COLLEGE of AMERICAN PATHOLOGISTS

June 19, 2015

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

The Honorable Frank Pallone
Committee on Energy and Commerce
2424 Rayburn House Office Building
Washington, D.C., 20515

Dear Chairman Upton and Ranking Member Pallone:

The College of American Pathologists (CAP) appreciates the opportunity to comment on the Energy and Commerce Committee's (E&C) discussion draft that establishes a regulatory framework for Laboratory Developed Tests (LDTs). The CAP represents 18,000 pathologists who practice clinical and/or anatomic pathology in community hospitals, independent laboratories, academic medical centers, and federal and state health facilities. CAP members are at the forefront of utilizing new methods including molecular and genomic testing that predict and diagnose disease, and guide specific patient treatment. Utilizing teams of practicing laboratory professionals as inspectors, the CAP Laboratory Accreditation Program helps laboratories maintain consistently high levels of service throughout all levels of laboratory operations. Based on rigorous accreditation standards translated into detailed and focused checklist requirements, the CAP program provides a quality practice blueprint for laboratories to follow and has done so for more than 50 years. As part of our continuing effort to improve laboratory quality, in 2009, the CAP put forth a comprehensive reform proposal to modernize the oversight of LDTs. Given the CAP's extensive experience in assuring reliable and accurate laboratory testing, we welcome the opportunity to provide comments on the committee's draft proposal.

The CAP appreciates the challenges facing the committee to develop a regulatory framework that enhances patient safety, and maintains quality laboratory testing and innovation without creating a significant regulatory burden on laboratories. To effectively meet these goals, the CAP believes that any legislation should rely on the existing Clinical Laboratory Improvement Amendments (CLIA) framework as much as possible while also taking into account the unique roles of the Centers for Medicare & Medicaid Services (CMS) and the Food and Drug Administration (FDA). Since 2009, the CAP has maintained that enacting modifications to CLIA is the most effective and least burdensome approach to achieving our mutual goals of ensuring patient safety and sustaining continued innovation in diagnostic testing. However, CAP continues to support a targeted role for the FDA to regulate those high risk LDTs that cannot be adequately regulated through enhancements to CLIA.

The CAP is concerned that the E&C legislative draft proposes an entirely new regulatory framework that creates regulatory complexity and increases the burden on laboratories. The CAP believes that such an approach is unnecessary to ensure appropriate oversight of LDTs. The CAP would like to call the committee's attention to the following key provisions in the draft that should be significantly altered or removed:

- In **Section 2.(a),** the draft reclassifies LDTs as in vitro clinical tests (IVCTs). It defines an IVCT as "an in vitro test that is a finished product or laboratory test protocol intended by the developer to be used in collection, preparation, analysis, or in vitro clinical examination of specimens taken or derived from the human body, solely or principally for the purpose of identifying, measuring, predicting, monitoring, or assisting in selecting treatment for, a disease or other condition; provided, however, that blood screening tests regulated under Section 351 of the Public Health Service Act are not in vitro clinical tests." The CAP disagrees with the draft concept that all LDTs, as laid out in the E&C definition, must go through the FDA as devices and that laboratories could no longer develop low- or moderate-risk LDTs outside of the FDA's authority. This is an unnecessary hurdle laboratories can

provide quality laboratory testing under CLIA, particularly for low- and moderate-risk LDTs where pathologists perform laboratory operations and develop LDTs. For laboratories that perform these activities, this provision creates an unnecessary regulatory burden that is better addressed through the existing CLIA process.

- In **Section 3.(b)(1) and Section 5.(a)(1)(A),** the draft seeks to limit FDA jurisdiction to activities related to test development (design, development, and validation) and provides that all other activities related to LDTs are a function of laboratory operations under the regulatory control of the CMS/CLIA. While the CAP believes the intent of the draft is to alleviate the burden on laboratories, we feel the draft falls short of this goal because the regulatory framework is unnecessarily complex. Further, the new proposed framework subjects all future LDTs to FDA approval, which the CAP believes is not necessary and will discourage innovation in diagnostic testing by laboratories.

- In **Section 3.(b)(2)(B) and Section 5.(a)(1)(B)(ii),** the draft contains a provision that stipulates the Secretary shall not regulate the practice of medicine under both the FDA and CMS regulatory sections**.** The provision then defines and codifies the practice of medicine in the legislation. The CAP does not support the codifying of the practice of medicine at the federal level and believe the practice of medicine should remain under the jurisdiction of individual states. Therefore, these provisions should be removed from the draft regardless of the committee's final legislative construct.

- In **Section 3. 590A(a)(1),** the draft proposes the FDA jurisdiction over the development of an LDT. We are concerned that laboratories could no longer develop low- or moderate-risk LDTs outside of FDA's authority. The CAP supports a three-tiered risk-classification, but believes the definition of an LDT and the high-risk test definition are problematic. Furthermore, the draft does not adequately define what constitutes a high-risk test and creates confusion between the risk classification of moderate and high-risk tests. Instead, we suggest the committee adopt the CAP's definition of high-risk LDTs, which is limited to tests where (1) the consequence of an incorrect result could lead to morbidity or mortality and (2) the test methodology is not independently verifiable.

  Additionally, the CAP does support an exemption for tests for rare diseases, unmet needs, and traditional LDTs and believe these tests should be classified as low-risk LDTs, regulated under CLIA rather than FDA.

- In **Section 3. 590B(k),** the draft establishes a process for modified IVCT premarket requirements. The CAP believes that a laboratory making a significant change to an LDT procedure or claim must validate those changes as specified in the draft proposal. We differ with the regulatory construct insofar as technical modifications of moderate and low-risk tests should remain under the oversight of the CMS or one of its deemed accrediting bodies as opposed to high risk LDT modifications which should be reported to FDA. The CAP also supports the draft provision that requires reporting of modifications to high and moderate-risk LDTs if the intended use changes and has "meaningful clinical impact." The CAP believes the definition of "meaningful clinical impact" is appropriate. The CAP further agrees that modifications to low-risk tests should not be subject to reporting unless they change the risk classification.

- In **Section 5.(d),** the draft expands the certification and standards for specialties and sub-specialties to include genetics, biochemical genetics, cytogenetics, flow cytometry, molecular pathology, microbiology, molecular microbiology, and other appropriate specialties and subspecialties. It is unnecessary for the committee to consider legislation that expands

certification and standards for subspecialties and develop new standards for genetic tests in the context of a LDT regulatory framework. This expansion only adds additional burdens to laboratories with regulation not integral to an LDT regulatory framework and, therefore, the CAP believes these provisions should be removed from the draft.

In 2007, the CMS rejected a Citizen Petition filed by Genetics & Public Policy Center, Public Citizen, and Genetic Alliance to create a genetic specialty. As part of its response, the CMS analyzed the viability of expanding CLIA specialties but concluded after careful study that the benefit of expanding specialties did not justify the cost or the imposed burden on society.[1] Instead, the Secretary established a regulatory scheme based on three categories of tests: waived or "simple" tests, moderate complexity tests, and high complexity tests, not specialties or sub-specialties. For example, various tests that we would all regard as "genetic tests" are in actuality dispersed throughout different operational sections of the laboratory and many are found in different existing CLIA specialties. This provision would require a teasing out of certain tests from some existing specialties, and cause some disruption to existing regulatory and payment structures. Further, the CMS explained from its 2007 response that in 2003 the CMS promulgated final regulatory amendments that reduced the number of specialties under CLIA in order to reduce complexity, standardize the requirements, and reflect current technologies that may overlap specialties. Through the same regulatory amendments, the CMS *increased the quality control requirements* that would apply to all laboratories conducting moderate or high complexity testing, so that the existence of a specialty area would be less of a factor.

The CAP Alternative LDT Oversight Framework

As you know, the CAP has advocated for its longstanding proposal to serve as a template for any regulatory oversight of LDTs. The CAP respectfully requests the committee to consider our approach as a substitute for any legislative proposal. The major elements of the CAP's proposal are:

- A tiered risk-based regulation that would focus FDA oversight to the tests that currently have the least transparency and highest potential patient risk.
- Allowance for evaluation of patient risk based on a laboratory's claims for the test and the potential for harm to patients of an incorrect or misinterpreted test.
- Provision for achievable and targeted FDA oversight of high-risk LDTs as we define these categories in our proposal.
- Provision for assurance of both analytic and clinical validity of laboratory tests.
- Requirement for notification by laboratories to the Secretary of each LDT in use since 2003.
- Allowance for continued CMS oversight of laboratory quality under CLIA for moderate- and low-risk LDTs as we define these categories in our proposal.
- Definition of a regulatory process for modified LDTs with significant modifications to report high-risk tests to the FDA and for moderate- or low-risk to CMS.
- Classification of LDTs for rare diseases, unmet diseases, and traditional LDTs as low-risk tests.
- Requirement for adverse event reporting by laboratories to the Secretary or deemed accrediting agencies.
- Promotion of transparency by making test information publicly available.
- Encouragement of coordination between the FDA and the CMS to avoid duplicative or unduly burdensome requirements on laboratories.

[1] www.dnapolicy.org/resources/CMSresponse8.15.07.pdf).

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The CAP would like to thank the committee for sharing its discussion draft of its framework for LDT oversight and allowing us to comment. The CAP is concerned that the current draft is unnecessarily complex and burdensome to laboratories and that our proposal offers a simplified yet practical and balanced risk-based approach for clinical laboratories to provide accurate and reliable test results for clinicians and patients. The CAP requests that the committee reconsider its draft legislative approach as the CAP cannot support the draft proposal as currently written. Finally, the CAP respectfully requests the committee to consider the CAP's proposal as an alternative approach to the regulation of diagnostic testing.

Sincerely,

Gene N. Herbek, MD, FCAP
President
College of American Pathologists