U.S. 418, 426 (1993)).
64. *Id.*
65. *Id.*
66. *American Society of Mechanical Engineers, Inc. v. Hydrolevel Corp.*, 456 U.S. 556 (1982) (holding that a nonprofit association violated antitrust laws when members of its standard setting council intentionally set standards to exclude certain types of manufacturers from the market for safety devices used in water boilers).

67. A third-party subpoena is one that is issued by a party in a lawsuit to a non-party that has information that the issuing party believes to be germane to the suit. See FED. R. CIV. P. 45.
68. *Id.*
69. See e.g. *McKinley v. Fed. Hous. Fin. Agency*, 789 F. Supp. 2d 85, 90 (D.D.C. 2011).
70. FED. R. CIV. PRO. 27–34.
71. FED. R. CIV. PRO. 26(c).
72. See, e.g., *Farnsworth v. Proctor & Gamble*, 758 F.2d 1545, 1547–48 (11th Cir. 1985) (stating that the interests against disclosing the names of patients participating in a CDC registry outweighed Proctor and Gamble’s need for disclosure of the personal information of the registry participants); *Deichtman v. E.R. Squibb & Sons*, 740 F.2d 556, 564–65 (7th Cir. 1984) (finding the interests of protecting patient information in a University-sponsored registry outweighed the company’s need for discovery).
73. See *Johnson v. Thompson*, 971 F.2d 1487 (10th Cir. 1992).
74. FED. R. EVID. 404.
75. 758 F.2d 1545 (11th Cir. 1985).
76. 740 F.2d 556 (7th Cir. 1984).
77. *Id.* at 566.
78. *Wolpin v. Philip Morris*, 189 F.R.D. 418 (C.D. Cal. 1999).
79. 45 C.F.R. §164.512(e).
80. 45 C.F.R. §164.502.
81. 42 U.S.C. §§ 299b-2, 299b-26. Patient safety work product means “any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements—
  - i. Which—
    - I. are assembled or developed by a provider for reporting to a patient safety organization and are reported to a patient safety organization; or
    - II. are developed by a patient safety organization for the conduct of patient safety activities; and which could result in improved patient safety, health care quality, or health care outcomes; or
  - ii. which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system.*Id.* at 42 U.S.C. § 299b–21(7)(A).  
 Patient safety work product does not include—
  - i. Information described in subparagraph (A) does not include a patient’s medical record, billing and discharge information, or any other original patient or provider record.
  - ii. Information described in subparagraph (A) does not include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Such separate information or a copy thereof reported to a patient safety organization shall not by reason of its reporting be considered patient safety work product.
  - iii. Nothing in this part shall be construed to limit—
    - I. the discovery of or admissibility of information described in this subparagraph in a criminal, civil, or administrative proceeding;
    - II. the reporting of information described in this subparagraph to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes; or
    - III. a provider’s recordkeeping obligation with respect to information described in this subparagraph under Federal, State, or local law.*Id.* at 42 U.S.C. § 299b–21(7)(B).
82. 42 U.S.C. § 299b-22.
83. 42 U.S.C. §§ 299b-21(2), 229b-24.
84. 42 U.S.C. § 299b-22.
85. *Id.*; 42 U.S.C. §299b-24; 42 C.F.R § 3.306 (2014); 42 C.F.R. § 3.308 (2014).
86. 42 C.F.R. §§ 3.206(a); 3.20 (2014).
87. 42 C.F.R. §§ 3.108(b)(3); (c)(2)(ii) (2014).
88. *Tibbs v. Bunnell*, No. 2012-SC-000603-MR at 13 (Ky. Aug. 21, 2014) (quoting 42 U.S.C. § 299b-21(7)(B)).
89. *Tibbs*, No. 2012-SC-000603-MR at 21–22 (citing 902 KAR 20:016 § 3).
90. *Id.* at 23. In dissent Justice Abramson disagreed, concluding that the PSO privilege “protect[s] provider safety data until it is published somehow outside the patient safety system,” for example, through a hospital record or report actually submitted to the government, and precludes the “invasion of the patient safety evaluation system itself.” *Id.* at 33–36.
91. *Charles v. Southern Baptist Hospital of Florida*, No. 16-2012-CA-002677 at 8 (Fla. Cir. Ct. Jul. 30, 2014)
92. *Id.* at 9. See also 73 Fed. Reg. 70,732, 70,742 (Nov. 21, 2008).
93. *Id.* at 8–9.
94. Susan Greene Merewitz, *Memorandum on Statutory Confidentiality Protection of Research Data*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (Apr. 16, 2001), <http://archive.ahrq.gov/fund/datamemo.htm>.

95. Steven Suydam, et al., *Patient Safety Data Sharing and Protection from Legal Discovery*, 3 ADVANCES IN PATIENT SAFETY 361, 363 (2005), available at <http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/advances-in-patient-safety/vol3/Suydam.pdf> .
96. *Contra* 42 U.S.C. § 241(d) (2013) (stating that the Secretary of HHS may authorize individuals involved in HHS-sponsored research to protect the identity of their subjects and stating that such information is not discoverable). For more information on the Certificates of Confidentiality discussed in 42 U.S.C. § 241(d), see § II(e), *infra*.
97. United States Dep't of Health and Human Servs., *Certificates of Confidentiality: Background Information*, NAT'L INST. OF HEALTH, <http://grants2.nih.gov/grants/policy/coc/background.htm> (last updated Jan. 20, 2011). See also United States Dep't of Health and Human Servs., *Certificates of Confidentiality: Frequently Asked Questions*, HEALTH RES. AND SERV. ADMIN., <http://www.hrsa.gov/publichealth/clinical/HumanSubjects/faqs.html> (last visited Sept. 1, 2014).
98. 42 U.S.C. § 241(d) (2014).
99. United States Dep't of Health and Human Servs., *Certificates of Confidentiality: Background Information*, NAT'L INST. OF HEALTH, <http://grants2.nih.gov/grants/policy/coc/background.htm> (last updated Jan. 20, 2011).
100. United States Dep't of Health and Human Servs., *Frequently Asked Questions: Certificates of Confidentiality*, NAT'L INST. OF HEALTH, <http://grants.nih.gov/grants/policy/coc/faqs.htm> (last revised June 20, 2011).
101. *Id.*
102. *Id.*
103. See, e.g., Illinois Medical Studies Act, 735 ILL COMP. STAT. 5/8-2101 (2014).
104. *Application of American Tobacco Co.*, 880 F.2d 1520, 1528 (2d Cir. 1989) (citing *Deitchman*, 740 F.2d at 560–61) (holding that in New York there was no such “scholar’s privilege”).
105. 672 F.2d 1262 (7th Cir. 1982).
106. 162 F.3d 708 (1st Cir. 1998).
107. *Id.* (citing *In re Madden*, 151 F.3d 125, 12–31 (3d Cir. 1998)); *Shoen v. Shoen*, 5 F.3d 1289, 1293–94 (9th Cir. 1993); *von Bulow v. von Bulow*, 811 F.2d 136, 142–44 (2d Cir. 1987).
108. See e.g., *Humane Society of the United States v. Superior Court of Yolo County*, 214 Cal. App. 4th 1233 (Cal. App. 2013).



February 10, 2015

The Honorable Fred Upton  
Chairman, House Energy and Commerce Committee  
2125 Rayburn House Office Building  
Washington, DC 20515

Dear Congressman Upton:

On behalf of the over 3,000 members of the Population Association of America (PAA) and more than 40 population research centers nationwide comprising the Association of Population Centers (APC), I am writing to share comments on the recently released draft of the 21<sup>st</sup> Century Cures discussion draft. I am commenting on the discussion draft in my capacity as the Chair of the PAA/APC Government and Public Affairs Committee. Also, in the interest of full disclosure, I am a former Deputy Director for Extramural Research at the National Institutes of Health (NIH).

To refresh your memory from previous correspondence, PAA ([www.popassoc.org](http://www.popassoc.org)) and APC ([www.popcenters.org](http://www.popcenters.org)) are two affiliated organizations that together represent over 3,000 behavioral and social scientists, demographers, epidemiologists, economists, sociologists, and over 40 population research centers nationwide, including two centers in Michigan, that conduct research on the implications of population change. Our members' research interests are very diverse and include longevity, chronic diseases, disability, adolescent health, population aging, immigration, marriage and divorce, health disparities, and population forecasting. Our members compete for discretionary grant funds awarded primarily by the NIH and National Science Foundation (NSF) and rely on data generated by the federal statistical agencies to conduct research and evaluation activities and train undergraduate and graduate students. Therefore, our interests in the 21<sup>st</sup> Century Cures bill are limited to its potential impact on the NIH. Below are our specific recommendations on certain sections of the discussion draft affecting the NIH.

**TITLE II- BUILDING THE FOUNDATION FOR 21<sup>ST</sup> CENTURY MEDICINE, INCLUDING HELPING YOUNG SCIENTISTS**

**Subtitle N-21<sup>st</sup> Century Chronic Disease Initiative Act**

The discussion draft includes this provision, requiring NIH to “plan” for a longitudinal study regarding chronic disease and Alzheimer’s disease, in particular. Our members are experts in the design, development, and execution of NIH-funded, large-scale multidisciplinary-longitudinal studies. Our members include the principal investigators of some of the most prominent longitudinal studies the NIH supports, such as the Health and Retirement Study, National Longitudinal Study on Adolescent to Adult Health, and National Health and Aging Trends Study. These studies, as well as many others, have been in the field for over 20 years, gathering demographic, social, behavioral, biological, health, and genetic data about their participants. Many of these studies have evolved into invaluable resources for understanding the health outcomes targeted proposals the Committee is considering in the current discussion draft. They also have made clear the need for long-term surveillance of large representative cohorts and the incorporation of measurement of early life, behavioral,

social, and economic factors with genetic and biological data to understand complex diseases. These surveys represent decades of thoughtful investment and scientific design.

NIH already devotes significant funding to a number of large-scale longitudinal studies involving individuals throughout the life course. Given the current inventory of varied studies and the significant fiscal resources it requires to design, launch, and manage another large-scale longitudinal study, I am pleased that the current draft recommends a preliminary planning stage rather than requiring the agency to launch immediately a costly and cumbersome longitudinal study. Nonetheless, NIH's recent decision to terminate the National Children's Study, a proposed longitudinal study that would have followed 100,000 children from birth to age 21, after years of "planning" and over a billion dollars of initial investment, is a cautionary example. The language in this section may seem benign, yet I recommend the Committee remove it and consider a modified proposal that would achieve the study's objectives by building upon existing NIH-funded longitudinal studies. I recommend including language in the bill report rather than in the bill, encouraging the NIH to expand existing longitudinal studies to achieve the proposal's objectives.

#### **Subtitle O-Helping Young Emerging Scientists**

The average age of the first-time NIH grantees has been steadily increasing for a number of reasons. While NIH policies and procedures may have inadvertently contributed to the current circumstances, the agency is not solely responsible. Contributing factors may also include enhanced graduate research training requirements, the availability of faculty appointments at research universities, heightened competition, and decreased availability of funding. The discussion draft authorizes NIH to conduct a study on the reasons why there has been a "substantial increase" in the age of first-time NIH grantees. A thorough, objective examination of the topic should produce new insights to inform thoughtful changes in extramural and institutional policies and, ideally, encourage early career investigators.

I am concerned that this section, however, also would redirect funds from the Public Health Service Evaluation Set-Aside fund back to the NIH to support grants for emerging scientists. Mandating NIH to spend funds in this matter, particularly before the agency examines the underlying issues and submits the required report, is a premature and potentially detrimental proposal. I am concerned that compelling NIH to use evaluation tap funds in this manner will undermine support for other important trans-NIH and HHS evaluation activities and divert funding for proposals that may score better in peer review. For these reasons, I support eliminating this section of Subtitle O.

### **TITLE IV- ACCELERATING THE DISCOVERY, DEVELOPMENT, AND DELIVERY CYCLE AND CONTINUING 21<sup>ST</sup> CENTURY INNOVATION AT NIH, FDA, CDC, AND CMS**

#### **Subtitle A -National Institutes of Health**

Section 4001 requires the NIH to issue "a "5-year biomedical research strategic investment plan" to make funding allocation decisions, including strategic investment for each institute; have a common format; and identify strategic focus areas. While I can see the appeal of a trans-NIH strategic plan, I believe it is superfluous. Currently, each NIH Institute and Center produces its own 5-year strategic plan, allowing public participation and comments. Because each Institute and Center receives its own annual

appropriation, I believe the current approach ensures each IC is developing visionary, but attainable, goals and making strategic investments. The Institutes vary in terms of the range of mechanisms that support their scientific mission; having a homogenous plan could work against this necessary variability. I am not convinced that an overarching NIH strategic plan will enhance fiscal or scientific transparency or accountability. I am also concerned that the plan will be used to ensure NIH is spending “at least 55 percent” of its funds to support basic biomedical extramural research. Different areas of science are more or less ready to move to the clinical application of basic research findings. The process of peer review to determine merit and Council review to assist the Institutes in making portfolio judgments is sufficient without an arbitrary percentage goal. This language imposes a congressional mandate on a process that works well already to select the most meritorious science research projects. In addition, I am concerned that this language could exclude the participation of certain scientific disciplines in the NIH peer review and award processes. At the very least, I recommend modifying this section by eliminating the word “biomedical.” I am certain that the authors of this provision did not mean to exclude the full range of scientific disciplines, including the physical, engineering, biological, social, and behavioral sciences and interdisciplinary research teams from competing for NIH funds; however, this language could have such a chilling effect.

**Section 4004—Increasing Accountability at the National Institutes of Health**

The proposed IC Director term limits could have unintended consequences, particularly on the agency’s management and decision making processes. The NIH Director already has the authority to hire and fire IC Directors. Further, NIH convenes groups of internal and external experts on a regular basis to review the IC Directors. I am not convinced that term limits will add value to this process. In addition, I believe language requiring the IC Directors to review all “R series” awards is unnecessary. IC Directors, in collaboration with program staffs and the national advisory councils, which provide the second level of peer review, already review all grants recommended for funding.

Thank you for your consideration of my views on behalf of the PAA and APC. The PAA Director of Government and Public Affairs, Mary Jo Hoeksema, and I are happy to discuss our views with your staff as the 21<sup>st</sup> Century Cures Discussion Draft proceeds through the legislative process.

Sincerely,



Wendy Baldwin, Ph.D.  
Chair, PAA/APC Government and Public Affairs Committee

cc The Honorable Diana DeGette



# Prescriptions for a Healthy America

"A Partnership for Advancing Medication Adherence"

February 10, 2015

Chairman Fred Upton  
Committee on Energy & Commerce  
United States House of Representatives  
2125 Rayburn House Office Building  
Washington, DC 20515

Dear Chairman Upton,

Prescriptions for a Healthy America (P4HA; [www.adhereforhealth.org](http://www.adhereforhealth.org)) appreciates the opportunity to comment on your draft 21<sup>st</sup> Century Cures legislation. P4HA is a multi-stakeholder alliance representing patients, providers, pharmacies, pharmacists, employers and life science companies. We joined together to raise awareness on the growing challenges posed by medication nonadherence and to advance public policy solutions that will help reduce health care costs and improve the lives of patients across the nation through improved medication adherence.

Poor medication adherence, or non-adherence, limits effective management and control of chronic illnesses. Non-adherence increases the likelihood of preventable disease progression, increased hospitalizations, avoidable doctor and emergency room visits, and other problems arising from poor health, which can significantly increase costs. At least 125,000 Americans die annually due to poor medication adherence. We know that as adherence declines, emergency room visits increase and hospital stays increase. Poor medication adherence results in 33% to 69% of medication-related hospital admissions in the United States, at a cost of roughly \$100 billion per year. This is why CBO has changed its methodology related to adherence by recognizing health services savings resulting from increased utilization of prescription medications.

P4HA strongly supports the Committee's proposal for accelerating the discovery, development, and delivery of promising new treatments and cures for patients. Because treatments do not work in patients who do not take them, patient engagement during the delivery of care is essential. Policies and models that therefore aim to improve proper medication adherence, defined as when a patient takes their medications as directed, have considerable potential to reduce health spending and improve health outcomes and should be considered within the 21<sup>st</sup> Century Cures initiative.

Our comments are outlined below:

**Title I. Subtitle M- New Therapeutic Entities**

*Sec. 1241- Extended exclusivity period for certain new drug applications and abbreviated new drug applications.*

Section 1241 extends the exclusivity period for new drug applications if the new therapy has been reformulated or redesigned to promote greater patient adherence relative to the previously approved formulation of the drug. While we applaud the Committee for recognizing the importance of improving patient adherence, we believe that there is not enough guidance in the draft legislation on how to determine whether the redesigned products improve adherence enough to receive the additional patent exclusivity. We suggest providing parameters around the incentive to help ensure it is targeted appropriately at those products that truly improve medication adherence.

Medication adherence is commonly measured in Medicare Part D based on the proportion of days covered (PDC), which has been endorsed by both the Pharmacy Quality Alliance (PQA) and the National Quality Forum (NQF). This measurement, however, is based on pharmacy fill data for chronic medications and may not adequately measure adherence to new therapies.

Instead, the Committee should explore a more integrated measure of increased adherence by coordinating the medical or clinical outcomes data to pharmacy fill data. This method would correlate improved adherence with improved clinical outcomes, thus illustrating a more meaningful measure for the value of improved patient adherence to treatments. Linking the medical data to pharmacy data will also allow for a more adequate snapshot of the monetary value of improved adherence.

We look forward to working with the Committee to ensure this section of the bill is more robustly developed.

## **Title II, Subtitle E- Sensible Oversight for Technology Which Advances Regulatory Efficiency**

### *Sec. 2061- Medical and Health Software Defined*

Section 2061 clarifies that software intended for use by patients for self-management or self-monitoring of a disease or condition, including management of medications is defined as 'health software' and is therefore not regulated by the FDA. P4HA supports this provision as it helps to clarify current uncertainty in the regulatory environment. This clarity helps to foster continued innovation in health software that can be further leveraged for increased patient engagement in the management of their medication regimens and health outcomes.

## **Title II, Subtitle F – Building a 21<sup>st</sup> Century Data Sharing Framework**

We appreciate the Committee's focus on the use and sharing of data to improve health and health outcomes. P4HA believes that as medication adherence is researched in the marketplace, data that links patient medical outcomes to patient pharmacy interventions is missing.

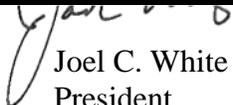
For example, currently, the Medicare Part D Medication Therapy Management (MTM) program is one of the only federal interventions in place that specifically aims to improve

medication adherence. CMS has tailored the program to target 25 percent of Medicare Part D beneficiaries, but only 9 percent of those beneficiaries opt in to the program. CMS, Medicare Part D plans, and Part D MTM providers are all limited in their ability to optimize the Part D MTM program because there is limited evidence on both program effectiveness and cost effectiveness. In order to gain a more accurate snapshot of why the program is not reaching its intended audience (i.e. the target criteria are outdated and inadequate, the beneficiaries are not notified appropriately, the intervention is not ideal, and/or beneficiaries do not benefit medically from the program, etc.), we believe the Committee should include the following provisions:

1. Collect and release data for the purpose of analyzing the MTM program (include in *Section 2086. Empowering patient research and better outcomes through CMS data*)
  - CMS data on Medicare Part D plans should be made available to external researchers. All qualified researchers in the private or public sectors should be permitted access.
  - The MTM data file should include identifiers that allow direct linkages to the traditionally available CMS chronic condition warehouse research identifiable files, including CMS beneficiary administrative records, Parts A, B, and D claims data, and plan characteristics files. In particular, data elements should include: indicators for eligibility and participation in MTM and receipt of a Comprehensive Medication Review (CMR) or Targeted Medication Review (TMR); characteristics of the MTM services provided (e.g. setting, mode of delivery, date and duration of service, initial vs. follow up); provider characteristics; and characteristics of outreach efforts (e.g. frequency, method).
  - Data on medical service use should also be made available for Medicare Advantage enrollees to allow for broader analysis of this and other programs.
2. PDPs should have timely access to Parts A and B data for their enrollees (include in *Section 2085. Expanding availability of Medicare data*)
  - PDPs are limited in their ability to identify beneficiaries who are most likely to benefit from MTM or other adherence improving activities because they cannot observe Medicare Parts A and B claims data, which can provide critical information about enrollees' use and spending on medical services, risk for adverse health events, and transitions in care. These data should be provided to PDPs on a regular basis in a format that is readily accessible to PDPs in their quality improvement efforts (e.g. flags indicating beneficiaries who recently experienced a hospital readmission).

Thank you for the opportunity to comment on the draft legislation. We look forward to working with you to further improve 21<sup>st</sup> Century Cures and ensure patients are properly adhering to those cures. If you have any questions or would like to discuss further, please do not hesitate to reach out via email ([joel.white@cahc.net](mailto:joel.white@cahc.net)) or phone (202-559-0192).



  
Joel C. White  
President

February 10, 2015

The Honorable Fred Upton  
Chairman  
Energy & Commerce Committee  
United States House of Representatives  
Washington, DC 20515

Dear Chairman Upton:

Purdue University commends leadership and members of the Energy & Commerce Committee on the draft language for the *21<sup>st</sup> Century Cures Act* and welcomes the opportunity to comment on certain provisions. With preeminent scientists and scholars in agriculture, business, education, engineering, science, health care, environmental and energy sciences, humanities, manufacturing, technology, veterinary medicine and the arts, Purdue is a national and global leader in discovery and innovation.

The Purdue research enterprise received \$390 million in sponsored-program research funding in fiscal 2014, including \$229 million from federal government investments (ranked 25th out of 406 public academic institutions for federal R&D) in fiscal year 2013. Among its many research strengths, Purdue has committed to maintaining and increasing its global leadership in biomedical, pharmaceutical, and cancer research.

The *21<sup>st</sup> Century Cures* draft language has many provisions of interest to Purdue University; the comments below pertain only to the provisions of highest priority for the University:

- The 21<sup>st</sup> Century Cures Consortium
- Medical Product Innovation Advisory Commission
- Helping Young Emerging Scientists
- *Clinical Research Modernization Act*
- Additional Funding for NIH Brain Research

**TITLE II**

**21<sup>st</sup> Century Cures Consortium, and**  
**Medical Product Innovation Advisory Commission**

Purdue University's Center for Cancer Research is one of only seven National Cancer Institute-designated basic research centers in the nation. The Center promotes interdisciplinary research in prevention, detection and treatment of cancer – advancing discoveries from the lab to be used by doctors to benefit patients. As one of the preeminent drug discovery centers in the United States, we engage in drug discovery across disciplines and institutions, translate basic research into clinical applications, educate the next generation of researchers in drug discovery and commercialize innovations for the marketplace — all with the goal of developing new diagnostic tools and treatments for people in need. More than 100 faculty members at Purdue focus on discoveries to improve lives for people affected by cancer. Currently, there are 14 Purdue-developed drugs in clinical trials, while there are 36 Purdue-developed compounds currently in clinical development.

Boilermaker Health Innovations is a not-for-profit company created by Purdue researchers to take early drug discoveries and move them through proof of principal clinical trials. A new approach to improve drug development, Boilermaker Health Innovations has the potential to move drugs faster from discovery to the clinic and fund future research from successes.

As a global leader in drug discovery research, Purdue University strongly supports the establishment of the public-private partnership consortium through the language of the *21<sup>st</sup> Century Cures Consortium Act* (Section 2001); and the Medical Product Innovation Advisory Commission (Section 2021). With ample drug discovery expertise, Purdue would be eager to nominate well-qualified candidates from its faculty to serve on either of these groups if they were to come to fruition.

### **Helping Young Emerging Scientists**

Purdue University supports new programs of competitive research out of existing funding opportunities at federal science agencies targeted toward exceptional young scientists and engineers. This could include expanding existing early career award programs, creating new young investigator research awards for promising scientists under 45 years old, and grants to top postdoctoral appointees who are seeking their first faculty appointments.

As the federal grant process continues to become more competitive, and the ratio of grant proposals to awards continues to climb, guaranteeing a funding set aside for young scientists insures the pipeline of scientific researchers continues to produce the best and brightest. Young scientists are also often cited for new and novel approaches to questions and theories of research merit, providing both the critical and innovative approach to science that often provides for scientific breakthroughs.

### **TITLE III**

#### **Clinical Research Modernization Act**

Purdue University supports the inclusion of the *Clinical Research Modernization Act* in *21<sup>st</sup> Century Cures*. By reducing regulatory overlap and administrative inefficiency, in addition to encouraging broader utilization of efficient, flexible trial designs, the *Clinical Research Modernization Act* would eliminate redundant procedural requirements from the institutional review board process that do not add to the safety or efficacy of the research being conducted. Simplifying the regulatory system without reducing the necessary oversight and safety requirements for federal research grants will allow researchers and grantees to focus more of their time and resources on scientific pursuits.

#### **Additional Funding for NIH Brain Research**

A primary goal of the BRAIN Initiative is to understand human brain function in a way that will translate new discoveries and technological advances into effective diagnosis, prevention, and treatment of human brain disorders. The study of human brain function faces major challenges because many experimental approaches applicable to laboratory animals cannot be deployed in humans. Nevertheless, direct study of the human brain is critical because of our unique cognitive abilities as well the profound personal and societal consequences of human brain disorders.

The Honorable Fred Upton  
February 10, 2015  
Page 3

Purdue Neurotrauma Group's (PNG) current research examines the connection between mild traumatic brain injury (mTBI) biomechanics and the underlying pathophysiology as well as methods for the prevention of mTBI. Our research methods include the use of functional magnetic resonance imaging (fMRI), neurocognitive testing, sports telemetry, and finite element analysis. By combining these diverse methods, PNG seeks to better understand the nature of mTBI and to develop improved methods of detection and prevention.

The NIH, the National Science Foundation, the Food and Drug Administration and the Defense Advanced Research Projects Agency committed more than \$110 million to the BRAIN Initiative for fiscal year 2014. Maintaining this funding level will provide the sustainability and certainty needed by researchers to remain intensely dedicated to scientific studies that will lead to a greater understanding of the human brain.

### **Conclusion**

We hope you find this input to the draft language informative, and we welcome the opportunity to continue the dialogue on this bill and related matters. Thank you again for your thoughtful leadership and the opportunity to comment.

Sincerely,



Suresh V. Garimella  
Executive Vice President for Research and Partnerships  
Purdue University



The Honorable Fred Upton  
Chairman  
House Committee on Energy and Commerce  
2125 Rayburn House Office Building  
Washington, DC 20515

The Honorable Diana DeGette  
Ranking Member  
Subcommittee on Oversight and Investigations  
House Committee on Energy and Commerce  
2368 Rayburn House Office Building  
Washington, DC 20515

February 10, 2015

Dear Chairman Upton and Ranking Member DeGette,

The Roundtable on Critical Care Policy appreciates the work of Committee leaders thus far on the discussion draft of the 21st Century Cures initiative. We believe this draft legislative language takes important initial steps toward crafting a policy framework that can accelerate the discovery, development, and delivery of promising new treatments and cures for patients, in particular the critically ill and injured. That said, we also hope that as the draft goes through coming revisions, you will consider making further enhancements to support medical innovation in the critical care community – for patients, caregivers and intensive care units (ICUs) themselves – on whose behalf the Roundtable advocates.

Critical care medicine is the care of patients whose illnesses or injuries present a significant danger to life, limb, or organ function, and encompasses a wide array of diseases and health issues, including respiratory failure, shock, severe infection, traumatic injury, burns, neurological emergencies and multi-system organ failure. Care provided to patients in the ICU is highly specialized and complex due to the extreme severity of illness of its patient population, and often involves multiple disease processes in different organ systems at the same time. Each year, five million Americans are admitted into adult medical, surgical, pediatric, or neo-natal ICUs<sup>1</sup>.

Given the expansive application of critical care medicine across patient categories – from those with chronic diseases to those who have medical emergencies; from infants born prematurely to aging Americans with advanced illness – there is little doubt that policies which can foster innovation in critical care therapies are fully aligned with the objectives of the 21st Century Cures initiative. And while we have witnessed major innovations in virtually every other segment of medicine, there have been relatively few advances in critical care therapies in recent decades. For the population of patients who require critical care – where there is grave need and treatment can be exceedingly risky and costly – the next generation of innovation is truly necessary. We know that there is currently no formal coordination within the federal research infrastructure for critical care therapies and treatments, and we believe that this lack of coordination can be addressed in ways that will appropriately prioritize critical care research as a distinct and vital field of medicine. This will also ensure that ongoing research

activities are streamlined and fully leveraged for the best possible outcomes in next-generation critical care medicine.

With this in mind, we respectfully urge the Committee to consider adding language to its draft that will improve the coordination of research aimed at the critically ill and injured. More specifically, the Roundtable encourages the inclusion of legislative language that was a central element of the bipartisan Critical Care Assessment and Improvement Act in the 113<sup>th</sup> Congress (H.R. 2651 and Senate companion S. 2966). The legislation creates a Critical Care Coordinating Working Group within the National Institutes of Health (NIH) to help facilitate information sharing among the various Institutes, grantees and affiliates. A Coordinating Working Group, which would add no new cost to the system, would serve to both identify critical care research gaps where resources could be more appropriately allocated, as well as identify duplicative projects. Such a Working Group would also foster needed collaboration between the institutes and strengthen partnerships between the NIH and public and private entities to expand cross-cutting critical care research without costing the Federal government additional money. The language from those measures is below.

*NIH CRITICAL CARE COORDINATING WORKING GROUP.*

*(a) Establishment- The Secretary shall establish a working group within the National Institutes of Health to be known as the Critical Care Coordinating Working Group (in this section referred to as the `Working Group').*

*(b) Membership- The Secretary shall ensure that the membership of the Working Group includes representatives throughout the National Institutes of Health and any other component of the Department of Health and Human Services, as the Secretary determines appropriate to increase agency coordination on critical care, and based on existing resources, such as --*

*(1) the National Heart, Lung, and Blood Institute;*

*(2) the National Institute of Nursing Research;*

*(3) the Eunice Kennedy Shriver National Institute of Child Health and Human Development;*

*(4) the National Institute of General Medical Sciences;*

*(5) the National Institute on Aging; and*

*(6) the National Institutes of Minority Health.*

*(c) Duties- The Working Group shall--*

*(1) serve as the focal point and catalyst across the National Institutes of Health and any other component of the Department of Health and Human Services, as the Secretary determines appropriate for advancing research and research training in the critical care setting;*

*(2) coordinate funding opportunities that involve multiple components of the Department of Health and Human Services;*

*(3) catalyze the development of new funding opportunities;*

*(4) inform investigators about funding opportunities in their areas of interest;*

*(5) represent the National Institutes of Health in government-wide efforts to improve the Nation's critical care system;*

- (6) coordinate the collection and analysis of information on current research of the National Institutes of Health relating to the care of the critically ill and injured and identify gaps in such research;*
- (7) provide an annual report to the Director on the National Institutes of Health regarding research efforts of the Institutes relating to the care of the critically ill and injured; and*
- (8) make recommendations in such report on how to strengthen partnerships within the National Institutes of Health and between the Department of Health and Human Services and public and private entities to expand collaborative, cross cutting research.*

While we hope that this no-cost, non-partisan modification can be made to the draft, we also note that we were pleased that two Roundtable-supported provisions—the utilization of real-world evidence in the regulatory decision-making process when evaluating new treatments and the incorporation of patient- and physician-reported outcomes—were included in the recently released discussion draft. We believe both these measures will facilitate the innovation of new therapies in the ICU, and recognize the unique challenges of critical care patients, and we commend the Committee for their support of this community. There are many patients – including those in the ICU, neonatal ICU and pediatric ICU – who cannot provide feedback in the evaluation of critical care therapies, and thus physician-reported data are also appropriate and necessary for the critical care population. The Roundtable encourages the Committee to ensure that physician perspectives are considered, especially for vulnerable populations such as critical care patients, when considering patient perspectives in drug development. We encourage the Committee to ensure that both real world evidence and patient- and physician-reported outcomes remain in any final proposal.

We thank you for your consideration of our request and feedback. Should you have any questions, please don't hesitate to contact Erik Olson at [eolson@criticalcareroundtable.org](mailto:eolson@criticalcareroundtable.org), or (202)466-8700.



*Stephanie Silverman*

Stephanie Silverman  
President

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<sup>i</sup> Society of Critical Care Medicine. Critical care statistics in the United States.  
<http://www.sccm.org/AboutSCCM/Public%20Relations/Pages/Statistics.aspx>



SAREPTA  
THERAPEUTICS

February 10, 2015

The Honorable Fred Upton, Chairman  
The Honorable Diana DeGette  
Committee on Energy and Commerce  
United States House of Representatives  
2125 Rayburn House Office Building  
Washington, DC 20515

**Re: Comments on 21<sup>st</sup> Century Cures Initiative Discussion Draft**

Dear Chairman Upton and Representative DeGette:

Sarepta Therapeutics commends the United States House of Representatives Committee on Energy and Commerce for its leadership on the 21<sup>st</sup> Century Cures Initiative and the release of the first legislative discussion draft. We share your goal of accelerating the discovery, development and delivery of next generation modern medicines that will transform the lives of patients. The discussion draft truly reflects the hard work undertaken by you and your staff to ensure input from a broad range of stakeholders in the health community is considered as an integral part of your legislative process.

We are pleased to see a provision included in the discussion draft that aims to advance FDA's regulatory processes and policies to keep pace with the development of innovative personalized/precision therapies which hold the promise of treating the ever smaller patient populations and subpopulations that are being identified. Section 2051 – *Genetically Targeted Therapeutic Platform Technologies for Rare Diseases* – provides a clear regulatory framework that will spur innovation and recognize the potential benefits afforded by personalized therapeutic platform approaches, help overcome the difficulties of doing conventional trials for many extremely rare conditions, create efficiencies in the FDA's review process, and, most importantly, result in bringing much needed treatments to patients faster and where there are urgent unmet medical needs.

To aid in your discussions regarding provisions contained in the discussion draft, we are submitting a one-pager attached to this letter that will provide you more context and rationale supporting the need for Section 2051. In addition, we are providing for your consideration edits on Section 2051, based on initial feedback we received, with the intent of clarifying that extrapolation of data should only be allowable where that data is owned by the applicant or there is otherwise a right of reference. We will be sure to continue to share with you any other feedback we receive during our discussions with industry and the rare disease community.

There are many other provisions contained in the discussion draft that we embrace, including the focus on precision medicine, modernizing clinical trials, and, most importantly the efforts you have taken to build upon the groundwork in FDASIA to ensure patients play a key role in the drug development and regulatory processes. Section 2051 is inextricably linked to the patient community, as it was the urgent demand from the Duchenne muscular dystrophy community for drugs to treat all subpopulations, down to the rarest, of the disease that spurred the need for having a viable, clear regulatory pathway. We will continue to work with and support the efforts of our partners in the patient community as the draft bill evolves.

We look forward to continuing to work with you and other members of the Committee on this critical initiative.

Sincerely,

Chris Garabedian  
President & CEO  
Sarepta Therapeutics

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**Florence P. Haseltine, PhD, MD**  
Founder  
Society for Women's Health Research  
Alexandria, VA

**Phyllis Greenberger, MSW**  
President and CEO  
Society for Women's Health Research  
Washington, D.C.

February 12, 2015

The Honorable Fred Upton  
Chairman  
Committee on Energy and Commerce  
2125 Rayburn House Office Building  
Washington, DC 20515

The Honorable Diane DeGette  
Committee on Energy and Commerce  
2125 Rayburn House Office Building  
Washington, D.C. 20515

Dear Chairman Upton and Representative DeGette:

On behalf of the Society for Women's Health Research (SWHR), we would like to thank you for providing the opportunity to comment on the current 21<sup>st</sup> Century Cures Discussion Draft.

We support the work of the "21<sup>st</sup> Century Cures Initiative" and its efforts to accelerate the discovery, development, and delivery of new medical treatments and cures to patients. We also appreciate the approach to this task, which has provided a systematic examination of the needs of the country's biomedical infrastructure and the essential tools and investments that our federal agencies will need to maintain the United States' standing as the leader in biomedical research and innovation. SWHR has long advocated for sustained investment in biomedical research and has specific recommendations enumerated on the discussion draft that are discussed in greater detail in the document below.

SWHR is a national nonprofit organization based in Washington, D.C. dedicated to improving women's health through advocacy, education, and research, and is widely recognized as the thought leader in promoting women's health research and sex-based biology. Since its founding 25 years ago, SWHR has been a strong advocate of greater public and private funding for basic science and biomedical research that can advance scientific knowledge, transform the quality of medical care, and enable personalized evidence-based treatment options for women. Our organization was instrumental in securing the mandate to include women and minorities in federally funded research in the passage of the National Institutes of Health (NIH) Reauthorization of 1993.

Science has demonstrated that the future of medicine lies in

developing therapies to targeted populations, yet women and minorities are still vastly underrepresented in the medical research enterprise. Much work remains to be done to combat this inequity. Part of that effort is the continuing need to increase knowledge of the importance of sex and gender differences during all phases of medical research so that clinical trials can be designed to truly reflect patient populations and lead to improved treatments.

Issues surrounding the collection, analysis, and usage of data are fundamental components of the discussion draft, as all research relies upon the strength of data generated. Medical research could be revolutionized by appropriately capturing, analyzing and translating better demographic data to researchers, physicians, and patients. SWHR has long argued that all stages of biomedical research must include sex as a fundamental biological variable where appropriate. In 2001, the Institute of Medicine (IOM) definitively confirmed that being male or female, was an important “basic variable that should be considered in designing and analyzing studies in all areas and at all levels of biomedical and health related research.”<sup>i</sup> Unfortunately, sex is still not considered a critical variable in most basic biological studies and research data is generally not analyzed by sex or by other critical subgroups (i.e. age, race, ethnicity) when it is published. This lack of attention to and recognition of the importance of data as fundamental as one’s biological “sex” must be addressed in our biomedical and health research infrastructure, both public and private, in order to improve research and the translation of that research to the patient.

Outlined below by Title and Subsection SWHR has identified specific areas of interest and or concern. We hope the Committee will find our comments helpful as you continue to work on this important effort.

**Title 1- Putting Patients First By Incorporating Their Perspectives Into the Regulatory Process and Addressing Unmet Needs**

**Subtitle A – Patient Focused Drug Development**

**Section 1001-** SWHR believes that additional methodological considerations need to be incorporated in Title 1- Subtitle A Section 1001-(a) (y) (2) under the meaning of “patient experience data.” These additions would be “patient desired outcomes from new therapies or treatments” and “patient perspective in the decision over assessing benefit versus risk“. These additions also need to be incorporated into section 1001-(b) (1)(B) (i), pertaining to the data points to be collected under the guidance document.

**Subsection D- Antibacterial and Antifungal**

**Section 1064-** The language in the discussion draft presumes that antifungal and antibacterial research trials are appropriately populated with a diverse cross-section of the population impacted. SWHR believes this presumption is not accurate and that there is not sufficient representation from women and minorities in such medical research used to develop these therapies. This belief is backed by information released on November 21, 2014 on the Food and Drug Administration’s Drug SNAPSHOT website which indicated that one antifungal drug, Jublia, was approved in June 2014 with only 23% women in the trial<sup>ii</sup>. Additionally, minority representation was very low, with African American participation at 5.9%<sup>iii</sup>.

**Subtitle E- Priority Review of Breakthrough Devices and Accelerated Approval**

**Section 1081—** SWHR is concerned with language included in Section 515B(b)(2)(c) that would allow for a sponsor to conduct post market data collection to verify clinical benefit or effectiveness after the device has been approved. Priority review and approval of devices should not be allowed when there is inadequate clinical trial data due to insufficient representation of women and minorities to

determine safety and effectiveness in these populations. Many device trials, particularly those in the area of cardiovascular disease (CVD) frequently lack adequate representation of women, minorities and the elderly to thus determine statistical significance or clinical relevance. This lack of adequate representation in CVD trials would only be exacerbated by allowing priority review and accelerated approval. The FDA approval process needs to ensure that a medical product is safe and effective in the populations it is intended to be used in. There is simply too much we do not know about the impact of hormones, reproductive status, body structures, and other differences between women, men, and the impact of age, race, and ethnicity for these to be discovered post approval and after adverse events and side effects are captured. This does a disservice to a large section of the population and is a safety issue. Post-market surveillance, while a valuable source of information that needs adequate FDA monitoring and enforcement, is not enough and should not be the norm or a substitute for what should be discovered in premarket approval.

Companies will meet FDA mandates regarding clinical trial representation (recruitment and retention) to avoid any delay in review and consideration of their applications. If applications must include appropriate subpopulation representation and analysis, then sponsors will ensure that clinical trial participation will change at all phases, and less will need to be discovered post market, often years after approval and use. **We strongly recommend that this draft not provide for this acceleration to market without appropriate study of safety and effectiveness on the populations for which device is intended.** SWHR firmly believes that FDA will work with sponsors and patient groups to address the many gaps in knowledge that do exist as well as representation/participation to capture all potential information possible in a trial prior to approval.

#### **Subtitle J- Streamlined Data Review**

**Section 1181**-SWHR supports a streamlined review process for adding indications to a drug label; however, we feel that the current language makes a presumption that current data demonstrating safety and effectiveness actually includes all demographic subgroup populations, in particular women and minorities, which is often not the case (see previous comment). Language in Section 505F (b)(5) should state that the full data sets submitted to the Secretary and summary data include demographic subgroup analysis.

### **Title II – Building the Foundation For 21<sup>st</sup> Century Medicine, Including Helping Young Scientists**

#### **Subtitle F- Building a 21<sup>st</sup> Century Data Sharing Framework**

**Section 2081**- In clinical research, SWHR still believes that there is insufficient standardization in our clinical trial data collection process which causes researchers to lose a great deal of demographic data that could shed significant light on medical product usage, safety, and effectiveness among women and minorities.

#### **Subtitle G – Utilizing Real World Evidence**

**Section 2101**- SWHR remains concerned that not all available post market data generated by biopharmaceutical companies on real world medication use is reaching health care providers and patients due to restrictions from the FDA, particularly concerning pregnant women, for whom all medicines are generally prescribed off label. We believe open and transparent communication of important scientifically accurate data is important to advancing medical treatments in the digital age and key to fostering discovery and quicker translation to patients.

Companies collect data directly through clinical research, observational studies, exposure registries and medical record research in order to help inform them on the medical decision process and to

drive new research and innovation. They examine comparative data on the actual real world use of approved medicines and look at comparisons between two or more therapies. Further, companies look at sub-populations for safety and effectiveness, including sex and race, to advance scientific knowledge and the opportunity to potentially help healthcare professionals tailor their treatment to meet the needs of individual patients.

Companies are generally restricted by FDA from proactively sharing much of the data that they collect that exists outside of the package insert (PI) and may not add it to the labeling information for usage, as this would be considered a new indication and such data may not have been generated as part of the clinical trials for drug approval. SWHR believes language should be inserted in the proposed guidance in Section 505H(c) that allows for appropriate communication on real world medication use between health care providers and patients, quality of care received, and informed medical decisions on the off label usage of drugs, particularly in pregnant women, if the provisions outlined in Section 505H(c)(2)(a)(b) are met. Access to company data should be established in a way that provides for appropriate communication to health care professionals and patients on medication usage that could improve patients' health outcomes. In particular, subgroup analysis can shed light on important sex differences that will help physicians tailor treatments differently to their male and female populations. For example, companies are required to collect this data in exposure registries by the FDA when a medication is used by pregnant women (as all medications used during pregnancy are off-label) but they are not allowed to discuss any of their findings from their registries directly with health care providers or patients.

SWHR would suggest that this real world data be made accessible and transparently shared with open equal access to all stakeholders from researchers, clinicians, patients and the government as it is critical to ensuring that patients are receiving the most effective care possible.

Additionally, SWHR recommends that the proposed guidance include in Section 505H(c)(2)(B) recommendations on when such data from real world use would trigger FDA requirements for a submission of a new indication for the medical product, and what that process should be to seek such additional indication in light of the real world data, particularly for populations, such as pregnant women where research is restricted or where sufficient numbers of patients for additional research trials are harder to obtain.

### **Title III – Modernizing Clinical Trials**

#### **Subtitle A – Clinical Research Modernization Act**

**Section 3001-** SWHR recommends that the following language be added after Section 491A(b)(3)(B) to instruct IRB's, central, multisite, single and local, to take into account inclusion of both sexes in dual-sex clinical trials and that other demographic subgroups (such as race, age and ethnicity) are adequately represented, data standardized and appropriately analyzed to ensure clinical trials are designed to maximize efficiency.

#### **Subtitle B – Broader Application of Bayesian Statistics and Adaptive Trial Design**

**Section 3021-** SWHR believes our medical research enterprise, including NIH and FDA, should be provided appropriate authority and flexibility to implement a more strategic and efficient trial design to meet the needs of a 21<sup>st</sup> century research design.

We believe that the discussion draft should include language in Section 507B(b) that requires the FDA and NIH to eliminate unnecessary exclusions (such as the automatic exclusion of anyone over

age 75 or pregnant women) from clinical trial protocols, to the maximum extent feasible. As a general rule, FDA and NIH should seek to ensure that study participants reflect the real-world population for which the treatment/intervention will ultimately be used.

Additionally, language should be inserted after Section 507B(b)(2)(3) that requires FDA to establish an ongoing Advisory Committee for **subgroups underrepresented in clinical research studies** (women, minorities, the elderly) that will make recommendations to improve participation rates, analysis of subgroup data, reporting and making publically available all subgroup data. This Advisory Group would be similar to the FDA's Pediatric Advisory Committee. The voting members should include at least one representative from a relevant patient or patient-family organization and one representative that represents consumer interests and is recommended by either a consortium of consumer-oriented organizations or other interested persons.

**Title IV- Accelerating the Discovery, Development, and Delivery Cycle and Continuing 21<sup>st</sup> Century Innovation at NIH, FDA, CDC, AND CMS**

**Subsection A – National Institutes of Health**

In 2014, the National Institutes of Health (NIH) signaled that they will be developing policies that require applicants to report their plans to balance male and female cells and animals in preclinical studies in all future applications, unless sex-specific inclusion is unwarranted, based on rigorously define exceptions. We believe that the 21st Century Cures Discussion Draft could provide the NIH with appropriate incentives and accountability to codify the development and full implementation of these policies. NIH is considered the world leader in biomedical research. When NIH implements policies that stress the importance of biological sex as a fundamental variable in research and require analysis of data by sex as a part of grant progress reporting and published results, others will follow suit.

**SWHR proposes that the Committee include the following language under Title IV, Subsection A, Section 4001- of the current 21st Century Cures discussion draft.**

1. Authorize NIH to develop policies that require research applicants to report their plans for the inclusion of male and female cells and animals in preclinical studies in all future applications, unless sex-specific inclusion is unwarranted, based on rigorously defined exceptions. No later than one year after enactment of this legislation NIH shall publish the draft policy via a notice of proposed rulemaking to allow for public comment and response. The expansion of such current policies shall include plans for:
  - a. Investigators to prominently indicate the sex of their experimental model in their grant application and progress reports.
  - b. Investigators studying one sex should provide justification as to why the study is limited to one sex as a part of the grant reporting process and in published reports. When studying both sexes, investigators should report, and when appropriate, analyze their data by sex as part of grant progress reporting to the Agency and in published results.
  - c. Investigators to consider sex as a biological variable in relevant research on animals, cells, and human subjects.

2. Direct NIH to monitor compliance of sex and gender inclusion in preclinical research funded by the agency through data-mining techniques that are currently being developed and implemented. Encourage NIH to work with publishers to promote the publication of such research results.
3. Authorize the Director of the NIH to establish a Trans-NIH Working Group on Sex Differences in Research, which shall be comprised of representatives of each Institute and Center, the Office of Research on Women's Health, as well as appropriate members of the scientific and academic communities and patient organizations as determined by the NIH Director. Additionally, the Working Group shall ensure appropriate implementation of the regulations proposed above; determine the progress of NIH's strategic plan on sex difference in research and to ensure open collaboration between ICs on this matter. The Working Group shall provide a written report to the Director to be included in the NIH biannual report that details the inclusion of females and advances in sex differences in pre-clinical research and include the proportion of women and minorities as subjects in clinical research participant enrollment by trial phase and in all studies of human subjects, the proportion of studies that incorporate sex as a biological variable and of those studies which analyze data by sex as part of grant review, award, and oversight processes and this data should be reported by Institute and Center across the Agency.
4. The National Library of Medicine is urged to implement changes to Clinicaltrials.gov that will require users to input the number of participants that drop out of trials and break those participants out by sex/gender and race. Such data should be provided for all phases of clinical trials to the extent possible.
5. Authorize the Specialized Centers of Research on Sex Differences program, to support interdisciplinary collaborations on sex and gender influences in health, and bridges basic- and clinical-research approaches. This program also facilitates training in sex and gender considerations in experimental design and analysis.

#### **Section 4004- Increasing Accountability at the National Institutes of Health**

SWHR agrees with efforts to increase accountability at the NIH; however, we do not agree with usage of percentages to determine investments in both intramural and extramural research. Basic science investments should flow into areas that are most promising, which due to the nature of science, cannot be pre-determined or predicted. We believe that the NIH Director with the critical input of Institutes, Centers and Offices Directors should have the flexibility to best determine investments in research proposed.

#### **Subtitle S – Continuing Medical Education Sunshine Exemption**

**Section 4381-** CMS's efforts to clarify reporting under the Physician Sunshine Payment Act has resulted in confusion and inconsistency. SWHR believes that there should be language added after Sec.4381 (b) which addresses what is a reportable indirect payment in order that manufactures truly understand when reporting is required and when it is not.

The lack of clarity in reporting and exemptions is causing great confusion and frustration for nonprofit organization and other stakeholders as it directly impacts participation of scientists, researchers and clinicians in important scientific forums and meetings. SWHR understands that only applicable manufacturers and applicable group purchasing organizations (GPOs) have reportable

payments or other transfers of value, ownership or investment interest, or both are required to register and report in Open Payments (FAQ 9138). In general, all direct or indirect payments or transfers of value made by an applicable manufacturer to a covered recipient (physician or teaching hospital) must be reported in Open Payments. As described in 42 C.F.R. §403.902, an indirect payment is a payment or other transfer of value made by an applicable manufacturer to a covered recipient through a third party, where the applicable manufacturer requires, instructs, directs, or otherwise causes the third party to provide the payment or other transfer of value, in whole or in part, to a covered recipient. An exclusion applies if the applicable manufacturer does not know the identity of the covered recipient during the reporting year or by the end of the second quarter of the following reporting year.

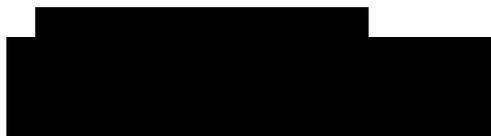
If an applicable manufacturer provides an unrestricted payment or transfer of value to a third party to use at the third party's discretion, this would not constitute an indirect payment (78 FR 9490). This unrestricted payment should not have to be reported but unfortunately there is insufficient assurance to the manufacturers to date causing them to require reporting unnecessarily directly impacting scientific discussion.

SWHR appreciates the hard work the committee has done to reach a comprehensive discussion draft of this magnitude and for being allowed to provide extensive to the review process. We hope that you will find our comments helpful as you review and refine the draft legislation. We look forward to working with the Committee going forward to you endeavor to transform the US biomedical enterprise.

Sincerely,



Martha Nolan  
Vice President, Public Policy



Director, Government Affairs

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<sup>i</sup> Wizemann TM, and Pardue, Mary-Lou, eds. Exploring the Biological Contributions to Human Health: Does Sex Matter? Washington, D.C.: National Academies Press; 2001.2-11

<sup>ii</sup> FDA Website. Drug Trials Snapshot: Jublia (efinaconazole).

<http://www.fda.gov/Drugs/InformationOnDrugs/ucm422419.htm>. Accessed February 9 2015.

<sup>iii</sup> FDA Website. Drug Trials Snapshot: Jublia (efinaconazole).

<http://www.fda.gov/Drugs/InformationOnDrugs/ucm422419.htm>. Accessed February 9 2015.



February 10, 2015

Committee on Energy and Commerce  
2125 Rayburn House Office Building  
Washington, DC 20515



Congressman Member Pallone:

We write to applaud your efforts to accelerate the pace of cures and medical breakthroughs and to specifically support Subtitle G - Disposable Medical Technologies, authored by Representatives Ellmers (R-NC) and Butterfield (D-NC), in the 21 Century Cures Discussion Draft. We strongly encourage you to maintain this provision that ensures Medicare beneficiaries have access to disposable medical technologies in the home and community setting in the introduced legislation. This is critical to improving the care of people with Spina Bifida, a birth defect with profound health implications throughout a person's life.

The future holds much promise for breakthroughs and innovation for patients. To harness this potential and add value for people with Spina Bifida, the creation of innovative technologies must go hand and hand with access to these technologies. A critical element to bringing innovation to patients is Medicare reimbursement. Recent developments in medical technology have delivered significant advancements in patient care for people with Spina Bifida, often with less risk, lower cost, and improved outcomes. Not surprisingly, clinical practice and standards of care evolve along with these advancements. As these changes occur, Medicare payment policy also must evolve to support home-based, patient-friendly technologies.

Unfortunately, Medicare does not recognize the value of disposable technologies in the home because of a conflict with the decades-old definition of durable medical equipment (DME). These items are commonly reimbursed by private payers, as they are easier to use, less expensive, and provide excellent outcomes. We therefore urge you to include the Disposable Medical Technologies provision in your 21<sup>st</sup> Century Cures legislation to ensure patients have access to disposable medical technologies that would otherwise be covered as DME but for the fact they are not durable.

The outdated Medicare definition of DME precludes consideration of these modern technologies well suited for home-based care. By providing coverage for disposable medical technologies in the home, Medicare would promote continuity of care between care settings, facilitate better outcomes, reduce costs, and enhance system efficiencies. Moreover, Medicare coverage would ensure that patients do not lose

*Promoting the prevention of Spina Bifida and enhancing the lives of all affected.*

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Page Two of SBA Letter to Committee on Energy and Commerce

access to these technologies as they transition from private insurance at age 64 to Medicare at age 65.



Sara Struwe, President & CEO

*Promoting the prevention of Spina Bifida and enhancing the lives of all affected.*

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 /spina.bifida.learn •  @SpinaBifidaAssn • [spinabifidaassociation.org](http://spinabifidaassociation.org)

I represent Tremor Action Network ([www.tremoraction.org](http://www.tremoraction.org)) and am one of the over ten million Americans who have essential tremor. Our patient advocacy organization has been reviewing the recently released documents for the 21st century cures Bill. On behalf of Tremor Action Network I am submitting the following questions and comments:

1. When 21st century cures is passed, how will all diseases be spoken for; for example, the input for our disease essential tremor?

2. Who will be responsible for databases and protecting them, such as "bio markers and personalized medicines"?

3. Under 21st century cures will there be improvements for regulating and tracking DBS? As of now there is no one unified source for doing so.

4. In section SUBTITLE G—EXPANDED ACCESS, it states, "place transparency requirements on certain drug companies regarding their expanded access programs (programs for patients to access drugs before they are approved). " Why certain drug companies, and who would these certain drug companies be?

5. In section SUBTITLE H—FACILITATING RESPONSIBLE COMMUNICATION OF SCIENTIFIC AND MEDICAL DEVELOPMENTS FDA's, it states "scientific and medical developments can be shared with physicians, insurers, and researchers, with appropriate safeguards, in order to optimize patient care." Will the appropriate safeguards be regulated like the HIPAA Act?

6. In section SUBTITLE K—CURES ACCELERATION NETWORK Section 1202 "would authorize additional funds for research on repurposing drugs for new uses. One of NCATS' projects involves finding new uses for old drugs (i.e., using a drug for cancer for a rare disease)." This Section is very important for diseases like essential tremor that have only 1 FDA approved drug that was initially approved for high BP. All other drugs are "off label." How will stakeholders - patient advocacy organizations be involved in working with NCATS to insure new uses for old drugs? For example, there is a promising clinical trial for essential tremor at NIH/NINDS, Octanoic Acid, that has been stalled for over a year.

7. In section SUBTITLE L—DORMANT THERAPIES The provision (Sections 1221-1223) " is based on the MODDERN Cures Act,The Dormant Therapies Act would address this issue by rewarding investment in treatments and cures for patients where there are unmet medical needs." Like Section 1202, Sections 1221-1223 is very important for essential tremor, a disease with unmet medical needs. Specifically, what is the criteria for defining diseases with unmet medical needs?

8. SUBTITLE A—21ST CENTURY CURES CONSORTIUM ACT This provision (Section 2001), "establish a public-private partnership to accelerate the discovery, development, and delivery in the United States of innovative cures, treatments, and preventive measures for patients. " How will essential tremor be represented so as not to get left behind on cures, treatments and prevention?

9. SUBTITLE N—21ST CENTURY CHRONIC DISEASE INITIATIVE ACT "would require the Secretary of Health and Human Services (HHS) to develop a plan to carry out a longitudinal study designed to improve the outcomes of patients with chronic disease. " How will essential tremor be included as a chronic disease so as to be part of the longitudinal study?

10. SUBTITLE A—NATIONAL INSTITUTES OF HEALTH Section 4001 "establish a working group composed of NIH and stakeholders to provide recommendations on how to streamline the grant process for researchers." How will stakeholders be chosen to work with NIH?

11. Section 4008 "would authorize funding for the NIH's BRAIN initiative." Tremor Action Network supports Section 4008, having attended the 1st work group meeting of the BRAiN initiative that was held in San Francisco, followed by the work group meeting in MA.

Tremor Action Network has been sharing our excitement over the possibilities of 21st century cures in our Blog (<http://tremoraction.org/2015/01/path2cures-21st-century-cures-initiative/>), on Facebook (<https://www.facebook.com/tremoraction>) and Twitter (<https://twitter.com/tremoraction>). We are eager to help make this the best legislation it can be for essential tremor/movement disorders patients, as well as all Patients.

Thank you in advance for your time and consideration in reviewing our questions and comments.

Sincerely,

Nannette Halliwell  
Tremor Action Network Board Member  
[Gatun.czone@gmail.com](mailto:Gatun.czone@gmail.com)

[kwelker@tremoraction.org](mailto:kwelker@tremoraction.org)



February 12, 2015

Chairman Fred Upton  
2138 Rayburn House Office Building  
Washington, DC 20515

Chairman Joe Pitts  
420 Cannon House Office Building  
Washington, DC 20515

Ranking Member Frank Pallone  
237 Cannon House Office Building  
Washington, DC 20515

Ranking Member Gene Green  
2470 Rayburn House Office Building  
Washington, DC 20515

Rep. Diana DeGette  
2368 Rayburn House Office Building  
Washington, DC 20515

Dear Chairman Upton, Ranking Member Pallone, Chairman Pitts, Ranking Member Greene, and Congresswoman DeGette:

On behalf of Trust for America's Health (TFAH), we appreciate the opportunity to provide comments on the discussion draft of the *21<sup>st</sup> Century Cures Act*. TFAH is a non-profit, non-partisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. We thank the Committee for your continued commitment to spurring development of life-saving medical products. Our comments focus only on the stated sections related to antibiotic development, vaccines, medical devices and prescription drug abuse. These comments do not reflect a TFAH position on the proposed legislation as a whole.

### **Title I, Subtitle D – Antibiotic Drug Development**

#### *Sec. 1061 – Approval of certain drugs for use in a limited population of patients*

TFAH strongly supports inclusion of legislative language to create a limited population drug approval pathway for antibiotic drugs to treat serious infections for which there is an unmet medical need. Development of any new drug is challenging, but development of novel antibiotics to treat extremely resistant bacterial infections is especially difficult because there are a limited number of patients with such infections available to participate in clinical trials.<sup>1</sup> At the same time, the Centers for Disease Control and Prevention (CDC) reports that in the United States at least 2 million people become infected with resistant bacteria each year, and at least 23,000 die from these infections.<sup>2</sup> For these reasons, the President's Council of Advisors on Science and Technology (PCAST) recommended creation of a drug approval pathway based on clinical trials in limited patient populations for antibiotic resistant bacteria.<sup>3</sup> TFAH is one of

<sup>1</sup> The Pew Charitable Trusts. [Tracking the Pipeline of Antibiotics in Development](#). Sept 30, 2014.

<sup>2</sup> Centers for Disease Control and Prevention. [Antibiotic/Antimicrobial Resistance](#). March 4, 2014.

<sup>3</sup> President's Council of Advisors on Science and Technology. [Report to the President on Combating Antibiotic Resistance](#). Sept 2014. pp. 32-33.

multiple health and public health organizations that have expressed support for the Antibiotic Development to Advance Patient Treatment (ADAPT) Act in the last Congress.<sup>4</sup>

We submit the following comments on the language in the discussion draft:

- **Pages 36-39:** We are concerned about the feasibility of the meetings requirements within sec. 1061. While this provision is intended to create flexibility necessary to bring new drug candidates to market, we fear this language is overly burdensome on the Food and Drug Administration (FDA) and may create an unnecessary obstacle in the review process. For example, p. 36 lines 12-16 states that FDA must meet with the sponsor within 60 days of receiving the request. We recommend working with FDA to ensure a reasonable time frame without being overly prescriptive.
- **Pages 37-38:** In addition, the definitions of “assessment meetings” seem to prescribe agreements between FDA and drug sponsors that may be impossible to map out before a submission begins, such as the clinical development program, post-approval commitments and what type of data would be necessary to achieve broader drug approval. At the very least, this language should be changed to create flexibility to allow for meetings to discuss post-approval data, but not require formal agreement before the submission process begins.
- **Pages 43-44:** We support language in the draft that would contribute to judicious use of new products approved under the limited population pathway. It is essential that new antibiotic drugs approved under this pathway be used appropriately both to slow the rate of resistance to the new products and ensure that a limited population drug is only used for the indicated population – those with very serious infections that cannot be treated with existing drugs. We also support language on pp. 43-44 to ensure monitoring of use of antibacterial drugs and changes in resistance patterns.
- **Page 39:** We support language requiring a labeling statement (p. 39) on any drug approved under this pathway to ensure the products are only used as intended. However, we urge the Committee to strengthen the labeling requirement by adding a visual element or logo so that healthcare providers can immediately see that the drugs are approved for a limited population with serious or life-threatening resistant infections for which there are few other treatment options.

#### **Title IV, Subtitle C – Vaccine Access, Certainty, and Innovation**

##### **Part 1 – Development, Licensure, and Recommendations**

TFAH supports the Committee’s commitment to vaccine development, including provisions to improve guidance to vaccine developers (sec. 4043) and to spur vaccine research at NIH (sec. 4048). We have some concerns with other sections within this subtitle:

*Sec. 4041 – Prompt review of vaccines by the Advisory Committee on Immunization Practices*

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<sup>4</sup> [Letter to Representatives Gingrey and Green](#). Feb 26, 2014.

**Page 261:** While we understand the goal of this section is to ensure ACIP makes timely recommendations regarding vaccine administration, we are concerned that the time limits prescribed in the bill (120 days after licensure and 60 days after a sponsor's request) would unduly constrain the review process. ACIP must review a wide range of scientific data before making a recommendation, and placing artificial timelines on the process will only lead to complications and possible mistakes. Because vaccines are generally used by broad swaths of the population, it is imperative that ACIP's process be scientifically vigorous and independent.

Additionally, ACIP would not receive additional funding to perform an expedited review process, which could compromise the strength and integrity of ACIP's recommendations.

*Sec. 4042 – Review of Transparency and Consistency of ACIP Recommendation Process*

TFAH believes this provision is unnecessary, as ACIP is a Federal Advisory Committee, and thus governed by rules regarding public access. ACIP meetings are open to the public, and working group decisions and criteria are shared publicly at ACIP meetings. TFAH is unaware of any problems regarding transparency and consistency and feels this provision would distract CDC staff from more pressing vaccine issues.

*Sec. 4044 – Meetings Between CDC and Vaccine Developers*

While we understand the goal for increased coordination and communication between vaccine developers and public health, TFAH is concerned that this provision would be extremely impractical and an impediment to timely vaccine development. In particular, requiring CDC to convene a meeting with vaccine developers, experts in immunization, epidemiologists, FDA, the National Vaccine Program and others and provide epidemiological and other data to developers, without providing any additional funding to CDC, would create an excessive strain on CDC.

**Part 2 – Medicare, Medicaid, and Other Provisions**

*Sec. 4061 – Requiring prompt updates to Medicare program upon issuance of ACIP recommendations*

TFAH supports this provision, which would ensure prompt access to needed vaccines for the Medicare population as soon as possible after ACIP issues a recommendation.

*Sec. 4062 – Encouraging health plans to establish programs to increase adult immunization*

We applaud the Committee's recognition of the vexing problem of adult immunization gaps. TFAH first highlighted the problem of low adult vaccination rates in 2010 with our report [\*Adult Immunization: Shots to Save Lives\*](#). We support the provision's allowance of health insurance plans to use adult immunization programs as a quality improvement activity for purposes of calculating the Medical Loss Ratio. We urge the Committee to strengthen this provision by requiring plans to show the impact of these activities on immunization rates – not just the existence of a program – in order to qualify for the benefit.

In addition, we encourage the Committee to address inconsistent coverage policies under Medicare Part B and Part D, which leaves many seniors with gaps in coverage. Beneficiaries can

get their flu, pneumonia, and HBV (for at-risk individuals) vaccine covered under Part B, but an out-of-pocket payment may be required, depending on the shot and provider. The rest of the recommended vaccines are covered under Medicare Part D, so the patient must find a provider who accepts Part D and carries the needed vaccine. And not all seniors have Part D plans, and even those who do often have a copayment. The Committee should include a provision requiring all ACIP-recommended vaccines be covered through both Medicare Part B and Part D without cost sharing to ensure complete, equitable access to vaccines for all Medicare beneficiaries.

#### **Title IV, Subtitle N, Medicare Part D Patient Safety and Drug Abuse Prevention**

TFAH is pleased that the Committee has included provisions in the discussion draft intended to decrease abuse of prescription opioids and other controlled substances among high-risk Medicare beneficiaries. Prescription drug abuse is a multi-faceted problem, and effective solutions will require partnerships across federal, state and local governments along with public health, medical and drug prevention experts, healthcare providers, the healthcare and benefits industries, pharmacies, the pharmaceutical industry, schools and universities, employers and others. TFAH examined many of the promising strategies being implemented by states in [Prescription Drug Abuse: Strategies to Stop the Epidemic](#) and makes a number of recommendations for ways to effectively implement policies to address this public health crisis, while ensuring that patients in need have access to appropriate medications.

##### *Section 4281 - Establishing PDP safety program to prevent fraud and abuse in Medicare prescription drug plans*

The proposed Prescription Drug Plan (PDP) Safety Program is an important step toward addressing potentially inappropriate opioid use in this patient population. These programs, which have also been called patient review and restriction programs (PRRs), would require patients at risk of drug abuse to utilize a designated pharmacy to obtain all prescriptions for opioids and other controlled substances. These programs also improve continuity of care among at-risk patients by providing improved drug therapy management. Use of these programs by sponsors of Medicare Part D and Medicare Advantage Prescription Drug (MA-PD) would expand the number of tools that plans have available to combat prescription drug abuse. Similar policies have been included in legislation proposed by members of Congress from both parties, as well as in the President's FY 2016 Budget request. The broad bipartisan support for this policy reflects the shared interest in advancing these programs as a means to address the nation's prescription drug abuse epidemic.

We are pleased that the discussion draft creates a PDP Safety Program to help address this problem, we offer the below changes to refine the current language in section 4281:

- **Page 309, lines 18-21 and page 310, lines 1-2;** Authorize the use of the PDP Safety Program in Part D and MA-PD plans rather than require use. While there is a need for federal guidance to support the implementation of these programs and to provide a framework that defines beneficiary protections that would be required across all programs, a mandate would be too prescriptive and would inhibit development of innovative practices that could improve the effectiveness of PRRs.

**Section 4281:** Provide plan sponsors with the option to restrict beneficiaries to a designated prescriber in addition to a designated pharmacy. A recent review of state Medicaid programs found that most PRRs restrict beneficiaries to a single pharmacy and a single prescriber. Inclusion of a prescriber component may improve the effectiveness of these programs by designating a single clinician to oversee the pain management needs of the patient. Medicare MA-PD plans are in an ideal position to implement effective prescriber- and pharmacy-based programs in light of their management of both medical and prescription benefits.

- **Section 4281, page 310, lines 6-10:** Revise requirements for the network of safe pharmacies that restrict participation to pre-approved contracted entities. The proposed language limits participation in the PDP Safety Program to a network of contracted pharmacies. TFAH is concerned that this approach could serve as a barrier to patient access to pain management therapies, especially in rural locations where the density of pharmacies is low compared with urban areas. TFAH supports the reasonable access conditions described in the paragraph that follows (page 310, lines 11-20), which take into account the location of the beneficiary's residence(s), work site(s), mobility, and other relevant factors. While program structures differ, PRRs in state Medicaid and private payer plans often allow the beneficiary to submit preferences for a prescriber and pharmacy that are approved unless the plan sponsor has determined that the selected prescriber or pharmacy is contributing to the patient's misuse of controlled substances.

#### *Section 4282 – Part D suspension of claims payment*

**Page 313, lines 1-4, and section 4284, page 317, lines 1-3:** We recommend the Committee delink the requirement for electronic prescribing from the compulsory procedures defined for the PDP Safety Program to ensure sufficient time for adoption of this technology by prescribers and pharmacies. The draft language includes a deadline of eight months following enactment of the legislation, after which time prescriptions for controlled substances for Medicare beneficiaries will be covered only if the prescription is transmitted electronically as described in Section 4284. There are conflicting reports on the readiness of prescribers to meet electronic prescribing requirements, and this abbreviated timeframe could delay implementation of the PDP Safety Program or result in substantial barriers to patient care if there is delayed or low uptake of this technology by prescribers and pharmacies in some geographic areas. Delinking the requirement for electronic prescribing will help ensure timely implementation of the PDP Safety Program.

#### **Medical Devices**

Many patients with life threatening and/or debilitating conditions lack sufficient treatment options, but the development of new technologies can take years. Many of the provisions in the 21st Century Cures discussion draft recognize the importance of prompt patient access to new technologies, while also acknowledging that the development and implementation of robust postmarket monitoring systems and policies are essential to protect patients from faulty products. Improving the research infrastructure to more efficiently and quickly collect data on the performance of medical devices—both pre- and post-market—can achieve both of these goals.

We are pleased that the discussion draft reinforces the importance of registries as an essential tool to efficiently collect data on product performance. In addition, as the Committee considers these and other proposals to accelerate the delivery of innovative devices to patients, these efforts should embody the following principles:

- **Ensure FDA has the tools to collect postmarket data and protect patients**

Several of the provisions in the discussion draft would accelerate patient access to new medical devices by relying on shorter clinical trials, surrogate endpoints, new statistical modeling techniques, and other methods. Under these provisions, the FDA may shift data typically collected premarket until after approval. That change would give the FDA less certainty on the full risks and benefits of particular products at the time new devices come to market.

The success of shifting data typically collected premarket to after approval relies on the prompt collection of postmarket data. The FDA must have the necessary tools to ensure that this information is quickly collected, potentially through mandatory postmarket studies or the use of registries. In addition, fulfillment of the FDA's national medical device postmarket surveillance plan—which outlines key steps to improve device safety—will help ensure that the necessary infrastructure exists to collect the necessary information.

Congress should evaluate whether the FDA has sufficient authorities to promptly withdraw product approvals if the necessary information is not promptly collected or suggests that the product benefits do not outweigh the risks. Should the FDA lack these authorities, Congress should provide the agency with enhanced abilities to protect the public when postmarket responsibilities are not fulfilled.

- **Include the unique device identifier system in claims data to ensure safety of medical devices**

Finally, the discussion draft emphasizes the value of claims data so that patients, clinicians, and regulators will have more and better information on medical interventions. Several provisions would make claims data more publicly available or enhance the use of this information to understand the safety and effectiveness of medical products.

Unlike some other forms of health data, claims provide long-term information on patient outcomes and span providers. Claims however, only document the procedure—such as a stent insertion or hip implant—not the specific product used. If added to claims, the new unique device identifier (UDI) system—which provides each medical device with a code corresponding to its manufacturer and model type—could provide the necessary details on what product is implanted in the patient. Documenting UDIs would make claims data valuable for analyses of product performance, and would increase transparency on the products used in care.

UDI data in claims could also enable the FDA's Sentinel Initiative—a postmarket surveillance monitoring program—to evaluate the safety of devices. Congress instructed the FDA to create the Sentinel program in 2007, and it has since been used both to identify safety concerns with products and to disprove suspected problems. Given Sentinel's successes, Congress instructed the FDA in 2012 to expand this system to devices. However, due to Sentinel's reliance on data derived from health insurance claims that currently lack information on the devices used in care, this system cannot efficiently assess device performance until claims include UDI data.

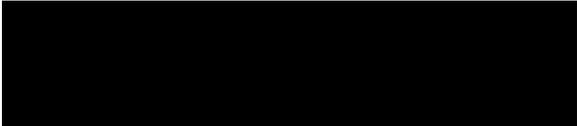
Given that the claims form is standard across payers, the creation of a new field would also enable the collection of UDI data by private health plans, such as Aetna, that have expressed an interest in obtaining this information.

While there is an administrative process to update claims standards to include a field for UDI, congressional action may be necessary to ensure that claims can contain this critical data and that Medicare utilizes the information to improve care.

We look forward to working with the Committee to refine proposals in the discussion draft to reflect these principles and facilitate more efficient data collection to spur innovation while ensuring the safety and quality of medical devices.

Thank you for your time and consideration of these comments. If you have additional questions, please contact Becky Salay, TFAH's Director of Government Relations, at [bsalay@tfah.org](mailto:bsalay@tfah.org) or Dara Lieberman, TFAH's Senior Government Relations Manager, at [dlieberman@tfah.org](mailto:dlieberman@tfah.org).

Sincerely,



Jeffrey Levi, PhD  
Executive Director



February 23, 2015

The Honorable Fred Upton  
Chairman  
House Committee on Energy & Commerce  
2125 Rayburn House Office Building  
Washington, DC 20515

Dear Chairman Upton:

On behalf of VIVUS Inc. (VIVUS), I am pleased to have this opportunity to submit comments on your 21<sup>st</sup> Century Cures discussion draft, which was released on January 27, 2015. VIVUS is a biopharmaceutical company developing innovative, next-generation therapies to address unmet needs in areas such as obesity, diabetes, and sleep apnea. We applaud your efforts in this discussion draft and for accepting comments that would enhance the regulatory framework in support of biomedical innovation in the United States.

Innovative medicines contribute enormous health, economic, and social welfare benefits to individuals. A healthy population is also more productive and less costly to public health programs. At VIVUS, we developed the weight management medication, Qsymia<sup>®</sup> (phentermine and topiramate extended-release) capsules CIV. Qsymia was approved by the Food and Drug Administration (FDA) in 2012 and is indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adult patients with an initial BMI of 30 or greater (obese), or 27 or greater (overweight) in the presence of at least one weight-related comorbidity such as hypertension, type 2 diabetes, or dyslipidemia.

Obesity is a major public health issue in our country. Around 36 percent of adults in the United States are obese, while many others are overweight and may soon be contending with obesity. Unfortunately, anyone who is overweight or obese can face health consequences. Obesity is linked to heart disease, stroke, cancer, type 2 diabetes, dyslipidemia, joint issues, obstructive sleep apnea, and many other conditions. Beyond the health risks, obesity carries significant stigma. Weight prejudice can have profound consequences in social acceptance, employment and even medical care. Tragically, these societal biases ignore an important fact: obesity is a medical condition as declared by the American Medical Association in 2013.

Given obesity's many consequences, people have a strong incentive to lose weight. While diet and exercise may succeed in the short-term, many have trouble maintaining their weight loss. The inability to maintain weight loss is not a function of will, but rather of biology. Obesity restructures how the body responds to food, and thus, measures beyond basic diet and exercise are sometimes required. Bariatric surgery has helped many people achieve significant weight

loss. More recently, pharmaceutical companies have developed a new generation of weight loss drugs. There are currently four FDA-approved medications for chronic weight management and more are in the pipeline.

Even with these advances, barriers to these medications for patients remain. Though many private health insurance policies cover anti-obesity and weight management drugs, Medicare does not cover them under Part D as there were no FDA-approved weight management drugs at the time the Part D program was created. The Social Security Act (specifically Section of Title 19), which, governs the Medicare Part D program, excludes or restricts certain drugs from basic coverage. Specifically, “agents when used for anorexia, weight loss, or weight gain,” are excluded from the definition of Part D covered drugs. Recently, Health and Human Services (HHS) Secretary Burwell has stated that expansion of Part D coverage would require a legislative change by Congress and has offered HHS staff to provide technical assistance while drafting such language. While coverage under Part D is not allowed, Part D plans wishing to provide coverage of chronic weight management medications may do so as a supplemental benefit as they can with other drugs that are excluded from the definition of Part D drugs.

Typically, payers and employers design drug benefit plans based on Part D guidance/requirements. Exclusion of anti-obesity and weight-management drugs from Part D creates further barriers for employers to add these therapies into their standard benefit design. Employers who want to cover anti-obesity and weight-management drugs need to buy a separate rider which is a cumbersome process creating more hurdles for patients to access these important therapies.

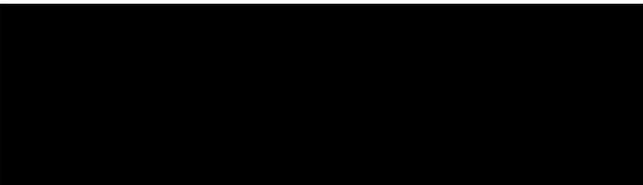
Along with many private health insurers, Federal government departments and agencies have recognized the adverse and costly impact of obesity and related chronic conditions to their beneficiaries and increasingly provided coverage for FDA-approved prescription drugs for obesity and weight management. In early 2014, the Office of Personnel Management announced that all insurance carriers offering coverage under the Federal Employees Health Benefits (FEHB) Program should cover prescription medications approved by the FDA for obesity. Shortly thereafter, the Department of Veterans Affairs and the Department of Defense released practice guidelines for obesity treatment which include recommendations for obesity and weight management drugs.

This disparity in coverage between Medicare and other payers puts Medicare beneficiaries at a great disadvantage. While they may be motivated to lose weight, they lack access to all available options. Between the human cost, the budgetary impact and the burden on our health care system, obesity has become an enormous policy issue. We must develop creative solutions to meet the policy challenge and allow our Medicare population to have the same access as individuals with private or other Federal coverage to help address obesity.

Last Congress, a former Energy & Commerce Member, Senator Bill Cassidy, introduced H.R. 2415, the Treat and Reduce Obesity Act. The bill would have authorized the Secretary to cover medications for the treatment of obesity or for weight loss management for an overweight individual with one or more comorbidities under Medicare Part D. The bi-partisan piece of legislation had 115 cosponsors in the House and over 40 patient groups, health care provider associations, and biomedical manufacturers supporting the measure.

It is clear that hard work has been put into the Committee's discussion draft and we agree with the goals that you have presented, especially: incorporating patient perspectives into the regulatory process; helping patients address their unmet medical needs; accelerating the discovery, development, and delivery cycle of medications; and supporting continued innovation at our Federal public health agencies. If the FDA approves medication to treat or cure a disease, all Americans should have access to it. Now we need to make sure that the Centers for Medicare and Medicaid Services has the legal authority to do so and request that you include such a provision in the Committee's bill.

We are pleased to see that so much work and dedication has gone into the 21<sup>st</sup> Century Cures initiative, and we are willing to make ourselves available as a resource to you and your staff at any time. We encourage the Committee to work with those who are battling obesity and overweight management issues, as it truly is a major health issue that needs to be addressed. Allowing every individual to have access to all the right tools will only help our country's health care system. If you have any questions or comments on this letter, please contact Sunil Karnawat at 510-566-7644 or [karnawat@vivus.com](mailto:karnawat@vivus.com).



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