

September 28, 2022

Dr. Robert Otto Valdez, Ph. D., M.H.S.A.
Director, Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Re: Comments on Draft Analysis of Requirements for Coverage with Evidence Development (CED)

Dear Dr. Valdez:

The 20 undersigned organizations are pleased to provide comments the Agency for Healthcare Quality and Research (AHRQ) on the Draft “Analysis of Requirements for Coverage with Evidence Development (CED)” (the “draft Report”).¹ **Together, we strongly urge AHRQ to revisit its draft, eliminate the “cost-effectiveness” research from its consideration, and revise its report to produce CED study principles that reinforce the Centers for Medicare and Medicaid Services’ (CMS’s) stated goal to “advance equity” by addressing the underlying factors contributing to disparities in access present under the current CED process.**

We appreciate the efforts of AHRQ to enhance the criteria for CED studies, but unfortunately we believe the draft falls short in its goals. As the draft itself acknowledges, the CED process has long been broken, delaying access for aging adults in the Medicare program, and in nearly all cases has created a series of “studies” that continue on without a clear or timely end. The result has been a virtual black hole of uncertainty, with patients in need of treatment being denied care because Medicare coverage is not available outside of academic medical centers or other limited study sites.

In our view, AHRQ has missed an important opportunity to address these issues within the scope of responding to the CMS request, and instead has produced a document that will further perpetuate the health equity challenges pervading the healthcare system, including the Medicare program. We urge AHRQ to revise its draft Report to address these issues.

Statement of Interest

Organizations listed on this letter may present their own responses to AHRQ and/or CMS and will actively advocate for those positions. These comments are not intended to impact adversely the ability of individual organizations, alone or in combination, to pursue separate

¹ Available at: <https://effectivehealthcare.ahrq.gov/products/coverage-evidence-development/draft-comment>

comments with respect to AHRQ's proposed Topic Refinement on CED or future activities or regulations drafted by CMS.

Overview of Comments:

Our comments in Section I address the state of the CED process today, including how the process has created barriers to access, and ultimately frustrated CMS' stated goals. Section II addresses several process flaws in AHRQ's and CMS's processes, which are not transparent; and an inappropriate reliance on cost-effectiveness studies, leading to an improper and possibly illegal report. Section III addresses substantive flaws in the proposed "clinical" and other trials that AHRQ suggests could qualify for the CED process, including a strong recommendation that AHRQ insist to CMS that all CED studies be listed on Clinicaltrials.gov. Finally, we conclude with several recommendations to AHRQ how its study should be revised.

I. The CED Process is Badly Damaged, with "No Clear Therapy-Specific Rubric for Successful Retirement of CED Data Collection Requirements," Defeating the Purpose for Which it Was Created

On page 29 of its draft report, AHRQ acknowledges the reality that the CED process is broken and is failing to serve either CMS or Medicare beneficiaries.² Although the draft report acknowledges that "action based on the results of CED studies was infrequent"³, the situation is far more dire. AHRQ does not acknowledge the millions of Medicare beneficiaries being denied access to treatment while nearly two dozen CEDs continue for years without an end in sight.

An April 2022 study published in the *American Journal of Managed Care (AJMC)* on the CED process⁴ notes that of 27 CEDs initiated over the past 15-20 years, only six have been retired (taking between 4-12 years for retirement, and one never even having started), with the others remaining ongoing. Of the six CEDs that were retired, two resulted in deferral to the Medicare Administrative Contractors for local coverage decisions. The AJMC study also found material inconsistency across the CED program, noting: "...significant variation in [CED] use over the past 15 years ... but there was tremendous variability in execution of the program across therapies

² We do not address in these comments why the CED process is in violation of the Medicare statute, as we appreciate that it is beyond the scope of AHRQ's study. We note, however, that Congress has never authorized a "Coverage with Evidence Development" pathway for the National Coverage Determination process, CMS lacked the statutory authority to issue its 2014 "Guidance Document" and lacks the same authority to update that document using the AHRQ analysis. We reserve the right to address these issues when the Medicare Evidence Development and Coverage Advisory Committee ("MEDCAC") considers the AHRQ study later this year.

³ draft Report at 29.

⁴ See Zeitler, Coverage With Evidence Development: Where Are We Now?, *The American Journal of Managed Care*, August 2022, Volume 28, Issue 8, *Am J Manag Care*. 2022;28(8):382-389.

<https://doi.org/10.37765/ajmc.2022.88870>. Dr. Zeitler's conclusions are not new – other studies have similarly concluded that "CED schemes...are often costly, complex, and challenging." Federici, Coverage with evidence development schemes for medical devices in Europe: characteristics and challenges. *Eur J Health Econ*. 2021 Nov;22(8):1253-73. <https://doi.org/10.1007/s10198-021-01334-9>. PMID: 34117987.

and services.”⁵ Even for relatively modest CEDs with only registry requirements, the study noted that “data collection ... was never systematically incorporated into clinical workflow. As such, substantial burden was shouldered by participating groups...”⁶

Perhaps most significant, however, Zeitler and colleagues identified in the AMJC article the lack of a “clear therapy-specific rubric for successful retirement of CED data collection requirements” as a crucial barrier, stating that such a rubric “should be established a priori to enhance the authority of CMS to reconsider CEDs if criteria are not met; such a rubric would offer transparency and predictability to patients, providers, and other data collection stakeholders while better aligning access to therapies and services with the available evidence in a timely manner.”

In its 2014 guidance on CED, within the section “Ending CED”, CMS states that the purpose of the CED studies is to “produce evidence that will lead to revisions in Medicare coverage policies,” and cites two examples of completed CED processes—NCDs for oncologic uses of fluorodeoxyglucose positron emission tomography, and ventricular assist devices. CMS implies, but does not make explicit, that there should be **a clear beginning and end to the CED process**. The “Ending CED” section further states that “Studies with a specific design, such as randomized clinical trials, have established start and end dates. When enrollment and follow up are complete, the data are to be analyzed and published in the peer reviewed medical literature.”⁷ However, that is not the reality, and nearly 20 CEDs initiated years ago remain pending with no end date in sight.

Even when investigators analyze CED study data and publish in “peer reviewed medical literature,” the current AHRQ CED study criteria do not outline CMS requirements to retire a CED NCD. For example, since 2010 access to stem cell transplant for myelodysplastic syndromes (MDS)—cancerous bone marrow diseases in older adults—has continued to be limited under CED,⁸ despite having a successful CED study published in 2020.⁹ The *JAMA Oncology* study concluded, “Availability of insurance coverage affects access to HCT [allogeneic hematopoietic stem cell transplantation, or HCT]. Outcomes in patients older than 65 years are only marginally different from those in younger patients. Based on current data, we would recommend coverage of HCT for MDS by CMS.”¹⁰ Stem cell transplant is the only curative therapy available for myelodysplastic syndromes, which impact an estimated 10,000 older adults every year in

⁵ *Id.*

⁶ *Id.*

⁷ <https://www.cms.gov/medicare-coverage-database/view/medicare-coverage-document.aspx?MCDId=27>.

⁸ <https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=238>.

⁹ Atallah E, Logan B, Chen M, Cutler C, Deeg J, Jacoby M, Champlin R, Nishihori T, Confer D, Gajewski J, Farnia S, Greenberg P, Warlick E, Weisdorf D, Saber W, Horowitz MM, Rizzo JD. Comparison of Patient Age Groups in Transplantation for Myelodysplastic Syndrome: The Medicare Coverage With Evidence Development Study. *JAMA Oncol.* 2020 Apr 1;6(4):486-493. doi: 10.1001/jamaoncol.2019.5140. PMID: 31830234; PMCID: PMC6990739.

¹⁰ *Ibid.*

the U.S.,¹¹ but data from 2019 Center for International Blood and Marrow Transplant Research reveal less than 1,000 HCT transplants performed in 2019.¹² The result is that patients, and particularly minorities, in need of access to stem cell transplant are being denied the only available treatment because twelve years after the start of the CED process, and two years after its completion with a positive recommendation, the CED remains open.

While CMS maintains that “studies conducted under a CED NCD will produce evidence that will lead to revisions to Medicare coverage policies,” the process is not functioning properly for either beneficiaries or the Medicare program. As demonstrated above, coverage policy revisions are not occurring in a timely manner – some studies are never started, others have no end dates, and even when concluded and additional data are available, the CED process remains open. **For these reasons, AHRQ’s study criteria should include more explicit recommendations on requirements for how CMS should retire an NCD CED.**

Additionally, the AJMC study¹³ found no definitive time period outlined for coverage reconsideration, which prevents the CED process from functioning.

Currently, data collection mechanisms for the CED program are designed and implemented without a specific and transparent timeline for coverage reconsideration by CMS. This is exemplified by the wide range of program duration ... thus, potential sponsors of CED registries or trials may be reluctant to fund these initiatives due to anxiety about the program’s duration, what constitutes “success,” and the possibility of “failure” that may eliminate any form of CMS coverage or even call FDA clearance or approval into question ... a timeline for reevaluation could offer the predictability necessary for collaborators to confidently invest resources in data collection infrastructure. Moreover, from the perspective of CMS and Medicare beneficiaries, a stalled program means either a potentially beneficial therapy is being withheld or a potentially harmful therapy is being furnished to beneficiaries. Measures of ongoing success could be in the form of clinical trial or registry milestones such as protocol design, enrollment initiation, data analysis, and the like. Regardless of the specifics, measures of progress and an assessment timeline should be identified a priori with a plan to address delays on a regular basis.

The AJMC study also revealed other methodologic flaws in the CED process. “One barrier to evidence development is the requirement for substantial logistical and financial investments,

¹¹ <https://www.cancer.net/cancer-types/myelodysplastic-syndromes-mds/treatment-options>.

¹² <https://bloodstemcell.hrsa.gov/data/donation-and-transplantation-statistics/transplant-activity-report#summary>.

¹³ Zeitler, Coverage With Evidence Development: Where Are We Now?, *The American Journal of Managed Care*, August 2022, Volume 28, Issue 8, *Am J Manag Care*. 2022;28(8):382-389. <https://doi.org/10.37765/ajmc.2022.88870>.

and it is not always clear what entity (or entities) should share this burden.” AHRQ, however, in its draft Report never identifies, much less addresses, any of these issues, and particularly the critical issue about lack of definitive timeframes leading to treatments being “stuck” in the CED process in perpetuity. Instead, the report appears to adopt at face value the belief from its sister agency that “CMS is confident that the CED NCD process is sound.”¹⁴ We believe this is a fundamental mistake.

As noted above, the result of today’s CED process is a system that defeats many of CMS’s goals for the Medicare program. Instead of providing Medicare beneficiary access to medically necessary care, the CED process contributes to an ongoing denial of access, often in a medically unethical manner (by requiring Medicare beneficiaries to take placebo rather than treatment for FDA-approved care). Rather than addressing health disparities and meeting CMS’s goal of promoting health equity, the CED requirements proposed by AHRQ would perpetuate minority and neurodiverse individuals’ access to care. The proposed CED requirements will disproportionately exclude people of color, people with intellectual disabilities including Down syndrome, those living with multiple chronic conditions, and those living in rural areas from access to treatment. In effect, the AHRQ proposals will continue to restrict access to an FDA-approved treatments to only small numbers of beneficiaries that are able to self-pay or participate via eligible trial sites.

AHRQ is undoubtedly aware of the recent and controversial CED for Alzheimer’s care, and CMS’s decision to reject the FDA’s determination that monoclonal antibody medication treatment was safe and effective for the treatment of mild Alzheimer’s disease in the Medicare population. CMS’s highly restrictive CED denies millions of Medicare beneficiaries the opportunity to potentially access treatment – even prospectively for future drugs in the class – for a progressive and ultimately fatal disease. Rather than address that issue, AHRQ seemingly has proposed a study framework that will empower even more such CMS actions in the future by building a framework for even more types of undefined “trials” without clear parameters or end dates for CMS to deploy in the future. In our view, this is unacceptable.

It is unclear why AHRQ has chosen to add to the existing confusion in the CED process by increasing the choice of studies available to CMS, rather than by addressing the serious flaws identified in the AJMC paper or through the recent monoclonal antibody for Alzheimer’s CED process. Rather than nod to the AJMC paper on page 29 of the draft Report, we urge AHRQ to address, and provide solutions, to the problems plaguing the CED process today. Unfortunately, the current report simply does not do so.

¹⁴ Draft Report at 3.

II. The AHRQ Study Process Has Been Procedurally Improper

As noted above, we believe that AHRQ has failed to address the critical issues holding back the CED process today. Beyond those issues, however, there are numerous substantive flaws in the additions and changes AHRQ does propose as modifications to the CED process. Before addressing the substantive flaws in the draft study, however, we note that there were several procedural defects in the AHRQ study which must be remedied before it can be finalized.

a. Transparency and Potential Bias

First, AHRQ acknowledges that it consulted with numerous outside “Key Informants” (“KIs”), Draft Report at 5-6, but has failed to identify those individuals prior to requesting public input, raising serious questions about both bias and whether the AHRQ process constituted a violation of the Federal Advisory Committee Act. Second, AHRQ concedes that its work was biased, in that it intentionally refused to consult with experts in the life sciences industry.¹⁵ This determination at a minimum calls into question the completeness and balance of the Report, and betrays an unfortunate bias in the results. Third, AHRQ has provided an unfortunately abbreviated comment period, which it has refused to extend at the behest of CMS, regarding issues of public importance and preventing the agency from obtaining or considering a full set of comments from interested stakeholders. Each of these process flaws requires that AHRQ reissue its study in a fair, unbiased, and transparent manner. We urge the Agency to do so.

b. Improper Reliance on Cost-Effectiveness Studies

There is another, more serious, flaw in the manner in which AHRQ has prepared its report. More specifically, AHRQ identified “similar decision-making bodies” as CMS in “candidate countries” for “CED schemes.” Under its “Methods” section, AHRQ lists the following comparison countries: Australia, Belgium, Canada, England, France, Germany, the Netherlands, Spain, Sweden, and Switzerland. Many of the reference countries, however, make reimbursement and coverage decisions using on cost-effectiveness assessments that rely on the Quality-Adjusted Life Year (QALY) metric. When applied to healthcare decision-making, the results can mean that some patients—particularly those with disabilities and chronic illnesses, and older adults—are deemed not worth the cost to treat.

The countries listed above use cost-effectiveness assessments to restrict citizens’ access to needed treatments. Specifically, many health technology assessments both (a) use QALYs and (b) establish coverage formularies based on cost thresholds that guide the resulting recommendations. For example, the National Institute of Health and Care Excellence (NICE) conducts cost-effectiveness analyses to determine what treatments and drugs will be covered

¹⁵ Draft Report at 6.

by Britain and Wales' National Health System (NHS). NICE's reports are known to restrict patients' access to care, particularly among individuals with complex conditions.¹⁶ Similarly, a 2018 Avalere Health study found that of over 329 cancer drugs with health technology assessments (HTA), only 29 percent of therapies were recommended "without restrictions."

It is highly inappropriate for AHRQ to have relied on these studies, given that the underlying methodology has been found to discriminate against the elderly and the disabled.¹⁷ Further, given that the AHRQ report will be used by CMS for the CED process, reliance on these studies is prohibited by Section 937 of the Patient Protection and Affordable Care Act ("ACA"). More specifically, the ACA disallows the HHS Secretary (and AHRQ, as an agency within HHS) to use QALY as "a threshold to determine coverage, [or] reimbursement," in the Medicare program.¹⁸ Despite this clear parameter, AHRQ, for purposes of a study that will directly impact the CMS CED process which will determine both coverage and reimbursement, is using such studies. We believe AHRQ's use and reliance upon these studies is in direct violation of law.

Further, while CMS in the past has claimed, and in the future will claim, that the CED process does not consider cost in the CED process, those claims will be belied by the fact that CMS will rely on the AHRQ study, which itself is based upon discriminatory cost-effectiveness reports. The public and fellow HHS agencies must not accept CMS's claim uncritically, as cost is a material consideration – named or unnamed – in whether Medicare issues an NCD in the first place. As noted by former Assistant Secretary for Planning and Evaluation Richard Frank and others in *Health Affairs* on the same day as the FDA's approval of aducanumab, "NCDs are the most powerful coverage tool that Medicare has and have generally been reserved for Medicare services that are costly or may be subject to variable local coverage decisions."¹⁹ If AHRQ does not want to taint the CED process, it must redo its study and not consider any of the "cost-effectiveness" research that used QALYs or other similar discriminatory metrics.

¹⁶ Sarah Long, "Squashed Dreams and Rare Breeds: Ableism and the Arbiters of Life and Death," *Disability and Society* 30 (2015): 1118–22.

¹⁷ National Council on Disability, *Quality-Adjusted Life Years and the Devaluation of Life with Disability* (Nov. 6, 2019), available at https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf See also Axelson, *Assessing the value of medicine for diverse patients: Implications of a QALY approach for health disparities*, Charles River Associations Nov. 11, 2021, available at <https://media.crai.com/wp-content/uploads/2021/11/15184733/CRA-Implications-of-a-QALY-approach-for-health-disparities-1.pdf> ("QALY-based cost-effectiveness approaches fail to consistently consider differences in patient experience of the disease, including those resulting from access disparities, structural racism (which affects transportation, job type, living situation and exposure to environmental factors) and other social determinants of health").

¹⁸ 42 U.S.C. § 1320e-1(e).

¹⁹ Dickson, Sean, Amy Killelea, and Richard G. Frank. *Limiting Coverage Based On Efficacy And Safety: A Path Forward For Medicare Regarding The Alzheimer's Treatment Aducanumab*. *Health Affairs*. June 7, 2022. <https://www.healthaffairs.org/doi/10.1377/forefront.20210604.489197/full/>

III. The AHRQ Proposed CED Trial Criteria Are Flawed and Contrary to Established Study Principles

The proposals for CED study design, informed consent, and the primary disclosure of key elements of the CED are seriously flawed.

Proposed CED Study Design

Table 5 in the draft Report presents “Amended Requirements Based on the Recommendations of the Key Informants,” with serious deficiencies that include but are not limited to the following:

- Item A (Team) requires that *“The study is sponsored by investigators...”*. The use of the term “sponsor” does not distinguish between the parties that will carry out the CED study and the parties that are responsible for the overall conduct, funding, and oversight of the CED study. Ziegler, et al. noted that the failure of the CED process to clarify who is to sponsor trials is a significant flaw in the current CED system. We urge AHRQ to clarify the term sponsor.
- Item E (Context) specifies that *“CMS and investigators agree upon the evidentiary threshold for the study as needed to demonstrate clinically meaningful difference in key outcome(s) with adequate precision.”* Using veiled and ambiguous language, this requirement directly infers that all CED studies are expected to have a primary efficacy or safety endpoint with a prespecified statistical threshold for “success”; *i.e.*, statistical superiority or non-inferiority to a comparator service or product. This proposed CED “pass or fail” construct is inappropriate for post-market CED of FDA-approved drugs and medical devices to demonstrate that use of an FDA-approved product is “reasonable and necessary” for Medicare Beneficiaries pursuant to 42 C.F.R. § 405.201.

The “reasonable and necessary standard,” for which CED studies are intended to provide evidence to demonstrate, does not require the whimsical selection of an arbitrary statistical threshold nor an arbitrary selected level of “targeted precision,” which is the prespecified boundary (confidence interval) of acceptable random error of the measured outcome result. In contrast with the FDA approval process for prescription drugs whereby “adequate and well-controlled” trials are a statutory requirement,²⁰ the use of post-market CED to support the multiple prongs of the “reasonable and necessary” standard for Medicare coverage usually involves consideration of multiple clinical outcomes, evolving evaluation over time as the service or product of interest is dispersed in its post-market use to multiple clinical sites,

²⁰ See section 505 of the FDCA and implementing regulation 21 C.F.R. § 314.26

providers, and patients that are more diverse than those in studies to support FDA product approval, and the application of informed and subjective clinical judgment by CMS and its physician and patient advisors.

- While we are pleased that the forced explicit inclusion of the Randomized Controlled Trial (RCT) as a study design for CED of innovative and novel FDA-approved drugs and devices has been proposed to be eliminated, it has been replaced by a more confusing set of criteria in Table 5 (Items G, H, I, J, K and L, for example) that seemingly are contradictory and unrealistic in the real world. The amended draft requirements fail to clearly state that the use of a RCT should be rare and relied on only in unusual circumstances. The implied use in a CED decision of a RCT with blinding of participants also raises serious ethical questions. For the vast majority of highly innovative and novel drugs and devices approved by FDA, the premarket FDA clinical investigations have demonstrated superiority to a comparator. A RCT study design in CED would, by definition, require some Medicare beneficiaries to receive a placebo for a device, diagnostic, or prescription drug found to be “safe and effective” by the FDA.

Further, we are particularly concerned that the selection of these criteria were inappropriately influenced by the recent public attention on the controversial history of FDA approval of Aduhelm (aducanumab) and the subsequent Medicare NCD for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer’s Disease. Any new study policy should not be a veiled “back door” approach for CMS to require participation in a RCT for CED for a novel drug that is authorized by FDA under 21 C.F.R. Part 314 Subpart H (Accelerated Approval of New Drugs for Serious or Life-Threatening Diseases).

- We further believe that it is necessary for ASPE to evaluate and provide CMS with guidance on the impact of requirements for RCTs, overly restrictive site of care restrictions, and, in some cases, registries in relation to collecting appropriate data. RCTs represent an inefficient and limited process for collecting information on how an intervention performs in real-world settings. Site of care restrictions often reinforce access limitations for communities of color.²¹ Registries collect real-world evidence (RWE); however, CMS lacks enforcement authority to require registries to regularly publicly report data in a timely manner. We ask AHRQ to examine these factors, evaluate how individual CED restrictions may impact equitable access and outcomes, and provide CMS with recommendations on how to limit unintended harmful outcomes.

²¹ Vemulapalli, Sreekanth, et. al. Mitral Valve Surgical Volume and Transcatheter Mitral Valve Repair Outcomes: Impact of a Proposed Volume Requirement on Geographic Access. *Journal of the American Heart Association*. Vol. 9, No. 11. 27 May 2020. <https://www.ahajournals.org/doi/10.1161/JAHA.119.016140>.

Informed Consent

The initial Informed Consent Proposal in Table 1 required that “*the investigators obtain meaningful informed consent...*” Table 5, Item S modifies the description of Informed Consent by omitting the phrase “meaningful informed consent.” It is critical that the framework for informed consent for CED does not permit this vague concept to reappear. The Final CED framework should clearly point to the Common Rule (45 C.F.R. Part 46), or if applicable, current FDA Regulations for Human Subjects Protection, including informed consent (21 C.F.R. Parts 50 and 56) The Common Rule and And the FDA regulations are based upon decades of evolution of the definition and application of informed consent for the protection of human subjects since the Belmont Report.²²

Proposed Public Disclosure of CED Protocols and Results

AHRQ proposes that the primary posting (e.g., public disclosure) of the CED protocol will be the CMS website whereas posting to ClinicalTrials.gov or elsewhere will be at the discretion of the investigator. See Table 5, Item E (Protocol). **We disagree and strongly recommend that the primary public website for disclosing the core elements of the CED protocol (including data sources, key outcomes, and key elements of design) should be the federal website ClinicalTrials.gov that is hosted and maintained by the U.S. National Library of Medicine.** Because each clinical study that is registered is assigned a unique permanent identifier (the NCT number), the CMS website can simply provide an electronic link to the unique NCT identifier electronically that will send a viewer directly to the ClinicalTrials.gov entry.

Only a small subset of CED are *Applicable Device Clinical Trials* or *Applicable Drug Clinical Trials* pursuant to 42 C.F.R § 11.10 that legally must be publicly disclosed on this federal website. However, the ClinicalTrials.gov platform is not limited to *Applicable Clinical Trials* and is readily accessible for voluntary entry and public disclosure of multiple types of prospective clinical investigations, including registries and observational studies, that do not legally require posting. As of September 15, 2022, there are 427, 974 clinical trials registered on Clinical Trials.gov. Of these, nearly one fourth are observational clinical studies (22%). (See <https://www.clinicaltrials.gov/ct2/resources/trends>) The posting of CED studies on ClinicalTrials.gov as the primary site has major public policy and practical advantages for patients, clinicians, clinical sites, and federal regulators.

- All CED decisions involve drugs, biologics, or medical devices regulated by FDA, which is the focus of ClinicalTrials.gov.

²² The Belmont Report. Accessed at <https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/read-the-belmont-report/index.html>

- Under the management of the National Library of Medicine, this database and its website are mature and has been under continuous expansion and improvement by experts in website design specific to clinical investigations.
- It is readily accessible for data entry and update, easily searchable, subject to sophisticated internal quality control, includes a permanent publicly accessible history of changes to entries, and provides clear and concise “assists” for new users.
- Most important, it is the primary source of information for patients, patient advocacy groups, clinicians, clinical sites, and IRBs to identify specific premarket and post-market clinical studies open for enrollment for specific conditions.

IV. **Conclusion**

As discussed above, the CED process today is fundamentally broken. CEDs are launched by CMS without regard to stakeholder participation, with ill-defined endpoints and with no end dates. As a result, of over 25 CEDs initiated, less than 20 percent have been concluded, and several never even resulted in a study. The implications for Medicare beneficiaries are devastating – potentially life-saving treatments are inaccessible to the vast majority of beneficiaries who are unable to access a CED trial or registry, and minorities and the disabled – who rarely are able to easily access care at academic medical centers where most CED trials are held, are particularly disadvantaged.

The draft Report briefly identifies these issues but does not address them. Instead, the draft Report proposes to add even more ill-defined study “options” to the list of CED study programs that CMS may already employ. The AHRQ report will thus not contribute to the improvement of the CED process, but rather further cloud the already muddy CED waters. For these reasons, we urge AHRQ to withdraw its study and:

- Remedy the procedural defects in its process, including publicly identifying its KIs, including KIs from the life sciences industry, eliminating the use of any cost-effectiveness studies from its literature review, ensuring that the improper use of QALYs or other “cost-effectiveness” metrics that discriminate against older persons, persons with disabilities, or neurodiverse individuals are excluded from consideration, and providing a sufficient 60-day comment period for any further drafts of the Report;
- Eliminate the use of procedurally flawed clinical trial or other study proposals, and ensure that any study proposals are consistent with good science and procedure;
- Require all CED trials to be listed on clinicaltrials.gov;

- Call on CMS to ensure that every CED has defined end-points, with specified time limits for completion of the studies.

By making these changes to its report, AHRQ can contribute to improving the CED process, improving health equity, and ensuring that Medicare beneficiaries have access to medically necessary treatment. CMS and AHRQ must not move forward without resolving these issues, as subsequent meetings of the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) are expected to review and make recommendations based on this report. We ask for any relevant MEDCAC meetings be postponed to permit these concerns to be remedied.

We welcome any questions or comments about the above recommendations, and welcome continuing to partner with AHRQ for the benefit of older Americans across the United States. Please contact Sue Peschin at speschin@agingresearch.org or Michael Ward at mward@agingresearch.org for any additional information.

Sincerely,

Alliance for Aging Research
Alliance for Patient Access
ALS Association
The American Society of Consultant Pharmacists
The Balm In Gilead, Inc - Brain Health Center for African Americans
BrightFocus Foundation
Caregiver Action Network
Global Alzheimer's Platform Foundation
The Global CEO Initiative on Alzheimer's Disease
Global Coalition on Aging's Alliance for Health Innovation
HealthyWomen
Heart Valve Voice US
Infusion Providers Alliance
Men's Health Network
National Minority Quality Forum
Partnership to Fight Chronic Disease
RetireSafe
Society for Women's Health Research
UsAgainstAlzheimer's
Voices of Alzheimer's