PERSONALIZED MEDICINE COALITION

November 24, 2015

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Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1621-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program: Medicare Clinical Diagnostic Laboratory Tests Payment System; Proposed Rule

Dear Acting Administrator Slavitt:

On behalf of the Personalized Medicine Coalition (PMC), I am pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS)' proposed rule on the Medicare Clinical Diagnostic Laboratory Tests Payment System, which is intended to implement § 216 of the Protecting Access to Medicare Act of 2014 (PAMA).

While the proposed rule is meant to base Medicare's Clinical Laboratory Fee Schedule (CLFS) payment rates for diagnostics on market rates, we are concerned that, if improperly implemented, that program will not perform as designed and could negatively impact the goal of the President's Precision Medicine Initiative to create a new era of medicine that delivers the right treatment to the right patient at the right time.

PMC appreciates the efforts of CMS to advance high-value, individualized health care, and we believe personalized medicine has an important role to play in achieving this goal. We also appreciate the Department of Health and Human Services' larger efforts to accelerate the advancement of precision medicine. We believe that implementing § 216 of PAMA offers CMS a unique opportunity to transform the payment system for clinical diagnostic laboratory tests to align with the principles of personalized medicine and ensure that these advances reach patients and improve health care outcomes.

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After explaining the importance of personalized medicine and the impact that an improperly designed and implemented rule might have on the field, we suggest that CMS:

1. Forestall paying for CLFS tests at the weighted median private payer rate until January 1, 2018;

2. Use the gap-filling process for pricing new Multianalyte Assays with Algorithmic Analyses (MAAAs);

3. Address outstanding issues regarding Advanced Diagnostic Laboratory Tests (ADLTs); and

4. Refine the process for seeking, obtaining and using codes for ADLTs.

Personalized Medicine and the Personalized Medicine Coalition

Personalized medicine is an evolving field in which physicians use diagnostic tests to determine which medical treatments will work best for each patient. By combining the data from those tests with an individual's medical history, circumstances, and values, health care providers can develop targeted treatment and prevention plans. Personalized medicine therefore has the potential to optimize delivery and dosing of treatments so patients can receive the most benefit with the least amount of risk, eliminating the difficulties of the "trial-and-error" process many patients endure to obtain the correct diagnosis and treatment for their condition.

PMC is an educational and advocacy organization that promotes the understanding and adoption of personalized medicine to benefit patients and the health care system. We represent more than 240 academic, patient, provider, and payer organizations, as well as drug and diagnostic manufacturers and clinical laboratories. Given the hopes and desires of the patient and health care stakeholder communities united in PMC, the Coalition has a keen interest in CMS' activities.

The Importance of Sustaining Progress in Personalized Medicine

At a time of unprecedented scientific and medical breakthroughs, personalized medicine has the capacity to more accurately diagnose human diseases, predict individual susceptibility to disease, detect the onset of disease at early stages, preempt its progression, target treatments, and increase the overall efficiency and effectiveness of the health care system.

These advances have already impacted the way we treat patients. Melanomas are now characterized as BRAF-positive or –negative. In addition, non-small cell lung cancer can be categorized as EGFR- or ALK-positive, and can be treated with the targeted drug most likely to improve the patient's health. Furthermore, targeted therapeutics account for 20 percent of FDA's 2014 new drug approvals, attesting to the growth of the field.

Personalized medicine is diagnostic dependent, and yet, payer coverage and payment policies often fail to recognize the guiding role of diagnostics in health care, in particular the significant costs of research and development to produce the clinical evidence required to demonstrate the necessity of the test.

In previous communications with CMS, PMC has raised concerns about the possible negative impact of some of CMS' policies on the improvement of health care. We hope that in this regulation CMS will avoid implementing policies that unintentionally impede the continued development of personalized medicine and the associated advances it offers patients.

Over the past three years, CMS has made many policy decisions that have hindered the field. Those include delays in recognizing new Molecular Pathology Current Procedural Terminology (CPT) codes for Medicare payment in 2012, stopping nearly all payments for genetic testing in the first quarter of 2013, and, more recently, permitting Medicare Administrative Contractors (MACs) to assign no payment rates to the vast majority of new CPT codes for Genomic Sequencing Procedures.

Finalization of this rule is an opportunity for CMS to support personalized medicine's continued advancement by making a number of changes in how Medicare will handle reimbursement for diagnostic tests. We present our recommendations below.

1. Forestall paying for CLFS tests at rates based on applicable information until January 1, 2018 to provide laboratories with the time and information necessary to comply with requirements.

To help assure that the data on which payment rates under the CLFS will be calculated are reasonably accurate, CMS should grant laboratories adequate time and information about requirements so they can prepare for reporting and do so in an orderly fashion.

CMS has proposed that the initial data collection period would begin on July 1, 2015, and end on December 31, 2015. This period was almost half over when CMS posted the proposed rule, and CMS has not yet provided laboratories with critical specifics regarding what and how they will be expected to report. We believe that the possibility of all applicable laboratories' accurately reporting under these circumstances is very low, while laboratories will be exposed to the risk of incurring large penalties for failure to submit complete and correct information. CMS failed to meet the statutory deadline for a final rule and now has proposed a compressed timeline that appears likely to result in substantial difficulties and inaccurate data on which to set payment rates.

Many laboratories do not yet know if they will be required to report. CMS proposes defining an applicable laboratory by Taxpayer Identification Number (TIN). However, in the proposed rule the agency acknowledges that it considered defining applicable laboratory by National Provider Identifier (NPI). Furthermore, the proposed rule specifically requests comments on the applicable laboratory definition and whether there are "possibly superior approaches to defining applicable laboratory." In addition, the definition of applicable laboratory requires consideration of Medicare revenues for laboratory tests paid on the CLFS, the Physician Fee Schedule

(PFS), and other Medicare revenues. The proposed rule also seeks comments on whether data should be reported at a higher level of aggregation (such as a corporate parent TIN on behalf of subsidiary TINs) or at a lower level (e.g., NPI).

Given this uncertainty about the definition and CMS' proposal that an entity that does not meet the definition of an applicable laboratory is prohibited from reporting applicable information, clinical laboratories need to have the final regulation as well as sub-regulatory guidance in hand in order to make this determination and begin to prepare to report if they are so required.

We are concerned that CMS' proposed definition of the applicable laboratory excludes about 40 percent of the market, and that such exclusion might artificially depress new market rates. However, we are also concerned that the reporting requirements and penalties are an unacceptable burden to place on many of the entities that CMS currently proposes to exclude. We ask that CMS ensure that market rates are appropriately set while not overburdening smaller entities. Overly burdensome requirements and artificially low market rates both threaten patients' timely access to medically necessary clinical tests.

Applicable laboratories will need adequate time to review the final regulation, gather, collect, collate, format and verify their data in the required format, and receive training on the use of CMS' data submission portal prior to submitting their data. The difficulty of this situation is compounded by the possibility that the Secretary may assess a civil monetary penalty of up to $10,000 per day, per violation, for a reporting mistake or failure to report.

PMC believes that a clearly defined set of reporting rules and a deliberate process for laboratories to implement them is critically important, particularly the first time applicable laboratories report applicable information, as the payment rates on the CLFS for clinical diagnostic laboratory tests (CDLTs) cannot be adjusted for three years.

PMC respectfully requests that CMS delay the start of the data collection period and the start of the data reporting period until after a final regulation and sub-regulatory guidance is released. CMS should forestall, until January 1, 2018, the use of CLFS rates based on applicable information, and adjust other deadlines accordingly. Congress intended for the implementation of PAMA's data reporting to occur over an 18-month time horizon, starting with the release of a final rule on the data reporting requirements by June 30, 2015. Laboratories still need this time to comply with the new requirements, despite the delay in rulemaking. CMS should provide detailed instructions to laboratories, and adopt a schedule that allows laboratories sufficient time to make accurate reports.

2. Use the gap-filling process for pricing MAAAs that received new CPT codes in the future.

For new MAAAs, CMS should be more receptive to use of gap-filling.

Under the new system of rate setting, CMS will still employ the existing methods — cross-walking and gap-filling — for setting payment rates for new tests (and, as proposed, certain other tests where information about private payer rates is not readily available). We believe that the decision of whether to cross-walk or gap-fill

should be made judiciously and reflect input from impacted stakeholders, the Advisory Committee on Clinical Diagnostic Laboratory Tests, and knowledgeable parties at the annual laboratory public meeting. However, CMS originally proposed, for CY 2016, to cross-walk the payment rates for a number of MAAAs, tests that are significant contributors in implementing precision treatments and that are likely to be an even more important part of personalized medicine in the future. CMS' proposal to use the cross-walking methodology to set 2016 CLFS payment rates for MAAAs with new CPT codes would have resulted in payment cuts of 30 to 90 percent for several well-established tests that MACs have paid through Local Coverage Determinations (LCDs) for years. As a result, we are greatly appreciative of CMS' decision to utilize gap-filling for the majority of payment rates for MAAAs in the final determinations.

After significant public outcry, CMS ultimately announced that the agencies will instruct MACs to use the gap-filling process to set 2016 CLFS payment rates for these tests, and CMS should be more receptive to use of gap-filling in the future in establishing payment rates for new MAAAs without reasonable cross-walk candidates. CMS proposes to provide explanations for gap-filling determinations; currently, explanations are provided for cross-walking, but not for gap-filling. PMC supports the agency's proposal to provide explanations for payment rates determined by gap-filling, but urges CMS to make other changes to the gap-filling process to improve not only the process, but also the prices that result from it. The regulations (42 CFR 414.508(b)) state that gap-filling is used "when no comparable existing test is available" and that rates determined using gap-filling should be informed by "(i) charges for the test and routine discounts to charges; (ii) resources required to perform the test; (iii) payment amounts determined by other payers; and (iv) charges, payment amounts, and resources required for other tests…"

To ensure the process functions in accordance with these regulations, PMC recommends that CMS clearly articulate to the MACs what data sources can be used in the process. Also, both MACs and laboratories should be educated on what is expected of them for the gap-filling process to work as intended. Most importantly, PMC requests that the process become more transparent, so that interested parties can better understand how the preliminary and final gap-filling determinations were reached. We believe that implementing these changes will significantly improve how the gap-filling process functions and its results.

3. Address outstanding issues regarding ADLTs.

The proposed rule does not satisfactorily address numerous areas regarding ADLTs.

A. The proposed definition of an ADLT should be harmonized with the statute and with the recommendations of the Advisory Committee on Clinical Diagnostic Laboratory Tests.

CMS' proposed definition of an ADLT is overly restrictive and directly conflicts with the statute. Section 1834A(d)(5) of the Social Security Act, added by § 216 of PAMA, defines an ADLT as a CDLT covered under Medicare Part B that is offered and furnished only by a single laboratory and not sold to other laboratories. Further, an ADLT must meet one of the following criteria:

1. The test is an analysis of multiple biomarkers of deoxyribonucleic acid (DNA), ribonucleic acid (RNA) or proteins combined with a unique algorithm to yield a single patient-specific result;

2. The test is cleared or approved by the Food and Drug Administration (FDA); or

3. The test meets other similar criteria established by the Secretary.

The proposed rule's interpretation of (1) is much narrower than the statute. It states that an ADLT:

i. Must be a molecular pathology test of multiple biomarkers of DNA or RNA;

ii. When combined with an empirically derived algorithm, yields a result that predicts the probability a specific individual patient will develop a certain condition(s) or respond to a particular therapy(ies);

iii. Provides new clinical diagnostic information that cannot be obtained from any other test or combination of tests; and

iv. May include other assays.

The significant differences between the proposed definition and the statutory provision are alarming to PMC members. Our Coalition urges CMS to adopt a definition of an ADLT in the final rule to faithfully conform with the clear language of the statute.

First, CMS should revise its proposed definition of ADLTs so that it would encompass a test that is "an analysis of multiple biomarkers of DNA, RNA, or proteins." Second, CMS should revise its proposed definition of a "unique algorithm" to reflect the statutory language and eliminate the need for a complex process for determining "uniqueness."

Making these changes will align the proposed rule's requirements with the recommendations of the CMS Advisory Panel on Clinical Diagnostic Laboratory Tests.

B. CMS should clarify the process for innovator laboratories to pursue ADLT designation.

CMS should provide information as soon as possible regarding what information will be required in the application for a test seeking ADLT designation. CMS should not require "proprietary information" or "trade secrets" in order to designate an assay as an ADLT. Adequate information exists in the public domain, including peer-reviewed publications, to determine that a unique algorithm is empirically derived for an assay of multiple biomarkers of RNA, DNA or proteins, and that the assay is furnished only by a single laboratory. Similarly, if the assay has FDA clearance or approval, that documentation should be adequate to meet the statutory definition of an ADLT without the lab needing to provide detailed mathematical information on its algorithm that the lab considers proprietary or a trade secret.

C. In connection with applications for ADLT status, CMS should protect innovators' "commercial or financial information" and "trade secrets" from public disclosure, as required by applicable laws.

PMC is particularly concerned about CMS' statement in the proposed rule regarding the confidentiality protections for ADLT applications.

The proposed rule indicates that while CMS does not "expect to make information in an ADLT application available to the public," it is not explicitly protected from disclosure under the confidentiality provisions of PAMA. Further, the proposed rule states that laboratories' ADLT applications are "not explicitly protected from disclosure in response to a Freedom of Information Act (FOIA) request" and that CMS would determine whether the information in the application qualified as "trade secrets and commercial or financial information" and was thus exempt from disclosure under FOIA exemption (b)(4). [1]

We emphasize our understanding that the intent of Congress was to protect the confidentiality of all information submitted by laboratories pursuant to § 216 of PAMA. We believe protection of information about proprietary algorithms is particularly important, and we are concerned that CMS be able to assure innovator laboratories that information it requires as part of ADLT applications, when appropriately identified as "trade secrets" and "commercial or financial information" at the time of the application, will be kept confidential. Lack of reasonable assurances may in effect foreclose this avenue in the eyes of some innovator laboratories.

CMS expects to "establish guidelines for laboratories to apply for ADLT status and submit documentation to support their application," including "evidence of their empirically derived algorithms." The preamble states that the applicant "may mark information as confidential and proprietary" but it may be subject to FOIA disclosure unless it is exempt under Exemption 4. According to CMS, applicants would need to submit a separate statement describing how the disclosure of the ADLT application "would cause substantial competitive harm."

CMS should clarify in the final rule that ADLT applications will necessarily contain "commercial or financial information" obtained from a person, and that such information, if marked at the time of the application as "privileged or confidential," is exempt from disclosure under FOIA Exemption 4.[2] FOIA does not apply to "commercial or financial information obtained from a person and privileged or confidential." 5 U.S.C. § 552(b)(4). Furthermore, CMS should clarify that information in an ADLT application that is marked as "trade secret" at the time of application is protected from disclosure under the Trade Secrets Act.[3] CMS should establish a clear

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[1] The Justice Department's "Freedom of Information Act Guide" says that Exemption 4 of FOIA "is intended to protect the interests of both the government and submitters of information... and affords protection to those submitters who are required to furnish commercial or financial information to the government by safeguarding them from the competitive disadvantages that could result from disclosure." See: http://www.justice.gov/oip/foia-guide-2004-edition-exemption-4

[2] The application for ADLT status, including documentation and evidence of empirically derived algorithms, will necessarily contain extensive commercial or financial information, obtained from a person, that is privileged or confidential. As such, the ADLT application marked "privileged or confidential" should be excepted from disclosure under FOIA Exemptions (b)(4). *See* 5 U.S.C. § 552(b)(4); *Canadian Comm. Corp. v. Dep't of the Air Force*, 442 F. Supp. 2d 15, 29 (D.D.C. 2006).

[3] When information is exempt from release under FOIA Exemption 4, the Government is precluded from releasing it under the Trade Secrets Act. *NASA*, 180 F.3d at 305 (citing *McDonnell Douglas Corp. v. Widnall,* 57 F.3d 1162, 1164 (D.C. Cir. 1995)). "Exemption 4

process and guidelines for laboratories to mark their information as "trade secrets" and / or as "privileged or confidential" "commercial or financial information" that they wish to protect from disclosure, if CMS requests such information.

CMS should also clarify in the final rule (1) that the process of applying for ADLT status is voluntary, meaning that information submitted is exempt from disclosure if it is of a kind that the company would customarily not release to the public or, at a minimum, clarify (2) that applicants need to submit a statement not that disclosure "would cause" substantial competitive harm, but only that disclosure "would likely cause" such harm to occur. Under FOIA case law, the question of whether information is proprietary and confidential, and therefore protected from disclosure, turns on whether it was provided to the government voluntarily or under compulsion.

McDonnell Douglas Corp. v. NASA, 180 F.3d 303, 304 (D.C. Cir. 1999); *Critical Mass Energy Project v. Nuclear Reg. Comm'n*, 975 F.2d 817 (D.C. Cir. 1992) (en banc).

Laboratories applying for the ADLT designation have discretion to (1) submit the evidence of their empirically derived algorithm to CMS for review, or (2) submit an application for premarket approval or 510(K) clearance from the FDA. Thus, the submission of evidence relating to an empirically derived algorithm to CMS is voluntary. Further, the laboratory's participation in the Medicare program is voluntary. For this reason, the information in the ADLT application is protected from disclosure under FOIA Exemption 4 under the *Critical Mass* rubric, which provides that voluntarily provided information should be kept confidential if the information is of a kind that the company would customarily not release to the public. *Critical Mass Energy Project*, 975 F.2d at 880 (D.C. Cir. 1992) (en banc).[4] CMS should establish clear processes for laboratories that reflect this analysis and aid laboratories in protecting their information.

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marks the outer boundaries of the government's FOIA privilege by identifying materials that a person making a FOIA request has no right to force the government to divulge, whereas the Trade Secrets Act establishes a private right against unauthorized governmental publications of confidential information." *McDonnell Douglas,* 57 F.3d at 1164. Thus, when requested information falls within Exemption 4, "the government is precluded from releasing the information by virtue of the Trade Secrets Act." *Id. See also Canadian Comm. Corp.*, 514 F.3d at 39 ("The upshot is that, unless another statute or a regulation authorizes disclosure of the information, the Trade Secrets Act requires each agency to withhold any information it may withhold under Exemption 4 of the FOIA.").

[4] As the court explained in that case: "It is a matter of common sense that the disclosure of information the Government has secured from **voluntary** sources on a confidential basis will both jeopardize its continuing ability to secure such data on a cooperative basis and injure the provider's interest in preventing its unauthorized release. Accordingly, while we reaffirm the *National Parks* test for determining the confidentiality of information submitted under compulsion, we conclude that financial or commercial information provided to the Government on a **voluntary** basis is "confidential" for the purpose of Exemption 4 if it is of a kind that would customarily not be released to the public by the person from whom it was obtained." *Id.* at 879.

Assuming *arguendo* that applications for ADLT status are **involuntary** submissions, their disclosure is still exempt from the FOIA requirements "if disclosure would be **likely** either (1) to impair the government's ability to obtain necessary information in the future; *or* (2) to cause **substantial harm to the competitive position** of the person from whom the information was obtained." *NASA*, 180 F.3d at 305 (citing *Nat'l Parks & Conservation Assoc. v. Morton*, 498 F.2d 765, 770 (D.C. Cir. 1974)) (emphasis supplied).

Even if CMS believes that the application for ADLT status is not voluntary and that a separate statement about "substantial competitive harm" is required, the case law requires applicants to demonstrate only that substantial competitive harm is "likely" to occur, not that it "would" occur.[5]

5. Refine the process for coding and coverage for new ADLTs and CDLTs.

A. PMC endorses using an existing approach to establish new codes, in a timely manner, for ADLTs and CDLTs that will ensure consistent coding across Medicare and other payers and one code for the life of a test.

CMS has proposed to create G codes to identify new and existing ADLTs and new and existing CDLTs (that are not ADLTs) that are cleared or approved by the FDA if a specific Healthcare Common Procedure Coding System (HCPCS) code does not already exist. In response to this proposal, the American Medical Association (AMA)'s Molecular Pathology Coding Workgroup has developed, and the CPT Editorial Panel has authorized, a new section in the CPT code set that will provide an appropriate coding solution and ensure consistent and accurate coding for all stakeholders, including payers, providers, and clearinghouses.

A clinical laboratory or manufacturer that meets certain criteria may request a code to more specifically identify their test. This section is separate from the Category I Pathology and Laboratory section of the CPT Manual and will include ADLTs and CDLTs as defined under PAMA. The clinical laboratory or manufacturer that offers the test must request the code. The AMA envisions that the codes in this new section will be issued on a quarterly basis and be effective the following quarter to allow payers time to enter them into their systems, and PMC is encouraged by this timely process. The CPT Editorial Panel would be responsible for verification of the information submitted and codification of tests in this section but will not determine whether or not the test meets the criteria of an ADLT, which will be determined by CMS.

B. PMC urges CMS to ensure that coverage decisions for new ADLTs and new CDLTs are developed in a transparent manner with input from the personalized medicine community.

PAMA mandates that MACs adhere to the process for developing LCDs. The potential for consolidation to one to four MACs would, if implemented, turn the coverage decisions made through the LCD process into a *de facto* national coverage decision (NCD). Because the protections, transparency and opportunity for stakeholder input are different for a LCD versus an NCD, this consolidation could create a system that mirrors the scope of an NCD, but lacks a commensurate process to ensure transparency, accountability, and stakeholder input. PMC is concerned that the process for determining coverage lacks adequate opportunity for stakeholder input in its current form. We urge CMS to work with the Advisory Panel on Clinical Diagnostic Laboratory Tests and stakeholders in the personalized medicine community to ensure that Medicare coverage decisions are consistent with the goals of the Precision Medicine Initiative.

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[5] "If commercial or financial information is **likely** to cause substantial competitive harm to the person who supplied it, that is the end of the matter." *MCI Worldcom v. GSA*, 163 F. Supp. 2d 28, 35 (D.D.C. 2001) (citing *NASA*, 180 F.3d at 306).

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As CMS works to implement § 216 of PAMA, it will be particularly important to ensure that the reforms to Medicare's CLFS payment system do not have unintended consequences that limit the continued development and adoption of personalized medicine. We would be pleased to discuss our recommendations with CMS in more detail and identify concrete steps PMC can take to support personalized medicine and its goal of achieving higher quality, higher value health care.

For more information, please contact Amy M. Miller, Ph.D., Executive Vice President of PMC, via email at amiller@personalizedmedicinecoalition.org or via phone at (202) 589-1769.

Sincerely yours,

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