April 10, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–3355–P
P.O. Box 8016
Baltimore, MD 21244-8016

American Clinical Laboratory Association

DELIVERED ELECTRONICALLY

Re: Clinical Laboratory Improvement Amendments of 1988 (CLIA) Proficiency Testing Regulations Related to Analytes and Acceptable Performance (CMS-3355-P)

The American Clinical Laboratory Association (ACLA) is pleased to submit these comments in response to the proposed rule issued by the Centers for Medicare & Medicaid Services (CMS or the Agency) entitled, "Clinical Laboratory Improvement Amendments of 1988 (CLIA) Proficiency Testing Regulations Related to Analytes and Acceptable Performance" (CMS-3355-P) (the Proposed Rule).[1] ACLA is a trade association representing the nation's leading providers of clinical laboratory services, including regional and national laboratories. Its diverse membership includes a broad array of clinical laboratories: large national independent labs, reference labs, esoteric labs, hospital labs, and nursing home labs.

I. In Developing New Regulations, CMS Should Carefully Consider Any Additional Costs or New Obligations Affecting the Clinical Laboratory Industry.

The clinical laboratory community is currently experiencing a dynamic time period of regulatory and reimbursement changes. ACLA encourages CMS to undertake a less-siloed approach to developing new regulations and policies that impact an industry operating under such pressures, which may include sweeping new federal diagnostics oversight reform legislation. Competing and potentially overlapping regulatory and reimbursement pressures will likely stifle innovation and impede patient access to cutting-edge diagnostic tests.

For example, in December 2018, CMS announced that it planned to increase CLIA fees by 20% across all schedule codes.[2] Now, the Proposed Rule raises the prospect of several additional costs and new obligations for the clinical laboratories on top of the CLIA fee increases. As the Agency considers finalizing the Proposed Rule and potentially issuing an additional CLIA-related rule in the near future[3], ACLA urges CMS to understand fully the financial and logistical burdens such new regulations may place on the clinical laboratory community. For example, the Proposed Rule would result in the following additional costs and new obligations, among others, for the clinical laboratory industry:

- ***Required Proficiency Testing for 29 New Analytes***. CMS proposes requiring proficiency testing (PT) for an additional 29 analytes.[4] While CLIA regulations already

[1] 84 Fed. Reg. 1536 (Feb. 4, 2019).
[2] 83 Fed. Reg. 67723 (Dec. 31, 2018).
[3] For example, based on the Fall 2018 Unified Agenda, we understand that CMS intends to publish another CLIA-related proposed rule as early as July 2019. *See* "Personnel, Proficiency Testing Referral, and Histocompatibility Requirement Updates" (CMS-3326-P) (RIN: 0938-AT47), *available at* https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201810&RIN=0938-AT47.
[4] 84 Fed. Reg. at 1542-1543.

require that laboratories verify the accuracy of tests not listed in 42 CFR subpart I ("Proficiency Testing Programs for Nonwaived Testing") at least twice annually[5], ACLA anticipates that there will be new, additional costs associated with the PT requirement for the 29 analytes. Such costs include: administrative functions related to PT ordering, result reporting, and record keeping. Further, since regulated analytes require five samples, there will be increased expense to test the required new analytes with the number of samples per event.

Further, ACLA is concerned that the Agency ultimately calculated the number of new analytes based on the requirement that any new analyte should be offered by at least three current PT programs, among other criteria.[6] Requiring PT for new analytes where there may be *only* three current PT programs could potentially result in an unfair market advantage, raise PT costs for laboratories, and/or create logistical difficulties in obtaining PT analytes. In the preamble of the Proposed Rule, CMS did not provide a satisfying explanation for why it did not increase the minimum number of required PT programs to four.[7] ACLA asks for further clarification on this point in the preamble to any final rule.

- ***Declaration of Patient Reporting Practices (Proposed § 493.801(b)(3))***. For microbiology PT, CMS proposes that all laboratories should declare their patient reporting practices for organisms included in each challenge to the PT program.[8] Yet, it is an inspecting agency's responsibility – not the duty of the PT program – to review such information and take action if necessary.[9] This proposal would unnecessarily duplicate reporting obligations – and increase recordkeeping and reporting costs for a laboratory – while having a negligible impact on public health.

- ***Minimum Number of Laboratory Participants in PT Program for Each Analyte (Proposed § 493.901(a))***. The Agency proposes requiring a minimum of 10 laboratory participants before a program offers a PT analyte. ACLA recommends that this provision be eliminated. This requirement would mean that PT programs that have already prepared survey materials will have done so to no avail. The outcome is that laboratories may pay more for PT in the future. Further, laboratories may lose the ability to have any level of commercial material available for comparison purposes for tests with limited offerings.

- ***Increased Number of Challenges Per PT Event (e.g., Proposed § 493.913(a)(5))***. CMS proposes to increase the number of challenges per PT event for certain types of testing. For example, the Agency wishes to increase the number of challenges per PT event for susceptibility or resistance testing from one to two challenges for each microbiology subspecialty.[10] Any increase in the number of challenges per event for certain types of

[5] *See* 42 CFR § 493.1236(c)(1).
[6] 84 Fed. Reg. at 1540-1541.
[7] *Id.* at 1541 ("[I]ncreasing the minimum number of PT programs to four, while presumably increasing PT program availability and access for a given analyte, decreased the number of analytes under consideration to 164").
[8] *Id.* at 1538.
[9] *Id.*
[10] *Id.* at 1539.

PT testing will simultaneously increase the costs for laboratories participating in those PT programs.

- ***Submission of Electronic PT Data (Proposed § 493.901(c)(6))***. CMS proposes to require that PT programs limit participants' online submission of PT data to one submission or that a method be provided to track changes made to electronically reported results.[11] Any costs associated with PT programs reconfiguring existing or adopting new technologies capable of documenting an audit trail likely would be passed on to participating laboratories.

ACLA encourages the Agency to consider any new costs and additional obligations as it contemplates future CLIA-related rulemakings as well as other additional CMS-issued rules and policies that may affect the clinical laboratory community. The Agency must consider the impacts of such rulemakings and policies in the context of the larger regulatory landscape.

II. The Agency's Proposed Accuracy Goals Raise Additional Concerns.

Current CLIA regulations include a variety of PT acceptance limits (ALs).[12] CMS believes that it would be appropriate to now update the ALs. For example, for all new and currently required non-microbiology analytes, the Agency proposes to "use fixed ALs, preferably as percentage limits rather than concentration limits."[13]

We are concerned that in certain circumstances the only test methods that could meet the proposed percentage limits are the most expensive (e.g., liquid chromatography with tandem mass spectrometry (LC-MS/MS)). This is despite the fact that the use of more complex methods may not translate to higher reimbursement because of analyte-specific coding.[14]

Additionally, under the proposed accuracy goals, there is a significant risk of failure with low concentration specimens. In order to prevent such failures, PT providers may avoid the development and distribution of PT materials with low analyte concentrations. This could potentially result in a decreased PT assessment of the low end of assay analytical measurement ranges. ACLA believes that standard deviation-based grading has worked well since the development of the original CLIA regulations. We recommend that the Agency permit such grading until the public can thoroughly review and provide comment on the underlying simulation data that CMS used in proposing the new ALs.[15] Further, PT programs should be required to make a selection of values at or near the medical decision limits, rather than unrealistically high or low values that laboratories would not normally see with patients.

Finally, ACLA does not believe that the Agency's proposed approach necessarily aligns with international thinking on how accuracy goals should be established.[16] Recent industry discussions led by

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[11] *Id*.

[12] This includes a multiple of the standard deviation of results from the mean of other participants in a peer group; fixed limit as a percentage of the assigned value; fixed limit in concentration units; and a mixture of percentage and concentration units, depending on the concentration of the analyte. *Id*. at 1544.

[13] *Id*.

[14] For example, Estradiol is an analyte where no currently-available immunoassay could meet the Agency's proposed accuracy goals. The only method that could meet the proposed goals is a CDC protocol using LC-MS/MS. The cost of LC-MS/MS testing for Estradiol is significantly higher than the other clinical methods, but because of analyte-specific coding, reimbursement is the same.

[15] *See* 84 Fed. Reg. at 1544 ("Changing Acceptance Limits").

[16] *See, e.g.*, Miller WG, Shimmel H, Rej R, et al. IFCC Working Group Recommendations for Assessing Commutability Part 1: General Experimental Design. Clin. Chem. 2018;64(3):447-454; Nilsson G, Budd JR,

the European Federation of Clinical Chemists and the European Federation of Laboratory Medicine have recognized the need to establish a three-level database of acceptable reference ranges for within group and within individual biological variability based on how directly the assay is tied to a highly accurate standard reference method. The first level would involve methods anchored to a reference method; the second would involve those that are not anchored to a reference method, but whose accuracy and precision are still good; and the third would involve methods that meet neither of the first two criteria but consist of the best available technology at the time. The Proposed Rule does not acknowledge or accommodate this approach.

III. Conclusion.

Thank you for the opportunity to submit these comments concerning the Proposed Rule. We look forward to working with CMS and other stakeholders on issues concerning the Proposed Rule. If you have any questions, please do not hesitate to contact me. We appreciate your consideration of ACLA's comments.

Sincerely,

Thomas Sparkman
Vice President Government Affairs
American Clinical Laboratory Association

Greenberg N, et al. IFCC Working Group Recommendations for Assessing Commutability Part 2: Using the Difference in Bias between a Reference Material and Clinical Samples. Clin. Chem. 2018;64(3):455-464; Budd JR, Weykamp C, Rej R, et al. Clin. Chem. IFCC Working Group Recommendations for Assessing Commutability Part 3: Using the Calibration Effectiveness of a Reference Material. 2018;64(3):465-474.