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August 16, 2007

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Comments also submitted electronically on CMS website,
https://www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?id=210

RE: Proposed Decision Memorandum for Second Reconsideration of the Clinical Trial Policy, Renamed the Clinical Research Policy (CAG-00071R2)

Dear Dr. Phurrough:

The Association of American Medical colleges represents all 125 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and 94 academic and scientific societies. Through these institutions and organizations, the AAMC represents 109,000 faculty members, 67,000 medical students, and 104,000 resident physicians.

The Association appreciates the time and effort that CMS has to devoted to developing a policy covering Medicare payments for beneficiaries enrolled in clinical trials, including the August 7 Open Door Forum (ODF). However, we believe that the policy needs further major revisions, as discussed below, so that the system that finally is implemented will not impede the enrollment of Medicare beneficiaries in clinical trials, will not put hospitals and physicians at risk on the one hand for not getting paid for services that are needed by the patient, or on the other hand being subjected to False Claims Act suits, and will be easy to administer.

Rather than rushing to meet the October 17 deadline mandated by the national coverage decision (NCD) process, the AAMC urges CMS to use a rulemaking process to adequately consider the many issues that have been raised over the months since revisions to the 2000 NCD were first considered in late 2006. The NCD process was developed as a way for Medicare to add new items and services to national coverage. As such, it makes sense that there are extremely short comment periods and that the decision is effective on the date of coverage. Clinical trials cover a broad and complex system of items and services that would benefit from the longer comment period that rulemaking allows, and a reasonable amount of time to transition to new requirements once a final rule is published. The comments received

on this second reconsideration would be extremely useful in forming the basis for a proposed rule.

During the Open Door Forum Dr. Phurrough indicated that CMS will be engaging in rulemaking related to clinical trials, though there was no hint as to the issues that might be addressed. This leads one to wonder whether the requirements developed through the NCD process will be replaced by a rulemaking, or whether the rulemaking will address other, though related, topics. As stated above, the AAMC suggests that the proposed NCD not be finalized and that CMS issue a proposed rule instead. However, if CMS persists with the NCD process, then we request that any future rulemaking neither conflict with nor replace requirements in a final NCD, as it would be extremely burdensome to providers to implement a new system in October of 2007 only to learn that it will be changed shortly thereafter.

As CMS considers its responses to the comments on this second reconsideration, we urge the agency to remember that when Medicare coverage for clinical trials was proposed, a simple, easily administered system was envisioned by the Institute of Medicine. We hope that the system finally adopted by CMS—whether it be through the NCD process or a formal rulemaking-- avoids the complexities that have been introduced thus far and provides the clarity that all affected entities and individuals seek.

The AAMC has many concerns with the CMS proposal, as discussed below.

I. Deeming and Self-Certification

1. CMS Should Retain the Category of Deemed Studies

The AAMC strongly supports allowing certain studies to be "deemed." Studies that are federally funded or otherwise undergo rigorous review by federal agencies already are subject to adequate oversight and thus should be accorded special status. Further, allowing some studies to be deemed—and a substantial portion of studies at teaching institutions are supported by federal funding rather than by industry funding—will mean that hospitals and providers have absolute assurance that these studies qualify for Medicare coverage and will provide beneficiaries with prompt access to them. Finally, allowing some trials to be deemed will reduce the administrative burden by not requiring the extensive paperwork that will be needed to meet the self-certification requirements.

The AAMC recommends that CMS adopt the deeming language from the April 10 proposed decision memorandum, with a slight revision in the third bullet, as follows:

Studies that meet the following criteria are deemed to meet the standards set forth above and do not need to go through the certification process:

- Studies reviewed and approved by a program component of DHHS, the Veterans Administration, or the Department of Defense;
- Studies reviewed and approved by health care research centers or cooperative health care research groups, funded by one of the above Federal agencies,

provided that the Federal Agency reviews and approves the applicant research centers' or cooperative research groups' subcontract and sub-grant funding requirements, selection procedures, and oversight methods, and determines that those processes provide the same level of protocol review as provided by the Federal agency

- Studies conducted under an investigational new drug application (IND) when the FDA has reviewed the study protocol and the IND is not currently on hold
- The study is required and approved by the FDA as a post-approval study
- The study is required as an outcome of the NCD process using CED.

The AAMC recognizes that should CMS reinstate deemed status, the Agency will need to devise a way to be notified about the existence of such studies. We would be pleased to work with the Agency on this.

For billing purposes, the AAMC suggests that the requirement for billing a deemed study be that the bill must include the NCT and a code to be developed by CMS that indicates the study is deemed.

2. Self-Certification and the Importance of Prompt Posting on CMS Website

It is extremely important that the posting of a self-certified study on the CMS website occur quickly. No one will be willing to enroll patients until they are assured that the study will be covered, so any delays by CMS in making this information public will be detrimental to beneficiaries. During the ODF Dr. Phurrough said that CMS will post information about a trial on its website within 1-2 days after receipt of a complete self-certification letter. We are pleased that the posting will be done expeditiously and ask that you confirm that this is CMS's intention.

3. Other Concerns About Self-Certification

a. Hospital/Provider Responsibility in Light of Self-Certification Process

During the ODF Dr. Phurrough said that the ONLY responsibilities of a hospital or provider are to check the CMS website to ensure that a study is certified and to put the NCT number and required modifiers on the bill submitted to Medicare. We ask that this be stated explicitly in the final decision memorandum and in any related instructions.

Despite these assurances from CMS, the AAMC is concerned that the OIG may not take the same view of a hospital or provider's obligations, and that a whistleblower may still have the ability to file under the False Claims Act if a bill is submitted for a trial that has been incorrectly certified, regardless of whether the incorrect certification was intentional or done in error. The AAMC requests that in the final decision memorandum CMS indicate whether the Agency has discussed its view regarding the extent of hospital and provider obligations with the HHS Office of Inspector General (OIG) , or whether there are plans to do so. Comments directly from the OIG on this issue also would be extremely useful.

b. Contractor Responsibility

During the ODF Dr. Phurrough stated that the sole responsibility of Medicare contractors will be to ensure that a claim for services contains the NCT and appropriate modifiers. Please confirm that it is CMS's intention that there will be no other contractor review of bills submitted for items or services that are part of a certified clinical trial. This information also should be placed in instructions.

c. CMS Review of Self-Certification Letters

In the proposed NCD CMS says it will review certification letters only for completeness. Elsewhere, the NCD states that Medicare will pay "unless the CMS Chief Medical Officer finds that the study does not meet the criteria in this policy or the study jeopardizes the health or safety of Medicare beneficiaries." During the ODF Dr. Phurrough said that CMO review would be triggered only if there is some indication of problems with the trial. If that is correct, we ask that you confirm this in the final NCD and related instructions.

On the call, Dr. Phurrough also said that a retrospective review that results in determination that a trial should not have been covered would not involve a recoupment, provided that the hospital/provider had met the obligations of checking the CMS list and billing with NCT number and modifier. Please confirm that this is correct and that there will be no other consequences to a hospital or other entity that submits a bill for services provided under this NCD, even if there is a later determination that the study does not meet the NCD criteria.

d. Who Should Certify?

The proposed 2007 NCD calls for certification by the sponsor or PI. The AAMC suggests that instead of specifying who must certify, CMS allow flexibility, as there may be institutions that have policies in place that make it more appropriate for the certification to be done by an institutional official or other designee rather than the PI.

e. Multi-Center Trials

Applying this decision to multi-center trials may pose major challenges that would benefit from guidance by CMS. For instance, it will be necessary to determine who the principal investigator is to avoid having each site register individually. One possibility is for CMS to specify that for multi-site trials, the designated PI(s) or Steering Committee that has overall responsibility for the trial must undertake this task. It should be noted that if CMS were to allow deeming, this problem would disappear for all federally-funded multi-center sites and also for many studies under an IND. This underscores the importance of deeming as a way to simplify the process of determining which trials will be covered by this NCD.

The AAMC would be pleased to work with the agency to explore issues raised by multi-center trials and to develop appropriate guidance.

II. Proposed Standards for Clinical Research

1. Formatting of Standards

For easy reference, the "standards of clinical research" should be numbered rather than bulleted.

2. Provide Guidance on Determining Duplication of Existing Studies

The NCD requires that the "research study does not unjustifiably duplicate existing studies." Making this determination is subject to judgment and debate. The AAMC requests that CMS provide guidance, including examples, of when one study would be considered to "unjustifiably duplicate" an existing study.

3. Clarification regarding requirement that the trial be conducted according to appropriate standards of scientific integrity

While it is true that this standard was included in the 2000 NCD, at the time it was part of the list of seven highly desirable characteristics of trials that were "automatically qualified to receive Medicare coverage." As such, it was applied only to deemed trials and thus there was never a need for further clarification. However, with the proposed self-certification process, it has become essential that CMS cite which specific standards apply so that it is clear what compliance is being measured against and should indicate who will make such a determination.

4. Delete the requirement that the protocol "addresses or incorporates by reference, the Medicare standards."

It is unclear to which Medicare standards this requirement refers. Further, it is not apparent why this standard is necessary. A written protocol is not intended to be a billing document, so it is inappropriate to require that it contain statement that it complies with Medicare standards. The self-certification letter itself is ample evidence that the trial complies with Medicare standards and should be considered sufficient. The AAMC urges that this requirement be deleted.

5. Which Studies Are Covered?

The NCD proposes limiting coverage to a "clinical research study [that is] not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Studies of all medical technologies measuring therapeutic outcomes as one of the objectives meets this standard only if the disease or condition being studied is life-threatening and the patient has no other viable treatment options."

a. Coverage should extend to diseases that are chronic, life-threatening, or debilitating

The CMS proposal can be read to impose a serious limitation on Medicare coverage. There are many diseases, such as arthritis, that affect that Medicare

population, yet are not life threatening though they are chronic or debilitating. The proposed CMS language appears to seriously reduce the opportunities for Medicare beneficiaries to participate in many clinical trials that would be of significant benefit to the Medicare population. The AAMC suggests that the Agency retain the language from the April 10 proposed Decision Memorandum and require that coverage be extended if "the disease being studied is chronic, life threatening, or debilitating."

b. There Should be Coverage for Some Phase I Studies

The proposed Decision Memorandum requires that the "clinical research study is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals." The April 10 Proposed Decision Memorandum was clear that some "Phase I studies, whose protocols commit to measuring therapeutic outcomes as one of the objectives" may be covered. The AAMC requests that CMS revert to this language so that it is clear that some Phase I studies may be able to qualify for coverage under the NCD.

c. Clarification Needed on Coverage for IND-Exempt Studies

The AAMC requests that CMS clarify whether any IND-Exempt studies will be covered under this policy.

6. Public Release of Results

The AAMC appreciates that CMS recognizes the importance of public release of study results and the Agency's implicit endorsement of requirements of the International Committee of Medical Journal Editors (ICMJE). The AAMC agrees that public release is vital and also strongly supports rapid public notification when a study is terminated for any reason, whether positive or negative. However, merely requiring public release of study outcomes does not guarantee that the information released is accurate and reliable. The AAMC recommends that this requirement be deleted for the time being and that CMS work with the research community and relevant federal agencies to determine the best way to ensure that research results are released rapidly but reliably and have undergone sufficient review to be considered trustworthy. This effort could include a consideration of reasonable time frames for releasing this information. Once this work is completed, this requirement should be added to the NCD.

7. Use "Anticipated" Study Start Date

The proposed NCD requires registration on ClinicalTrials.gov "prior to the enrollment of the first study subject." The AAMC suggests that to be consistent with the requirements for registration on ClinicalTrials.gov, the NCD should be revised to read: "prior to the anticipated start date."

III. What Happens When the Study Protocol Is Revised In The Course Of A Trial?

The AAMC asks that CMS provide guidance regarding what, if anything should happen, when the protocol of a certified study is revised during the course of a trial. Is there a need for recertification? If so, when should that occur? Who has responsibility?

IV. Clinical Trials Should Not Be Subject to Local Coverage Determinations

The AAMC realizes that beginning with the 2000 NCD, Medicare coverage has been subject to local coverage determinations. However this current reconsideration provides an opportunity to make revisions to portions of the earlier policy that may not have yet been problematic but could be in the future.

Allowing local coverage determinations to over-ride a national coverage decision could mean that in multi-site studies the coverage of items and services would vary from site to site. This variation in coverage would prove very challenging when negotiating with a sponsor for payment at multiple sites, each of which is governed by different payment rules. This may become such an impediment to the enrollment of Medicare beneficiaries that sponsors will prove reluctant to engage in these negotiations. Therefore, the AAMC suggests that CMS adopt the policy that when a research trial is covered under the NCD no local coverage determinations can limit the items or services that will be covered.

V. Standard of Care Should Be Covered, Regardless of Whether or Not a Trial is Certified

The proposed decision memo states that "items and services furnished to Medicare beneficiaries in clinical research studies that do not meet the requirements of this policy are not covered." During the Open Door Forum Dr. Phurrough confirmed that this means that if a beneficiary chooses to enroll in a non-certified trial, then there will be no Medicare coverage for any items and services within the trial, even if they would be covered were they received outside of the trial. For all the reasons stated in our letter of June 27 and available on the web at http://www.aamc.org/advocacy/library/teachhosp/corres/2007/062707.pdf, the AAMC continues to believe that this is an untenable position and should be changed.

CMS may believe that this policy "protects" beneficiaries from trials that do not meet certain standards, but its effect is to penalize beneficiaries and greatly limit their choices. This CMS policy also will create health disparities. Medicare beneficiaries who can afford to pay for standard of care services in a non-certified trial will be able to get the care that they need and enter the trial; other Medicare beneficiaries will not be so lucky. If less well-off beneficiaries choose to enter a non-certified trial, not even the treatment that is recognized and paid for by Medicare as standard of care for their disease or condition under every other circumstance will be covered.

The policy articulated by CMS during the ODF also raises serious implementation issues. For example, if a Medicare beneficiary wants to enroll in a non-certified outpatient trial, must an ABN be issued? What about an inpatient stay where, during the course of the stay, a decision is made to enroll the patient in a non-certified trial? Does the hospital have to back out all costs of the stay—including standard of care—that are associated with the non-certified trial?

If CMS persists in implementing this policy, it should be done on a prospective basis only, as there has been—and continues to be—much confusion surrounding this policy. The AAMC also urges CMS to issue guidance as to the implementation issues raised above.

VI. Problems Related to the Transition to the New NCD

1. Need for Grandfathering

The proposed CMS transition plan is that this policy "will not apply to any clinical research study that was covered under any previous policy that has begun enrollment prior to the effective date of this decision." This is not adequate. There will be studies that will have been approved by the IRB as of the NCD effective date, but have not yet begun enrolling patients. There also will be studies that are undergoing IRB review as of the effective date of the NCD. In both cases, much work has been done to get the studies to the point of either IRB approval or review. It would vastly delay Medicare beneficiary access to these studies if they have to begin the entire process again because they have not—or cannot-enroll patients as of the effective date of the NCD. Both types of studies described should be grandfathered and then be allowed to come into compliance at a later date (as described below).

2. Need to Allow Studies Operating under 2000 NCD to Come Into Compliance with 2007 NCD

During the ODF CMS acknowledged that over the next several years there will be two systems in place for clinical trials—one for those operating under the 2000 NCD and those operating under the 2007 NCD. It will be extremely difficult and burdensome for institutions to implement two separate systems to ensure correct billing. Underscoring the need to allow 2000 NCD trials to transition to the 2007 rules is that during the ODF Dr. Phurrough said there will be no further clarifications of the 2000 NCD, despite continuing confusion about many of that NCD's requirements. Therefore, the AAMC urges CMS to allow trials operating under the 2000 NCD to come into compliance with the 2007 NCD within 2 years of the effective date of the NCD.

If CMS adopts this suggestion, the only 2007 criteria that it may be impossible for trials to meet is registration on ClinicalTrials.gov prior to enrollment of the first participant. For these on-going trials that choose to transition to the 2007 NCD, CMS can substitute the requirement that the trial be registered on ClinicalTrials.gov at the time the certification letter is submitted.

3. Need for a Real Transition Period for Everyone

The 2007 NCD, and especially the self-certification process, is an entirely new process. If adopted as proposed, there should be at least a 1 year transition period. This will allow sufficient time to ensure that the self-certification process is workable and that CMS is prepared to promptly post certification information on its website. It

also will allow hospitals and providers to make the necessary changes to their claim forms so that they can be submitted with the NCT and appropriate modifiers.

VII. Exclusions

According to Dr. Phurrough's hand-out from the ODF, the NCD provides an exclusion for "prospective studies that do not change the behavior of patients and physicians." In response to a question about this exclusion, Dr. Phurrough indicated that if an informed consent is required, then he would consider that behavior is being influenced and, therefore, the study would not fall under the exclusion. If Dr. Phurrough's remark accurately reflects CMS's interpretation of this exclusion, then it will be so narrow as to be of little use. The AAMC asks that CMS clarify that whether or not a study falls into this exclusion category is not determined by the presence of an informed consent, but by the other factors that are detailed in the actual NCD language.

VIII. MSP and Medicare Advantage Issues

Once a final NCD is issued, two areas will not have been addressed that have been raised repeatedly with CMS and that will greatly affect Medicare beneficiaries' ability to participate in clinical trials: (1) the interaction of Medicare's secondary payer rules and payment for clinical trials and (2) the enrollment of beneficiaries who participate in Medicare Advantage plans in clinical trials. It is essential that CMS clearly state its policies regarding the issues in these two areas and the AAMC urges that the agency to do so simultaneously with the issuance of the final NCD.

If you have any questions or require additional information, please contact Ivy Baer, ibaer@aamc.org or 202-828-0499.

Sincerely,

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