January 13, 2023

VIA Electronic Mail to: Tara.Hall@cms.hhs.gov

Tara Hall
MEDCAC Coordinator
Centers for Medicare & Medicaid Services
Central Building
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Virtual Meeting of the Medicare Evidence Development and Coverage Advisory Committee — February 13, 2023, and February 14, 2023, Meetings

Dear MEDCAC Members,

Edwards Lifesciences ("Edwards") appreciates the opportunity to comment in advance of the Medicare Evidence Development & Coverage Advisory Committee ("MEDCAC") meetings on February 13, 2023, and February 14, 2023, to discuss the Coverage with Evidence Development ("CED") criteria. In early November 2022, Edwards submitted comments in anticipation of the MEDCAC meeting originally scheduled for December 2022, and the comments in this letter build upon our previous submission.

Edwards is the global leader of patient-focused innovations for structural heart disease and critical care monitoring. Our technologies address patient populations in which there are significant unmet clinical needs, such as structural heart disease, heart valve disease and advanced monitoring of the critically ill. Many of our technologies are utilized in the care of Medicare patients undergoing higher-risk surgical procedures, especially in complex cases with severe comorbidities requiring specialized care. Because of this, we have a sincere interest in ensuring continuous improvement in the Medicare coverage landscape and also that patients have more timely and predictable access to life-saving medical technologies and services. Further, any changes to Medicare coverage policy must promote high quality care and ensure greater access to care for all beneficiaries.

Edwards supports and recognizes CMS' authority to use CED. Section 1862(a)(1)(E) gives the agency coverage authority when conducting research using section 1142 when the items or services have not been deemed reasonable and necessary. The specific statutory reference follows:

> *Section 1862(a)(1)(E) in the case of research conducted pursuant to section 1142, which is not reasonable and necessary to carry out the purpose of that section*[1]

Edwards believes in and invests in the evidence generation process for our technologies and supports the use of the National Coverage Determination ("NCD") process, which utilizes CED in circumstances where additional clinical evidence is determined to be needed to demonstrate that the technologies meet the reasonable and necessary standard. NCD with CED requirements should only be used in those very specific circumstances in order to make a coverage determination. Edwards has been engaged with CMS and has committed to the CED pathway for more than a decade, first with the Transcatheter Aortic Valve Replacement ("TAVR") CED and more recently with the Mitral Transcatheter Edge-to-Edge (TEER) CED. Given this, we offer the following principles

[1] https://www.ssa.gov/OP_Home/ssact/title18/1862.htm

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and recommendations to improve the NCD with CED process. Our focus is on balancing the need for the Centers for Medicare & Medicaid Services ("CMS") to receive the additional evidence necessary to make coverage determinations, along with the desire to ensure broader beneficiary access to new, ground-breaking FDA-cleared and approved products where there remains a significant unmet patient need.

NCD with CED requirements, when streamlined, efficient and time-limited, can be a powerful tool for CMS to ensure patients have early and broad access, while ensuring additional evidence is developed for promising technologies. In short, it can offer the following benefits:

- Allows patients in need to access innovative technologies sooner;
- Addresses barriers to entry, helping smaller innovators bring competitive products to market; and
- Decreases the cost and burden of product development by leveraging registry data.

I. Edwards CED Principles

As a member of the Advanced Medical Technology Association ("AdvaMed"), Edwards agrees with AdvaMed's support for the NCD with CED pathway, and its recommendations of the following policy tenets, including (i) ensuring a timely and predictable process that is sensitive to patient needs, (ii) encouraging innovation, (iii) maintaining a transparent process, (iv) appreciating the practical challenges of evidence generation, and (v) supporting patient participation in clinical trials. We concur and offer the following additional principles that guide our recommendations for enhancing the NCD with CED pathway:

- Patients' timely access to FDA-approved and cleared innovative therapies for serious health conditions;
- Post-approval data collection of additional evidence where needed to:
  - Address clinically relevant, unanswered or unresolved questions
  - Provide patients, providers and regulators with meaningful information about outcomes
  - Assess therapy performance in a real-world setting (beyond clinical trials)
  - Improve quality through ongoing performance measurement
  - Develop and improve upon innovations
- Reduced administrative burden through "flexible coverage" that follows FDA-approved expanded indications within a therapy category

These principles are critical to supporting patient access to innovation, while also producing the vital data necessary for CMS to make coverage determinations.

II. Feedback on the MEDCAC Panel Questions

Edwards appreciates the opportunity to provide feedback on the MEDCAC panel questions regarding the CED revised requirements. In September 2022, Edwards submitted comments on these requirements as outlined in the Agency for Healthcare Research and Quality (AHRQ) draft report, "Analysis of Requirements for Coverage with Evidence Development – Topic Refinement." As stated above, Edwards believes that CED can be a powerful tool for CMS to ensure additional evidence is developed while allowing patients to have early and broad access to promising new technologies. It is important, however, that the CED is collaborative between CMS and the manufacturer and implemented in a least-burdensome way. From that perspective, Edwards offers feedback on the following panel voting questions, which represent the revised requirements from the AHRQ final report:

COMMUNICATION. A written plan describes the schedule for completion of key study milestones to ensure timely completion of the CED process.

Edwards supports the submission of a written plan that outlines the targeted schedule of key study milestones, particularly to ensure a clear and final milestone that would signify the completion of the CED process. Patients, providers and innovators need to clearly identify the study objectives and the defined timelines in advance (including clear rules for sunsetting data collection requirements). This step is important for stakeholders to plan and invest accordingly and to guarantee CMS obtains the data required to evaluate products properly. As important, it is also critical so that innovators have a clear end goal and clear timeline to ensure that CED works as intended, i.e., driving the generation of evidence to revise and, where appropriate, broaden coverage policies to increase access to patients over time.

OUTCOMES. The primary outcome(s) for the study are clinically meaningful and important to patients. A surrogate outcome that reliably predicts these outcomes may be appropriate for some questions.

Edwards agrees that in designing the study, sponsors and investigators should establish study outcome(s) that are important and relevant to the patient. In addition, we concur with the findings in the final AHRQ report that the focus should not be on patient-reported outcomes. Our concern in this requirement rests with the use of the phrase "clinically meaningful" as that term is rather vague and could lead to variability in the interpretation and application of this term. With this requirement, as with the other requirements, it is critical that CMS be clear and transparent in its expectations, and collaborative in the process of determining the appropriate primary outcomes relevant to the study and the intended population. That would allow sponsors and/or investigators to design and implement their study in a way that meets the Agency's objectives without being unnecessarily burdensome.

PROTOCOL. The CED study is registered with ClinicalTrials.gov and a complete protocol is delivered to CMS.

Developing a study protocol requires a significant investment of time and resources by the investigators and the study sponsor. A written protocol for a successful study design addresses many parameters including, but not limited to:

- General information about the researchers and background information on the investigational product;
- Detailed description of the trial objectives, purpose, and design;
- Patient eligibility criteria;
- Treatment of the subjects or the diagnostic protocol;
- Statistical methods for analyzing the clinical trial data.

These protocols go through an iterative process in their development with updates as needed based on feedback or due to evolving circumstances.

We commend AHRQ for revising the requirement such that the CED study must be registered at https://clinicaltrials.gov/ and eliminating the requirement for public disclosure of the full study protocol. Edwards supports the confidential disclosure of the complete protocol to CMS; however, it is important to note that the protocol would contain information that is exempt from disclosure under the Freedom of Information Act Exemption 4, given the high likelihood that it would contain trade secrets and confidential commercial or financial information.

POPULATION. The study population reflects the demographic and clinical diversity among the Medicare beneficiaries who are the intended users of the intervention. This includes attention to the intended users' racial and ethnic backgrounds, gender, and socio-economic status, at a minimum.

As stated in our prior comments, Edwards commends AHRQ for the initial incorporation of this requirement and the revision of this requirement in the final AHRQ report as Edwards strongly supports diversity in the populations for its clinical trials. To promote this goal, Edwards:

1. Seeks to include diverse Principal Investigators and study Leadership Committee participants (race, gender, age, etc.) in our clinical trials to ensure study design considerations are inclusive of diverse patient populations, and that patients seeking trial participation are able to find representative physicians to treat them.
2. Trains sites during the start-up and enrollment process on the importance of diverse patient participation and access to research for all patients, as well as unconscious biases and barriers to trial participation (i.e., childcare, mid-day appointments, multiple appointments, language, etc.). As research sites are the front line of inclusion or exclusion of diverse patient participation, Edwards asks each site to self-assess their catchment area for diversity rates, so they can understand and impact their own clinical trial diversity and inclusion (D&I) metrics.
3. Offers D&I stipends to any site who seeks the extra funding to enhance D&I recruitment activities.
4. Provides multi-cultural and multi-linguistic recruitment tools at no charge to all sites.
5. Actively participates on multiple initiatives and work groups (AdvaMed's Women Heart Health, MedTech Color's Collaborative Community on Diversity and Inclusion in Medical Device Product Development

and Clinical Research, etc.) seeking to effect positive and meaningful change in clinical trial diversity and inclusion of all patients.

REPORTING. The study is submitted for peer review with the goal of publication using a reporting guideline appropriate for the study design and structured to enable replication.

Edwards questions the intent of requiring peer reviewed publication to satisfy the Key Informants' recommendation for public posting. We believe the existing CED reporting requirement allows for multiple options for publicly reporting results while still satisfying the need for transparency of the study design and methods. Limiting the reporting requirement to peer review publication is overly burdensome and jeopardizes timely stakeholder access to evidence generated under CED and, potentially, patient access to technologies. Edwards recommends retaining the following existing options for public reporting:

> *Final results must be reported in a publicly accessibly manner; either in a peer-reviewed scientific journal (in print or online), in an on-line publicly accessible registry dedicated to the dissemination of clinical trial information such as ClinicalTrials.gov, or in journals willing to publish in abbreviated format (e.g., for studies with negative or incomplete results).*

SHARING. The sponsors/investigators commit to sharing analytical output, methods, and analytic code with CMS or with a trusted third party in accordance with the rules of additional funders, institutional review boards, and data vendors as applicable. The schedule for sharing is included among the study milestones. The study should comply with all applicable laws regarding subject privacy, including section 165.514 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As articulated in our prior comment letter, Edwards supports the sharing of aggregated study data and a detailed overview of the methodology used in the data analysis. We continue to be concerned that adding a de-identified data sharing requirement would create substantial administrative burden without CMS providing appropriate justification for its inclusion as a criterion. Edwards supports the removal of the requirement that data be de-identified. However, we request that the language regarding incorporating the schedule for sharing into the study milestones be removed. The timing for sharing can be difficult to determine and should be evaluated on a case-by-case basis.

III. Coverage with Evidence Development versus Transitional Coverage for Emerging Technologies

Following the repeal of the Medicare Coverage of Innovative Technology ("MCIT") Final Rule, CMS has stated that it intends to put forth a new pathway, Transitional Coverage for Emerging Technologies ("TCET"), which seeks to ensure timely access to innovative and emerging technologies while addressing concerns with the MCIT pathway as originally designed. In one of its listening sessions held in early 2022, CMS sought feedback from stakeholders on numerous topics specific to TCET, including the evidence development process.

As MEDCAC and CMS contemplate changes to the NCD process and requirements as it relates to CED, Edwards believes it is important to distinguish between the two different pathways. As noted above, CED is an important process but as currently constructed, it is not set up to facilitate timely patient access to innovation. TCET should be viewed and constructed as a separate and distinct pathway for coverage – one for a subset of technologies that meet the definition of emerging and innovative and for which there is more timely access for beneficiaries. While TCET may have an evidence generation component, we believe the pathway for TCET should be separate from the NCD process utilizing CED to ensure a less burdensome process that establishes appropriate beneficiary safeguards while allowing Medicare beneficiaries access to potentially life-saving and life-enhancing technologies.

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Edwards thanks you for your consideration of these comments in advance of the MEDCAC meeting, and we look forward to hearing the MEDCAC members' perspectives on CED. If you have questions or would like additional information, please contact me at 949.250.0764 or at mary_coppage@edwards.com.

Sincerely,

Mary Coppage
Vice President, U.S. Healthcare Policy
Edwards Lifesciences