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LINKING MEDICARE COVERAGE TO RESEARCH PARTICIPATION: REASONABLE AND NECESSARY?

by
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TABLE OF CONTENTS

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INTRODUCTION

The Medicare program generally covers only items or services that are "*reasonable and necessary* for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."[1] This "reasonable and necessary" language is the basis for most Medicare coverage policies,[2] but its meaning remains ill-defined and controversial. After the Centers for Medicare and Medicaid Services (CMS) abandoned a 14-year effort to adopt regulations defining reasonableness and necessity in 2003, citing "substantial competing interests about the coverage criteria,"[3] Congress directed the agency to "make available to the public the factors

[1] 42 U.S.C. § 1395y(a)(1)(A) (emphasis added).

[2] Medicare has two types of coverage policies: (1) National Coverage Determinations (NCDs), which are issued by CMS, the agency that administers Medicare, and apply throughout the country; and (2) Local Coverage Determinations, which are issued by Medicare contractors (carriers and intermediaries) and only apply in that contractor's local area. NCDs usually specify whether or in what circumstances an item or service is "reasonable and necessary," and are preceded by draft and final decision memoranda that explain the rationale for the NCD; "coverage policies" are used here to refer both to the formal NCDs themselves and the related decision memoranda.

[3] 68 Fed. Reg. 55634, 55635 (Sept. 26, 2003).

considered in making national coverage determinations of whether an item or service is reasonable and necessary."[4]

Recently, CMS has issued a batch of coverage policies that highlight new questions about "reasonableness and necessity" and give the agency a "whole new role."[5] These policies reflect an approach variously called "coverage under protocol," "coverage with evidence development," or coverage "with data collection requirements," that links Medicare coverage to participation in clinical trials or registries, essentially using Medicare coverage policy to spur research.[6] Examples of this trend include a recent coverage policy on off-label uses of certain colorectal cancer drugs,[7] and several policies on diagnostic tests and devices.[8] Specifics of these policies

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[4]42 U.S.C. § 1395y(l)(1). CMS is required to disclose the factors it considers in making NCDs by developing guidance documents, using a process similar to FDA's good guidance practices.

[5]Gina Kolata, *Medicare Covers New Treatments with a Catch*, N.Y TIMES, Nov. 5, 2004 (quoting a CMS official).

[6]This approach is not entirely new (it was used in a few coverage policies issued in the mid-1990s when the concept was known as "coverage with conditions"), but has now become increasingly common.

[7]Jan. 28, 2005 Decision Memo for Anticancer Chemotherapy for Colorectal Cancer (CAG-00179N).

[8]*See, e.g.*, Jan. 28, 2005 Decision Memo for Positron Emission Tomography (FDG) for Brain, Cervical, Ovarian, Pancreatic, Small Cell Lung, and Testicular Cancers (CAG-00181N) (conditioning coverage of FDG-PET scans used to diagnose certain cancers on participation in a clinical trial or registry); Jan. 27, 2005 Decision Memo for Implantable Defibrillators (CAG-00157R3) (conditioning coverage of implantable defibrillators used for certain indications on participation in a clinical trial or registry); Sept. 15, 2004 Decision Memo for Positron Emission Tomography (FDG) and Other Neuroimaging Devices for Suspected Dementia (CAG-00088R) (covering FDG-PET scans for the diagnosis of Alzheimer's disease for certain patients only in the context of a clinical trial);

vary, but usually they limit coverage of the product in question to Medicare patients who enroll in certain clinical trials or registries.[9]

Pursuant to its new mandate to "make available to the public the factors considered in making national coverage determinations," CMS has just issued draft guidance (which will be finalized after a public comment period) on coverage with data collection requirements.[10] This WORKING PAPER describes some of the key questions raised by this new approach to coverage. It focuses on CMS' recent policy concerning off-label uses of colorectal cancer drugs — which CMS calls a "potential model" for other anti-cancer drugs — and begins with a brief summary of the background coverage rules relevant to understanding the policy.[11]

Oct. 1, 2003 Decision Memo for Ventricular Assist Devices as Destination Therapy (CAG-00119N) (conditioning coverage of left ventricular assist devices used as destination therapy on registry participation).

[9]Normally these policies only condition coverage of the product in question on research participation when the product is used for specified indications. For example, FDG-PET scans are covered to detect certain types of cancer only if the patient enrolls in a clinical trial or registry; when FDG-PET scans are used to diagnose other cancers, coverage is either less restrictive or else it is prohibited altogether.

[10]CMS Draft Guidance "Factors CMS Considers in Making a Determination of Coverage with Evidence Development" (Apr. 7, 2005) (hereinafter "April 7 CMS Draft Guidelines), available at http://www.cms.hhs.gov/coverage/download/guidanceced.pdf . Comments on the draft guidance are due by June 6, 2005.

[11]The coverage rules discussed here apply to the original Medicare program; a different regulatory regime applies to the Medicare Part D drug benefit that begins in 2006.

I. BACKGROUND COVERAGE RULES

A. "Medically Accepted Indications" for Anti-Cancer Drugs

Like most items and services, anti-cancer drugs must meet Medicare's "reasonable and necessary" requirement. However, the Medicare statute has a special definition of "medically accepted indications" for drugs used in an anti-cancer chemotherapeutic regimen, which essentially identifies certain indications that qualify as reasonable and necessary. "Medically accepted indications" for anti-cancer drugs include FDA-approved uses, plus off-label uses (1) supported by citations included or approved for inclusion in specified compendia (AHFS-Drug Information, and USP-Drug Information[12]), unless CMS decides the use is not medically appropriate or it is listed as "not indicated" in one of the specified compendia; or (2) determined to be medically accepted by the local Medicare contractor involved, based on peer-reviewed medical literature appearing in publications identified by CMS.[13] CMS guidance implementing this provision provides that medically accepted off-label uses for anti-cancer drugs include those supported by the relevant compendia or the medical literature, plus off-label uses "determined by the carrier to be medically

[12]The statutory definition also lists AMA Drug Evaluations (which is no longer in print), and permits CMS to revise the list of compendia as appropriate.

[13]42 U.S.C. § 1395x(t)(2)(B). This definition was added to the Medicare statute by a provision in the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) entitled "Uniform Coverage of 'Off-Label' Anticancer Drugs."

accepted generally as safe and effective."[14]

B. Medicare's Clinical Trials NCD

This NCD provides national coverage for "routine costs" of "qualifying" clinical trials.[15] "Qualifying" trials must evaluate an item or service within a Medicare benefit category; have "therapeutic intent;" enroll patients with diagnosed diseases (except trials of diagnostic tests may enroll healthy patients in the control group); and have specified "desirable characteristics." Certain trials are "deemed" to have these desirable characteristics.[16] "Routine costs" of qualifying trials include items or services that are otherwise generally covered by Medicare, except: (1) "the investigational item or service, itself;"[17] (2) items or services provided "solely

[14]Medicare Benefit Policy Manual, Chap. 15 § 50.4.5. This language is consistent with CMS policy on off-label uses for drugs generally, which allows coverage "if the carrier determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice." *Id.*, § 50.4.2.

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[15]Medicare National Coverage Determinations Manual, § 310.1.

[16]"Deemed" trials include: (1) trials funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality (AHRQ), CMS, the Defense Department, or the Department of Veterans Affairs; (2) trials supported by centers or cooperative groups funded by the agencies listed above; (3) trials conducted under an investigational new drug application (IND); and (4) IND-exempt drug trials. The Clinical Trials NCD also provides for AHRQ to convene a multi-agency panel charged with developing criteria to identify trials that exhibit the "desirable characteristics" listed in the NCD; once these criteria have been developed, trials other than "deemed" trials can be qualifying trials if the principal investigator certifies that the trial meets the criteria. However, CMS has not yet established the self-certification process contemplated by the NCD.

to satisfy data collection and analysis needs"; and (3) items or services "customarily provided by the research sponsors free of charge for any enrollee in the trial."

II. MEDICARE'S NEW COVERAGE POLICY ON COLORECTAL CANCER DRUGS

This coverage policy involves four drugs used in treating colorectal cancer (Eloxatin, Camptosar, Erbitux, and Avastin), but also "serve[s] as a potential model for additional coverage expansions in clinical trials for other anti-cancer chemotherapeutic agents."[18] The final policy, which was preceded by a draft policy released in 2004,[19] has two basic features.

First, the policy provides national coverage for off-label uses of these drugs in nine clinical trials sponsored by the National Cancer Institute (NCI).[20] CMS selected these particular trials by requesting that NCI "identif[y] high-priority clinical trials studying off-label uses of the four agents;" the two agencies agreed that the selected trials "should address

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[17]This does not necessarily mean that the investigational item is "non-covered;" the Clinical Trials NCD provides that it "does not withdraw coverage" for items or services that may be covered by Local Coverage Determinations of a Medicare contractor, or under Medicare's regulations on "Category B" devices.

[18]Jan. 28, 2005 Decision Memo for Anticancer Chemotherapy for Colorectal Cancer (CAG-00179N).

[19]Nov. 1, 2004 Draft Decision Memo for Anticancer Chemotherapy for Colorectal Cancer (CAG-00179N).

[20]While focusing on clinical trials, the policy also expresses interest in "identifying additional means of gathering evidence outside of a clinical trial setting . . . such as registries and analysis of routinely collected electronic data."

questions likely to lead to important changes in therapy."

Second, the policy "does not modify the existing requirement for coverage of . . . anticancer chemotherapeutic agents for FDA-approved indications or for indications listed in an approved compendium" and "makes no change in coverage for any off-label uses of these drugs provided outside of the [selected] clinical trials." Medicare contractors "will continue to make coverage determinations for medically accepted uses of off-label indications based on guidance provided by [CMS]." Thus, contractors can cover the off-label uses under evaluation in the selected trials for patients *not* enrolled in these trials if they determine that the use is "medically accepted." This is an important distinction from other "coverage under protocol" policies, which *restrict* coverage of the product in question to patients enrolled in certain clinical trials and/or registries.

III. DOES THE COLORECTAL CANCER DRUG POLICY EXPAND OR CONTRACT OFF-LABEL COVERAGE?

As noted earlier, existing CMS guidance provides that "medically accepted" off-label uses of anti-cancer drugs include uses supported by the approved compendia or medical literature, and that "*[u]nlabeled uses also may be considered medically accepted if determined by the carrier to be medically accepted generally as safe and effective*."[21] Many commenters

[21]Medicare Benefit Policy Manual, Chap. 15 § 50.4.5 (emphasis added).

on the draft colorectal cancer drug policy expressed concern about its failure to mention this principle,[22] emphasizing that any perceived restriction on contractors' discretion to cover off-label uses could deny cancer patients critical treatment alternatives.

In response to these concerns, the final policy did state that contractors would "continue to make coverage determinations for medically accepted uses of off-label indications based on guidance provided by [CMS]," and "clarif[ied] that contractors will continue to follow appropriate guidelines for all other uses of these drugs [outside the selected trials]." However, CMS never expressly mentioned the existing guidance allowing coverage of off-label uses which contractors consider "medically accepted generally as safe and effective," and also used some language suggesting a more restrictive approach.[23]

Thus, while the policy professes to "expand coverage," CMS still needs to reaffirm explicitly that contractors may continue to cover off-label uses "medically accepted generally as safe and effective." By doing so, CMS could ensure that a policy designed to expand coverage for certain off-label uses in the clinical trial setting cannot be misconstrued as *constricting* coverage in

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[22]Comments on CMS' draft coverage policies are available on the CMS website.

[23]For example, CMS stated that (apart from off-label uses supported by an approved compendium), "[o]ff-label coverage of these agents is . . . determined by the Medicare contractors based on their review of the medical literature," thus failing to note that contractors can also cover off-label uses generally accepted as safe and effective.

other cases. This is important because any perceived restriction on contractors' discretion to cover off-label uses could leave many cancer patients with few treatment options. Due to factors such as toxicity to certain agents, the rapidly changing nature of cancer progression, and underlying comorbidities, the viable treatment alternatives available to cancer patients are often quite limited, and any additional restrictions on Medicare coverage of off-label uses would exacerbate this problem.

IV. CRITERIA FOR SELECTING TRIALS OR REGISTRIES

Another recurring theme of the comments on the draft colorectal cancer drug policy was the lack of information on the nine NCI-sponsored trials selected for coverage and the rationale for selecting them. As CMS noted in the final policy, commenters felt that the draft policy "left too many unanswered questions regarding trial selection criteria and design to allow full endorsement; that the nine NCI-sponsored trials are too limited in scope and number; and that covering drugs for only NCI-sponsored trials could potentially decrease accruals to trials at non-NCI sites such as comprehensive cancer centers." In response, CMS stated that while complete details of the selected trials will not be available until the protocols are final, "sufficient information is available to determine that these are appropriate trials for CMS to cover." CMS also recognized that "a more

detailed process is necessary for selecting future trials," pledging to "work with industry and other stakeholders to define that process."

To date, CMS has not adopted uniform criteria for selecting clinical trials for "expanded" coverage (*i.e.*, coverage for "non-routine" costs, such as "the investigational item or service itself," that are not *already* covered under the Clinical Trials NCD in qualifying trials). Trial selection criteria have varied considerably from policy to policy, for unexplained reasons. For example, "coverage under protocol" policies involving devices usually cover (at a minimum) trials approved by the Food and Drug Administration (FDA) under an Investigational Device Exemption (which would suggest granting expanded coverage to FDA-approved IND trials in the drug context). Some policies have also granted expanded coverage to: (1) trials that are consistent with CMS's evidentiary requirements for national coverage analyses and meet certain quality standards;[24] (2) trials that represent "qualifying trials" under the Clinical Trials NCD;[25] (3) trials meeting four basic criteria *(i.e.*, written protocol on file, IRB review and approval,

[24]*See, e.g.*, Jan. 7, 2005 Draft Decision Memo for Cochlear Implantation (CAG-00107N). The "quality standards" incorporated in this draft policy require that: (1) the trial's principal investigator certifies that the trial protocol will be maintained on file and submitted to CMS on request; (2) an abstract of the trial protocol must be submitted to CMS; and (3) the protocol includes specified information.

[25]*See, e.g.*, Jan. 7, 2005 Draft Decision Memo for Cochlear Implantation; Jan. 27, 2005 Decision Memo for Implantable Defibrillators (CAG-00157R3). As noted earlier, "qualifying trials" under the Clinical Trials NCD currently include trials funded by specified Government agencies, trials supported by centers or cooperative groups funded by those agencies, FDA-approved IND trials, and IND-exempt drug trials.

scientific review and approval by two qualified individuals who are not part of the research team, and certification that researchers have not been disqualified);[26] and/or (4) trials that meet still other criteria.[27] Moreover, the type of "data collection system" required also varies; while some policies only cover patients enrolled in certain clinical trials, other policies also cover patients enrolled in registries with specified characteristics.

In short, Medicare's existing policies have linked coverage to participation in a wide and seemingly random assortment of "data collection systems." The criteria that CMS uses in deciding which kinds of data collection systems are needed in any particular case currently are not transparent. In developing its draft guidance on coverage policies with data collection requirements, CMS requested comments on the following options for obtaining additional evidence: (1) registries; (2) observational trials; (3) randomized controlled trials; and (4) "other methods for prospective evaluation."[28] The draft guidance itself describes the options as: (1) databases; (2) longitudinal or cohort studies; (3) prospective comparative

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[26]*See, e.g.*, Sept. 15, 2004 Decision Memo for Positron Emission Tomography (FDG) and Other Neuroimaging Devices for Suspected Dementia; Jan. 27, 2005 Draft Decision Memo for Ultrasound Stimulation for Nonunion Fracture Healing (CAG-00022R). The September 15, 2004 FDG-PET decision memo describes these four criteria as the same criteria that the multi-agency panel led by AHRQ recommended using as the basis for the self-certification process contemplated by the Clinical Trials NCD.

[27]*See, e.g.*, Jan. 28, 2005 Decision Memo for Position Emission Tomography (FDG) for Brain, Cervical, Ovarian, Pancreatic, Small Cell Lung, and Testicular Cancers.

[28]CMS notice on "Improving Evidence Development," available on the Council for Technology and Innovation section of the CMS website.

studies (also called practical clinical trials); and (4) randomized clinical trials.[29] Ultimately, the criteria for selecting data collection systems (and the threshold question of whether any data collection requirements are appropriate in the first place) depend on a larger issue discussed below: the purpose of linking coverage to data collection requirements.

V. THE RATIONALE FOR LINKING COVERAGE TO PARTICIPATION IN DATA COLLECTION SYSTEMS

At this point, CMS has not clearly articulated the rationale for linking coverage to data collection requirements and how this relates to reasonableness and necessity. In a notice concerning this approach to coverage, CMS expressed interest in "supporting the development of better scientific evidence to ensure improved patient outcomes and efficient health care delivery" and "bridging the 'gaps in knowledge,' which is essential to increasing the evidence base that allows physicians and patients to select appropriate diagnostic and therapeutic services."[30] However, the notice did not explain how these goals relate to the reasonableness and necessity standard. While everyone favors better evidence, it is unclear why a patient's decision to enlist — or not enlist — in the effort to advance knowledge should determine whether the healthcare services he or she

[29]April 7 CMS Draft Guidance.

[30]CMS notice, "Improving Evidence Development."

needs are covered by Medicare.[31]

Several coverage under protocol policies — as well as recent draft guidance on this approach to coverage — *have* touched on the question of how Medicare's reasonableness and necessity requirement relates to the patient's participation in a "data collection system" of one sort or another. While the explanations in CMS's policies vary, they typically suggest that clinical trials (or registries) involve largely-unspecified "protections and safeguards" that relate to reasonableness and necessity. Often it is unclear whether CMS is speaking of safeguards that improve the care of patients enrolled in the data collection system, or simply means that data collection is itself a "safeguard" that might benefit future patients (*e.g.*, more evidence might reveal unanticipated risks, better techniques for using a device, *etc.*). Some examples include:

- *Colorectal Cancer Drugs.* [A] sufficient inference of benefit can be drawn to support limited coverage in the context of an NCI-sponsored clinical trial that provides rigorous safeguards . . . . NCI-sponsored clinical trials offer safeguards for patients to ensure appropriate patient evaluation and selection and reasonable use of cancer chemotherapy. . . . [C]overage for the off-label use of cancer chemotherapy could provide clinical benefits . . . [that] are likely to be present in the context of a clinical trial that assures informed individualized analysis and evaluation of the response to

[31]Moreover, concerns have been expressed about whether "conscripting" Medicare patients into the effort to advance science is consistent with well-established principles of voluntary informed consent. For example, one commenter on CMS' draft policy on implantable defibrillators stated that "[i]t is clear to me that this falls within the definition of undue coercion as defined by both the Office of Human Research Protections and the Food and Drug Administration; another stated that "[p]atients should not be forced to participate in a study as a condition of receiving benefits."

chemotherapy and patient health status, as well as an adequate plan for data and safety monitoring.[32]

- *Implantable Defibrillators.* [A] data collection process is needed to assure patient safety and protection . . . These patient protections and safeguards require that data be made available . . . to providers and practitioners to inform their decisions, monitor performance quality, benchmark and identify best practices.[33]

- *Carotid Artery Stenting.* FDA-required post-approval studies can ensure patient protection while developing information on appropriate device use and best practices . . . . These patient protections and safeguards would only be available to the extent that post approval study data can be made available . . . to providers and practitioners to inform their decisions, monitor performance quality, and identify best practices.[34]

As summarized recently by a CMS official, "[c]ertain experimental interventions may be considered reasonable and necessary (and therefore covered by Medicare) only when they are provided in the context of additional protections provided in clinical research studies."[35] In the draft guidance released in April 2005, a slightly different theory of why data collection can make a treatment "reasonable and necessary" seemed to emerge. Though difficult to describe, the basic theory appears to be that physicians pay more attention (and thus provide better care) when required

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[32]Jan. 28, 2005 Decision Memo for Anticancer Chemotherapy for Colorectal Cancer.

[33]Jan. 27, 2005 Decision Memo for Implantable Defibrillators.

[34]Oct. 12, 2004 Decision Memo for Carotid Artery Stenting in Post-Approval Studies (CAG-00259N).

[35]S. Tunis, *A Clinical Research Strategy to Support Shared Decision Making*, HEALTH AFFAIRS, Jan./Feb. 2005; 24(1): 180-184.

to collect data on the patient. Specifically, CMS stated that a service may be reasonable and necessary only when accompanied by data collection "because the additional care in clinical decision making and monitoring of the patient offers greater assurance that the benefits of receiving the service will exceed the risks."[36] Put differently, "[c]are provided under these [data collection] protocols generally involves greater attention to appropriate patient evaluation and selection, as well as the appropriate application of the technology."[37]

Specificity about the precise reason why collecting data on a patient boosts a particular intervention to the "reasonable and necessary" level is essential to developing sound coverage policies through a meaningful public comment process. If data collection requirements are designed solely to advance research, CMS should say that explicitly, explain its statutory authority to promote research via coverage restrictions, and allow Congress to evaluate whether CMS should promote research by denying coverage to Medicare patients who are unable or unwilling to enlist in research efforts.[38]

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[36]April 7 CMS Draft Guidance, at 7.

[37]*Id*. at 4.

[38]The "reasonable and necessary" language in the Medicare statute has traditionally been thought of as relating chiefly to the safety and effectiveness of a product or service; it is not clear that this language implicitly authorizes CMS to condition coverage on a patient's participation in a data collection system simply to advance the agency's research goals, particularly as the statutory text refers to reasonableness and necessity "for the diagnosis or treatment of illness or injury" — not for advancing collateral policies such as "supporting the development of better scientific evidence." Moreover, in

And if data collection requirements are needed to enhance the safety or effectiveness of an intervention, they should be carefully tailored to that purpose, so as to avoid needless barriers to access.

Having decided that an intervention is "reasonable and necessary" in a particular research setting, CMS should therefore identify the specific rationale for that conclusion and examine whether it applies in a broader set of circumstances. Often such an analysis could reveal less restrictive alternatives that also met the reasonableness and necessity standard — thus allowing Medicare patients broader access to the therapy in question, and reducing the risk of a "two-tier" coverage package that discriminates against patients who may be unable or unwilling to participate in clinical trials or registries.

The comments CMS received on the draft colorectal cancer drug policy illustrate the importance of this approach. Many comments noted

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several instances Congress has passed legislation expressly authorizing mechanisms *outside* the coverage process to advance CMS's research priorities when it wanted CMS involved in shaping the federal research agenda. This is relevant to the interpretation of the "reasonable and necessary" provision because "the meaning of one statute may be affected by other Acts, *particularly where Congress has spoken subsequently and more specifically to the topic at hand.*" *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (emphasis added). For example, Section 1013 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the MMA) provides for the Agency for Healthcare Research and Quality (AHRQ) to "conduct and support research to meet the priorities and requests for scientific evidence and information identified by [Medicare and certain other programs]" subject to certain requirements. Among other things, AHRQ must "ensure that there is broad and ongoing consultation with relevant stakeholders in identifying the highest priorities for research," and CMS "may not use data obtained in accordance with [Section 1013] to withhold coverage of a prescription drug." Allowing CMS to adopt restrictions on coverage simply to generate evidence could essentially circumvent these statutory requirements.

that granting national coverage to patients who enroll in nine selected trials was likely to benefit only a limited subset of the relevant patient population. For example, the policy would not help patients who do not meet trial enrollment criteria (*e.g.*, due to exclusion criteria based on comorbidities or use of other drugs), patients in rural areas likely to be far away from trial sites, or other patients who would decline to enroll in the selected trials if they would be required to travel, change doctors, or bear additional costs. Moreover, while little information is available on the selected trials, at least some of these trials are randomized; consequently, patients who want the chemotherapy regimen recommended by their own doctors might decline to enroll in these trials to avoid the risk of being assigned to an arm of the trial involving a different treatment regimen.

The failure to expand national coverage beyond participants in the nine NCI-sponsored trials would be unobjectionable if these nine trials involve unique safeguards that make the chemotherapy regimens under evaluation "reasonable and necessary." However, the policy does not suggest that these trials (which lack finalized protocols) will have any unusual features connected to the reasonableness and necessity standard. As noted earlier, CMS stated that the clinical benefits of off-label uses of anti-cancer chemotherapy were "likely to be present in the context of a clinical trial that assures informed, individualized analysis and evaluation of

the response to chemotherapy and patient health status, as well as an adequate plan for data and safety monitoring." Yet individualized analysis and evaluation of a cancer patient's health status and response to chemotherapy are basic requirements of good patient care — not safeguards uniquely associated with nine clinical trials, or uniquely associated with the research setting generally. Consequently, it seems likely that CMS could provide national coverage for a much broader group of cancer patients — whether they are enrolled in additional clinical trials or enrolled in registries, or if they are not participating in any data collection system. To date, CMS has not cited any evidence for its theory that evidence collection requirements prompt "additional care in clinical decision making and monitoring of the patient."[39]

VI. COVERAGE UNDER PROTOCOL POLICIES AND THE CLINICAL TRIALS NCD

As the colorectal cancer drug policy illustrates, the effect of coverage policies linked to clinical trial participation must be evaluated in conjunction with the Clinical Trials NCD. The draft and final colorectal cancer drug policy both refer to "expanding coverage," but whether any expansion will occur is unclear. Assuming that the nine NCI-sponsored trials selected for coverage are all "qualifying trials" under the Clinical Trials

[39]April 7 CMS Draft Guidance, at 7.

NCD,[40] Medicare *already* covers "routine costs" (but not the investigational item itself, items or services "provided solely to satisfy data collection and analysis needs," or items or services customarily provided by research sponsors free of charge for any trial enrollee). The drugs themselves would be ineligible for coverage if they were free, and manufacturers commonly provide drugs without charge in clinical trials.[41]

In response to questions about whether any expansion in coverage would actually occur, the final policy stated that it would "ensure that clinical trials in which industry does not provide the drugs [for free] will be available to the Medicare beneficiary" (without specifying whether any of the nine selected trials actually fall into this category). Beyond that, the policy stated only that "[s]pecific reimbursements will be determined as the protocols are completed and the trials begin." Consequently, whether the new policy will expand coverage in any way is still uncertain.

VII. COSTS ASSOCIATED WITH COVERAGE UNDER PROTOCOL POLICIES

Coverage under protocol policies have also raised a number of questions about the costs they create and who will pay them. Several policies have conditioned coverage on participation in clinical trials or

[40]As discussed previously, "deemed" qualifying trials include trials funded by the National Institutes of Health (which includes NCI).

[41]In fact, FDA regulations generally require this in IND trials. *See* 21 CFR § 312.7(d).

registries that do not yet exist,[42] thus raising the question of who should bear the costs of organizing and operating the trials or registries CMS requires. Likewise, coverage under protocol policies generally raise the question of who should pay for the ongoing costs of inputting, reviewing, validating, and analyzing data, as well as the costs of extra services that patients only receive to satisfy Medicare's coverage requirements (*e.g.*, additional testing or follow-up visits necessary solely for data collection purposes).

Candidates for bearing these various costs might include CMS, government agencies charged with supporting research, manufacturers, providers, patients, or some combination of the above. Presumably, however, all of these "coverage policy-induced" costs should be Medicare-covered, *since the whole theory underlying coverage under protocol policies is that their data collection requirements make the intervention in question "reasonable and necessary*." However, if these costs *are* Medicare-covered, patients will be responsible for co-payments. This is problematic because it could saddle Medicare patients with co-payment obligations for services that their doctors may not consider medically necessary for diagnostic or treatment purposes, and that the patients only

[42]For example, a recent policy on using FDG-PET scans to diagnose certain cancers acknowledged "the complex nature of the prospective clinical studies discussed in this [policy]," and noted that "no clinical study will be fully operational by the effective date of this decision"; consequently, "while this coverage decision is effective, it will not be fully implemented until a clinical study is ready to enroll providers and patients."

received due to Medicare's coverage requirements.

However CMS resolves these issues, these "coverage policy-induced" costs will ultimately be borne either by CMS or other government agencies (thereby increasing government spending), or by private organizations and patients (essentially representing an "unfunded mandate"). This calls for caution in imposing these mandates. CMS can properly link coverage to any data collection requirements genuinely needed to boost a certain intervention to the "reasonable and necessary" level. For reasons discussed earlier, however, the agency's authority to impose data collection requirements — and their resulting costs — on patients, providers, and other private parties merely to "support the development of better scientific evidence"[43] seems doubtful.

VIII. PRUDENT ALLOCATION OF RESEARCH RESOURCES

CMS's goals of "supporting the development of better scientific evidence" and "increasing the evidence base that allows physicians and patients to select appropriate diagnostic and therapeutic services"[44] are widely shared. However, Medicare coverage policies are developed in a short period of time and involve specific items and services. Coverage

[43] CMS notice, "Improving Evidence Development."

[44] *Id*.

policies with data collection requirements will necessarily divert resources from other research endeavors, and it is not clear that Medicare's coverage process is an appropriate vehicle for establishing national research priorities and allocating scarce research resources in the most prudent fashion. The coverage process was not designed to gather and evaluate the wealth of information and expertise that should be brought to bear in designing research protocols and setting research priorities, nor does it involve the "broad and ongoing consultations with relevant stakeholders" that Congress recently required in authorizing the Agency for Healthcare Research and Quality (AHRQ) to support research meeting the priorities of Medicare and other government programs.[45]

In the context of oncology, for example, CMS's colorectal cancer drug policy identified nine specific trials for coverage, but stakeholders still have little information about these particular trials, and thus had little opportunity to provide meaningful comments on the draft policy. Moreover, the relatively short time frame associated with developing coverage policies by itself suggests the desirability of forging an agenda for cancer research through an alternative mechanism offering greater opportunities for deliberation, consensus-building, and broad public participation. For example, CMS could consider convening a broad policy discussion on the

[45]Medicare Modernization Act § 1013.

prioritization of oncology outcomes research led by an independent coalition. Such a coalition could include oncologists from academia and clinical practice settings, medical professional societies, patient advocacy groups, and manufacturers, and could focus on identifying the research questions most important to the advancement of patient care. Recommendations could be presented to CMS and other government agencies interested in advancing cancer treatment.

While this is only one example of a consultative mechanism that could help to provide the expertise and the range of perspectives necessary to target research resources prudently, there are a variety of models CMS might consider (including the existing AHRQ process) that would likely serve its goals better than using the Medicare coverage process as a vehicle for shaping critical research strategies.