DuVal CLIENT ALERT

Passing on Tribal Knowledge of FDA Law

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INDUSTRY RECAP 2022

KEEPING OUR FINGER ON THE PULSE OF THE INDUSTRY

Topic Quick Links

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eSTAR

Early in 2022, FDA released a voluntary program called "electronic Submission Template And Resource (eSTAR)" to help improve 510(k) and De Novo submission quality through the use of a standardized template. Two smart eSTAR PDF templates are available for free download from FDA's eSTAR website: one for in vitro diagnostic (IVD) devices and one for non-IVD devices. Over 2022, we submitted eSTAR 510(k) and De Novo submissions for both device types and share our overall experience.

eSTAR Template:

- **Content**: The eSTAR templates are designed to obtain all required content for a 510(k) or De Novo submission. Help features are provided throughout and include links to applicable guidance documents and tips for what type of information to provide.
- **Format:** The templates guide you through submission preparation by automatically generating required fields based on responses to radio buttons. Information is provided through

a combination of text fields and attachments, as allowed by the template.

Key Advantages:

- **No Refuse to Accept (RTA) Review**: In a 2022 survey conducted by DuVal & Associates and Introworks of industry experience with the 510(k) program, a significant number of respondents had received an RTA decision. Since eSTAR is a standardized format and required information must be provided for template completion, eSTAR submissions are not subject to the Acceptance review that can lead to an RTA Hold.
- **No eCopy Rules**: eSTAR submissions are not subject to eCopy rules.
- **No CDRH Cover Sheet**: Freedom from the time and tedium to complete FDA forms!
- **Review Process**: To date, we have been pleasantly surprised at the positive impact on review times and minimizing requests for additional information.

Challenges:

- **Advocacy**: At all our training events, we speak about the importance of advocating for the submission and having it "tell the story" of the subject device. With the modular format of eSTAR, it's harder to tell a cohesive story and, therefore, requires a thoughtful approach.
- **Complex Content**: The small text field boxes and limitations on what data can be provided via an Attachment are not yet sufficient to manage complex information.

For now, the eSTAR program is voluntary, however, ***starting October 1, 2023, the eSTAR submission format will be required for most 510(k) submissions***. To help you become familiar with this tool and learn how to

use it strategically, we will be releasing a multi-part Client Alert series on the eSTAR program that will debut in January 2023.

Sign up for the free Client Alert subscription (you don't need to be a client to do so) to shine bright in the eSTAR program!

Lisa Pritchard, BSEEE

Vice President of Regulatory, Quality, Clinical and Engineering

FDA Customer Collaboration Portal (CCP)

Long ago, in a regulated industry far away, regulatory professionals stayed up late into the night making multiple copies of submissions to send via weary FedEx professionals to FDA. The advent of the electronic submission (eCopy) in 2013 was a welcome innovation that initially allowed one electronic version and one paper version to be provided for each submission – this was both environmentally friendly (how many trees were saved?) and ergonomically friendly (how many backs were saved?)! The Food and Drug Administration Safety and Innovation Act (FDASIA) further improved things in 2020 by permitting submission of ONLY the eCopy with no paper copy when the eCopy rule was released. And yet, when the eCopy rule was released, it still felt somehow unsatisfying. It came so close but stopped short of the dream of a fully electronic submission. Why did we still

have to send a binder with a printed-out cover letter and a CD-ROM or flash drive containing our beloved requests to FDA?

In 2022, we finally earned the right to celebrate as FDA introduced the Customer Collaboration Portal (CCP) and opened access to all. The CCP is a unicorn in a sea of FDA activities. I can think of no other FDA activity on which all industry professionals (except possibly FedEx) seem to agree – this is a fabulous tool. We. Love. It! Please note, the use of the CCP does not preclude you from still going to your FedEx office and just visiting – they are left a bit lonelier than they were before; even though you no longer need them to deliver your submissions, it's ok to still show them some love.

The CCP is an electronic portal through which the completed submission (eCopy or eSTAR) can simply be "dragged and dropped" to be uploaded and with a simple click of a button, sent to FDA. Instant gratification comes in a confirmation that your beloved submission has found its way into the hands of FDA. Upload it before 4 pm Eastern, and even be rewarded with a same-day Acknowledgement Letter. But the excitement doesn't end there for 510(k) Submissions. The CCP also includes a tracking tool that lets you see your completed and in-process submissions including reviewer, review team, review division, office, significant events that have occurred, and days left on the FDA review clock. No more calculating where the FDA review clock stands. The portal and the built-in 510(k) tracker are fabulous innovations.

We look forward to the expansion of the tracker to other submission types in the future. To join our excitement in using this portal, the sign-up process is very easy. Click here and enter your email, name and preferred secure password to receive your own CCP account. Although use of this tool is currently optional, and you can still submit an old-fashioned eCopy, we highly recommend using it to experience the joy and benefits for yourself. *Our review of the CCP results in two thumbs way up. Thank you, FDA, for this fabulous tool!*

Aaron Hage, J.D.

Senior Director of Legal-Regulatory & Compliance

VALID Act

One of the big surprises as 2022 wraps up is the stalling of the Verifying Accurate Leading-edge IVCT Development (VALID) Act in Congress. The VALID Act was not incorporated into the recent Medical Device User Fee Amendments or the 2023 Omnibus spending bill package.

In the United States, the majority of diagnostic and treatment decisions are supported by laboratory testing. However, the common view is that these laboratory tests are not regulated by the FDA under the Food, Drug, & Cosmetic (FD&C) Act because they do not expressly fit the definition of a medical device and tests that are developed and remain within the laboratory are not generally introduced into interstate commerce. Rather, they are regulated by the Centers for Medicare & Medicaid Services (CMS) under the Clinical Laboratory Improvement Amendments (CLIA).

However, FDA has fundamentally disagreed with this position, largely due to the risk that as testing becomes more complex some laboratory-developed tests could result in significant patient harm due to incorrect or inaccurate results. As a result, knowing it is on perilous legal footing, the Agency has exercised its enforcement discretion in all but the highest-risk test situations.

The VALID Act would change all this. ***The VALID ACT would amend the FD&C Act to redefine a medical device to include in vitro laboratory tests and the associated testing services offered to be expressly within FDA's regulatory aim.*** On the one hand, this would potentially subject millions of laboratory tests to more burdensome regulatory requirements, which will have an impact on innovation and test availability. On the other hand, the VALID Act included provisions to grandfather and transition existing testing. Without these provisions, FDA has hinted that they will enforce laboratory tests under their current medical device regulatory scheme (e.g., Pre-market Approvals, De Novos, and 510(k)) resulting in the potential for even greater undesirable impacts than under VALID.

Without the enactment of the VALID Act, it is expected that in 2023 FDA will seek to further clarify their current regulatory enforcement position regarding laboratory testing. ***The result could be a chilling effect on laboratory testing innovation and availability.***

Enforcement & FMT

By Aaron Hage, J.D., Senior Director of Legal-Regulatory & Compliance

Throughout 2022, FDA continued to take a more passive-aggressive approach toward medical device regulatory enforcement. Although there has been a recent trend towards fewer warning letters directed at manufacturers, FDA has been more aggressive through other means, such as by broadening regulatory oversight through guidance documents and relying upon safety communications to exercise its enforcement. Both methods rely upon FDA's "current thinking" on an issue and often are not grounded in legal and regulatory authority.

FDA has used guidance documents to interpret their regulatory authority, arguably beyond the scope of what is authorized under the Food, Drug, &

Cosmetic Act. Two recent examples are FDA's final guidance documents on *Clinical Decision Support Software* and *Enforcement Policy Regarding Investigational New Drug Requirements for Use of Fecal Microbiota for Transplantation to Treat Clostridium difficile Infection Not Responsive to Standard Therapies*.

Regarding clinical decision support, the Food, Drug, & Cosmetic Act excludes certain software functions from definition of a device. This includes functions used in supporting or providing recommendations to a health care professional about the prevention, diagnosis, or treatment of a disease or condition if the basis for the recommendation can be independently reviewed and not primarily relied upon. Under FDA's final Clinical Decision Support Software guidance document, apart from removing the express enforcement discretion language afforded to caregivers and patients, FDA has started to eat away at the statutory exclusion as well.

For example, under its guidance, FDA does not consider providing specific diagnosis or treatment directions to an HCP or providing a risk score to be considered as merely a recommendation. Additionally, under the statute, the software function cannot be used to analyze medical images. Historically, even within FDA, medical images were thought to be images generated by a medical image system (e.g. x-ray or MRI). However, under the guidance, FDA has expanded their interpretation to include any image used for a medical purpose, which could include images from a mobile phone or other mobile platform if used for a medical purpose. ***This is a gross expansion of FDA's authority under the statute and will stifle innovation that will be used to treat patients.***

FDA has also increased their regulatory burden via guidance documents for Fecal Microbiota Transplantation (FMT). FDA has regulated FMT as a biologic for the past ten years, although its legal definition remains up for debate. Regardless, over the past ten years, FDA has exercised its enforcement discretion regarding a licensed health care provider using FMT

to treat *Clostridium difficile* infections without the need to obtain an investigational new drug authorization. However, one requirement is that the FMT sample not be obtained from a stool bank. Proponents of FMT treatments have argued that FDA is outside their regulatory authority and engaging in the practice of medicine by dictating how health care professionals treat patients, to which we would also agree. Nonetheless, FDA solidified their position with the issuance of its final version of the guidance this past fall. ***We will see how FDA moves forward with enforcing this position in the upcoming year, but it will likely have a chilling effect on health care professionals' use of FMT in the treatment of their patients***.

Another concern is the Center of Diagnostic and Radiologic Health's increased use of safety communications, nearly a 50% increase in 2022 over 2021. Usually, Warning Letters were a manufacturer's greatest concern from FDA. ***However, for some of our clients, 2022 saw FDA safety communications become a chief concern.***

Warning Letters are issued when there is a significant violation of FDA regulations or the Food, Drug, & Cosmetic Act, and require a manufacturer to take corrective and preventive action to close out the Warning Letter. Warning Letters require some level of evidentiary requirements against the manufacturer and often result from inspectional findings when the FDA visits a manufacturer's establishment. In contrast, safety communications do not implicate violations of regulation or law. ***Safety communications are based on FDA's "current thinking" and can be triggered by one or two adverse events reported to FDA, even where the root cause of the event is not device-related.*** Furthermore, safety communications can be issued more broadly towards industry without pointing to a specific manufacturer. But still have a profound effect on a manufacturer's ability to market and sell its product, and it allows FDA to implicate a particular swath of manufacturers without needing the evidence required to seek enforcement with a specific manufacturer.

The uptick in safety communications may be a result of fewer FDA inspections over the last few years due to the pandemic and the marketing of COVID countermeasures that may not meet desired performance requirements due to a lower bar set forth by Emergency Use Authorizations. *Hopefully in 2023, as FDA resumes its domestic inspectional activities and the pandemic wanes, we will see a more tailored and evidentiary approach to enforcement rather than broadly issued safety communications*.

In the past couple of years, we have seen FDA threaten to take steps to regain traction in areas where they had perilous legal and regulatory authority. With Congress unlikely to move forward with any meaningful device or biologic legislation in the current congressional session, *in 2023 expect FDA to start to move forward to once again increase its own regulatory authority.*

Mark DuVal, J.D., FRAPS

President & CEO

Office of Combination Products

The Office of Combination Products (OCP) remains an enigma for industry, or is it actually predictable? It is an enigma in that it is hard to believe OCP can find so many products are drugs under a Primary Mode of Action (PMOA) analysis or in a jurisdictional finding of whether a device-like product operates through "chemical action." One must consider OCP's everything-is-a-drug-like-bent in its decision-making and, intertwined with that, the presence and influence of Center for Drug Evaluation and Research (CDER) in Requests for Designation (RFDs) and product jurisdictional decisions. This is what is making OCP predictably wrong-headed. *CDER obviously has a disproportionate amount of influence over RFDs and jurisdictional decisions and, frankly, that has cost OCP some credibility marks in court and with industry.*

FDA frequently goes out of its way to conclude that many combination products with a device component are deemed to have a drug or biologic Primary Mode of Action (PMOA) and thus are regulated by CDER. This is problematic because the drug path is a much more expensive and time-consuming path which is a non-starter for many device products, and which stifles innovation. Nonetheless, FDA has attempted to preserve its "discretion" to make definitional decisions in policy and practice. In many jurisdictional decisions, FDA will also bend over backwards to make a

finding that a product has "chemical action" as its primary intended purpose and is therefore a drug, not a device. Do not take our word for this position (although you could from our experience), rather, follow the case law. FDA often presumptively and even imperiously—out of positional strength, not the persuasiveness of its argument—determines products to be drugs instead of devices. Upon exposure to an independent arbiter like the courts, FDA finds its decision-making being overturned. ***Courts have not infrequently used "arbitrary and capricious" to describe FDA decision-making on these definitional issues.***

Take for example the *Prevor* and *Genus Medical* cases. The first was a combination product assignment that FDA was convinced was a drug until the courts disagreed with their finding and reasoning. Prevor, a French company, developed a product called Diphoterine™ Skin Wash ("DSW") to mitigate chemical burn injuries in the industrial workplace. DSW consists of a liquid substance contained in a canister propelled by pressurized gas. The liquid substance is colorless and odorless and is comprised of roughly 96% water and 4% diphoterine. DSW is intended to: (1) remove splashes of acidic or basic substances off the skin by physically and mechanically washing the chemicals away from the skin, and (2) neutralize and dilute acids and bases.

FDA took the position that, despite the plain meaning of the statute, there could be ***two primary intended purposes*** for the product. FDA argued that if a product achieved its primary purpose "in part" through chemical action, then the product should be deemed a drug. This "in part" interpretation drew the following common-sense tutorial from the United States District Court for the District of Columbia, Judge Rosemary Collyer in 2012:

> "A product is not a "device" if it "achieve[s] its primary intended purposes through chemical action within or on the body of man." 21 U.S.C. § 321(h). ***Inasmuch as the statute seeks to identify primary intended purposes that are achieved through chemical action, it would be magnificently expanded if a primary purpose could automatically be achieved "at least in part" or***

> *"even in part" by chemical action. Primary means principal, first among others, foundational.* See Merriam-Webster Dictionary Online."

The Court disabused FDA of its weak analysis and remanded the case for a more reasoned finding. On reconsideration, the Court concluded:

> "…FDA hardly changed its reading of the statute and relied on an arbitrary standard that contravenes the plain meaning of the law. Accordingly, the Court will deny FDA's motion for summary judgment. *The Court will grant summary judgment in part to Prevor, finding that FDA acted arbitrarily and capriciously in violation of the Administrative Procedure Act."*

Fast forward to 2021 and consider the *Genus* case where FDA reasoned that a line of barium sulfate oral-solution contrast agents, ingested for diagnostic purposes, is both a drug and a device. Barium sulfate is an inert metal salt that does not interact with human cells or tissues or affect chemical bonds or the molecular structure of the gastrointestinal system, among other non-drug-like qualities. FDA made a fanciful definitional and jurisdictional argument that because "the definitions of drug and device are overlapping, rather than mutually exclusive," FDA has discretion to decide how it wants to regulate a diagnostic product that falls within both categories. ***FDA then decided the product should be regulated as a drug, despite the fact FDA agreed it was also a device.***

So, once again the courts tutored FDA. The court said the more specific the definition of a device should prevail under well-settled principles of statutory construction. The device definition is exclusionary. A device, unlike a drug, "***does not achieve its primary intended purposes through chemical action*** within or on the body of man or other animals" if the product does not achieve its primary intended purpose through chemical action, then it must be regulated as is a device. The statute gives no other choice. The

United States Court of Appeals for the District of Columbia concluded as follows:

> "And no one suggests that the FDCA requires products meeting both definitions to be regulated both as drugs and devices, which would create a breathtaking example of statutory redundancy. ***The statute, then, is clear: a product may be regulated as a drug or a device, but not both, and while a single product may simultaneously satisfy the linguistic elements of two definitions, it is not possible for the FDA to give simultaneous effect to both.*** Thus, this is precisely the sort of setting in which we must give effect to the specific over the general."

To give credit where it is due, following the *Genus* decision, FDA decided to publish a notice in the Federal Register that it would establish a process to reconsider products that FDA previously determined should be regulated as drugs to determine if those products should be regulated as a device under the *Genus* decision. *See* 86 Fed. Reg. 150 at 43553 (August 9, 2021).

Our firm is in the throes of working with FDA today on RFDs and product jurisdiction decisions. We remain hopeful that OCP has learned something from all of this and will apply a more constrained and informed view that has fidelity to the statute and regulations, instead of resembling results-oriented, jurisdiction-directing, decision-making.

Top New Guidance Documents

Lisa Pritchard, BSEEE, Vice President of Regulatory, Quality, Clinical and Engineering

The FDA issued 206 guidance documents in 2022 (through December 8) including 53 issued by or in collaboration with CDRH. About one-quarter of those are related to the COVID-19 pandemic. Following is a list, in no particular order, of what we consider the top 12 guidance documents of the year that relate to the Medical Device industry:

1. Principles for Selecting, Developing, Modifying, and Adapting Patient-Reported Outcome Instruments for Use in Medical Device Evaluation (Final Guidance): This final guidance provides key principles for the selection of patient-reported outcome (PRO) instruments and related best practices regarding their selection and
2. Center for Devices and Radiological Health (CDRH) Appeals Processes (Final Guidance): This final guidance updates a previous 1998 guidance and highlights the many avenues available to appeal a decision made by FDA and provides information about their application and how to use them.
3. Initiation of Voluntary Recalls Under 21 CFR Part 7, Subpart C (Final Guidance): This final guidance is presented in a Q&A format to provide insights to assist in the completion of a voluntary recall including general preparations before a recall is needed, recommendations for the development of procedures (SOPs), recommendations for conducting the recall and expectations for communication with FDA.
4. Refuse to Accept Policy for 510(k)s (Final Guidance): This final guidance provides updates to the expectations for the minimum required information for acceptance of a 510(k) submission for review. If a refuse to accept (RTA) decision is rendered, it is important to note that the FDA review clock does not begin until the concerns are addressed. RTAs have been a significant concern; an effective way to avoid them is through use of the RTA checklist as a quality check for an eCopy submission, or through use of the eSTAR template that is not subject to the RTA policy.

5. Electromagnetic Compatibility (EMC) of Medical Devices (Final Guidance): This final guidance replaces a previous guidance on supporting EMC claims, providing technical information to address the recommendations in the prior guidance. Detailed expectations for EMC content of premarket submissions are provided.
6. Electronic Submission Template for Medical Device 510(k) Submissions (Final Guidance): This guidance provides notification that use of the eSTAR format will become mandatory for most 510(k) submissions, including all original 510(k) submissions, beginning October 1, 2023. The guidance provides a high-level structure of the eSTAR template
7. Policy for Device Software Functions and Mobile Medical Applications (Final Guidance): This final guidance document update provides information on software products providing examples of products for which FDA intends to focus its oversight, those that are technically devices but where it plans to exercise enforcement discretion, and those that are considered outside the definition of a medical device. This guidance also includes lengthy lists of product examples requiring FDA oversight, and those that will not be considered a medical device.
8. Clinical Decision Support Software (Final Guidance): This final guidance provides information to assist in the determination of whether a clinical decision support (CDS) software includes device functionality (requiring FDA oversight) or not, including discussion of the interpretation of software definitional criteria from section 520(o)(1)(E) of the FD&C Act.

Enforcement by FDA and FTC - Make Up Your Mind

By Mark DuVal, J.D., President & CEO
Bryan Feldhaus, J.D., LL.M, VP of Legal-Regulatory & Compliance
Aaron Hage, J.D., Senior Director of Legal-Regulatory & Compliance

On December 20, 2022, the Federal Trade Commission (FTC) issued new guidance entitled "Health Products Compliance Guidance." This marked the Agency's first revision of its prior guidance entitled, "*Dietary Supplements: An Advertising Guide for Industry*," which was previously issued in 1998. The FTC's new guidance is not limited to dietary supplements but applies to all health-related products and related advertising activities. Additionally, FTC's new guidance ushers in several changes from the 1998 guidance, which are not the focus of this Client Alert. ***Instead, this Alert is focused on FTC's alleged coordination with FDA in the marketing of dietary supplements, foods, drugs, devices, and other health-related products***:

> *The FTC and the Food and Drug Administration (FDA) share jurisdiction over the marketing of dietary supplements, foods, drugs, devices and other health-related products. The agencies coordinate their enforcement and regulatory efforts pursuant to a Memorandum of Understanding – often called the "FDA-FTC Liaison Agreement" – that governs the basic division of responsibilities between them. The FDA has primary responsibility for claims that appear in labeling, including the package, product inserts and other promotional materials available at point of sale. The FTC has primary responsibility for claims in all forms of advertising.* ***Because of this shared jurisdiction, the two agencies work closely to ensure that their enforcement efforts are consistent to the fullest extent feasible.***

While FTC's guidance correctly states it shares jurisdiction over the marketing of health-related products with FDA, ***in our experience, the enforcement efforts of the Agencies are not consistent "to the fullest extent feasible."***

As legal and regulatory counsel to medical device, pharmaceutical, dietary supplement and other health-product companies, we frequently encounter the jurisdictional overlap between the FDA and FTC in products from these segments. Both Agencies have jurisdiction over claims made about health-related products, but the source of such jurisdiction emanates from different statutes. FDA administers the Food, Drug & Cosmetic Act, 21 U.S.C. §§ 301 *et seq.*, and operates from the vantage point that a product can be adulterated and/or misbranded if it does not make appropriate promotional claims that are truthful, not misleading (including proper substantiation) and fairly balanced. *See* 21 U.S.C. §§ 351, 352. FTC is authorized by the FTC Act and operates from a similar statutory mandate to ensure claims are not unfair, deceptive, or misleading. *See* 15 U.S.C. §§ 45, 52; 15 U.S.C. § 55(a)(1). In its recent guidance, however, FTC identifies three key differences with the FDA's statutory mandate: ***(1) FTC advertising applies to all product claims; (2) the FTC does not pre-approve "health" claims, as that term is defined by FDA labeling laws; and (3) FTC does not require notification for "structure/function" claims.***

While we can debate these "key differences," the jurisdictional overlap for both Agencies is obvious. Both Agencies must operate consistent with and in deference to the First Amendment to the U.S. Constitution, which is the foundation for all regulatory authority relating to advertising and promotion. ***Nonetheless, and despite the shared jurisdictional origin, both Agencies can get caught up with pedantic and arcane interpretations and authority they either promulgate into regulations or issue as guidance documents, such as the "Health Products Compliance Guidance."*** Further, both Agencies have a penchant for missing the forest for a single tree in that they issue volumes of guidance to provide specific and pseudo-sophisticated

guidance to address what is often common sense and protected under the First Amendment.

For example, take the issue of off-label dissemination first recognized in the now famous *Washington Legal Foundation (WLF) vs Henney*, 202 F.3d 331 (D.C. Cir. 2000) in which FDA was forced to contend with the idea that the exchange of medical and scientific information between manufacturers and the medical community is protected by the First Amendment. FDA issued off-label dissemination guidance to allow for such dissemination under a scheme designed mostly by the court in the *WLF* case but embellished upon by FDA in its two off-label dissemination guidance documents. While FDA's guidance is helpful it is unnecessarily cumbersome, at times awkward, and still constitutionally overbroad, but mostly livable for industry.

And now industry has the right to promote (as opposed to disseminate) off-label information if it meets the First Amendment standard of being truthful and not misleading. This was established in a series of cases, i.e., *Caronia, Amarin, Pacira and Howard Root/Vascular Solutions*. Following that series of judicial losses, FDA published a guidance on "*Medical Products Communications Consistent with the FDA-Required Labeling—Questions and Answers*," (June 2018) which permits manufacturers to communicate information about a product not found in the FDA-required labeling if it is consistent with that FDA-required labeling and is truthful, not misleading and promoted in proper context, i.e., it follows the U.S. Constitution. It was about time FDA took the First Amendment seriously and realized its regulatory regimes and rules must serve the First Amendment and not the other way around.

Despite these recent judicial experiences and the shared origin of their jurisdictional authority (the U.S. Constitution), the FDA and FTC operate in an asynchronous manner contrary to FTC's assertions in its recent guidance. For example, we frequently confront situations in which the FDA and FTC will jointly issue a warning letter to a health-related company regarding their

advertising activities. In those situations, we are often able (with much work) to obtain a close-out letter from FDA based upon sound regulatory, statutory and/or constitutional arguments, but in that same situation, with the same product and facts, FTC will refuse to allow a parallel close-out letter. In fact, in such situations, FTC may doggedly insist on holding onto their complaint often attempting to extract something more than FDA in enforcement consequences. The cause of such disparate treatment by FTC is unknown, but different internal processes (e.g., instances in which a close-out letter is or is not issued), litigation experiences, and overall role in the review of "health-related" claims (such as through FDA's premarket notification process) may explain the differential approaches. Or possibly it is plain old territorialism.

Nevertheless, the variability of enforcement efforts between the Agencies should be addressed. ***Both Agencies are often working from the same operative facts and source of jurisdictional authority, and the First Amendment is the common denominator that should constrain both Agencies from an overly-zealous and imprecise interpretation of law***. A recommended first step is an amendment to the *FDA-FTC Liaison Agreement* referenced in the FTC's recent guidance. By amending that Agreement, the Agencies can better identify potential disparities in enforcement efforts and synchronize their approaches. If one Agency is persuaded to issue a close-out letter or other type of resolution, the presumption should be that the other Agency should follow suit or provide a serious and compelling reason why it is not. After all, the authority of both Agencies emanates from the same authority under the U.S. Constitution. ***Allowing differential approaches to enforcement activities creates confusion in the marketplace, frustrates confidence in the administrative state, and undermines the Agencies' "common objective of preventing injury and deception of the consumer."*** *See Memorandum of Understanding Between the Federal Trade Commission and the Food and Drug Administration*, May 1971. Bottom line: the FDA and FTC should make up their mind and get aligned.

Bryan Feldhaus, J.D., LL.M

Vice President of
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"Money, It [may be] a Crime": Compliance Training and Updated Codes of Conduct

In 1973, the British rock group, Pink Floyd, released their hit song "*Money*," from the critically acclaimed album, *The Dark Side of the Moon.* Although the song concerns the chase for wealth and materiality, the following lyrics also reinforce important lessons for healthcare compliance:

Money
It's a crime
Share it fairly, but don't take a slice of my pie
Money
So they say
Is the root of all evil today
But if you ask for a rise
It's no surprise that they're giving none away

These lyrics are relevant to healthcare compliance for several reasons. ***First, money is often the trigger for healthcare compliance and legal misconduct.*** By emphasizing the possible criminality of money, the opening lyrics of this verse ("*Money, It's a crime*") provide a succinct reminder that unlawful

inducements, false claims, and illegal remuneration are prohibited under the Anti-Kickback Statute and False Claims Act. *See* 42 U.S.C. § 1320a-7b (b) and 31 U.S.C. § 3729. This does not mean, however, that all remunerative activities are unlawful. Rather, certain activities are permissible if carefully and lawfully structured in compliance with applicable law.

Second, the lyrics provide a benchmark when counseling clients on safe harbors to the Anti-Kickback Statute. For example, under the personal services and management contracts safe harbor to the Anti-Kickback Statute, any remuneration provided to a health care provider ("HCP") for personal services must satisfy the following requirements: (1) the methodology for determining compensation must be set in advance; (2) the compensation must be consistent with fair market value in an arm's length transaction; and (3) the compensation cannot be determined in a manner that takes into account the volume or value of any referrals or business for which payment may be made under a Federal health care program. *See* 42 CFR § 1001.952(d)[1]. ***Thus, the warning in the song to "Share it fairly" is a useful reminder that remuneration must be legitimate and predicated on fair market value.***

Finally, the remaining lyrics of this verse ("Money, So they say, Is the root of all evil today") seemingly reflect the perspective of the government, which is increasingly critical of remunerative activities between medical product companies and HCPs. Indeed, based upon the recent November 2020 Special Fraud Alert ("Alert") from the Office of Inspector General, Department of Health and Human Services ("OIG"), it is increasingly evident the government believes remunerative activities are of dubious value.

In its Alert, the OIG identifies the fraud and abuse risks associated with speaker programs and concludes that such programs are "inherently risky". (*Id.* p.6). Ultimately, the OIG uses the Alert to discourage against speaker

[1] There are additional elements that must be strictly satisfied to fall within the Personal Services and Manager Contracts Safe Harbor. *See id.*

programs stating it ***"has significant concerns about companies offering or paying remuneration (and HCPs soliciting or receiving remuneration) in connection with speaker programs."*** (*Id.*)

Underlying the OIG's concern is the substantial amount of remuneration paid by medical product companies to HCPs over the past three years through speaker programs. ***During that period, the OIG estimates nearly $2 billion has been paid through honoraria and remuneration***.[2] Additionally, there have been several, recent high-profile enforcement matters that precipitated the Special Fraud Alert.

Based upon these enforcement experiences, ***the OIG issued the Alert to express concern about the remuneration paid to HCPs through speaker programs***:

> "OIG has significant concerns about companies offering or paying remuneration (and HCPs soliciting or receiving remuneration) in connection with speaker programs. ***Based on our investigations and enforcement actions, this remuneration is often offered or paid to induce (or solicited or received in return for) ordering or prescribing items paid for by Federal health care programs.*** If the requisite intent is present, both the company and the HCPs may be subject to criminal, civil, and administrative enforcement actions."

(OIG Special Fraud Alert, p.6, Nov. 16, 2021.)

The motivation for issuance of the Alert is the protection and enforcement of the Anti-Kickback Statute. The Anti-Kickback Statute is intended to "protect patients from referrals and recommendations by HCPs who may be influenced by inappropriate financial incentives," by making it unlawful to

[2] *Id.* n.1, citing *Open Payments Datasets*, CMS, https://www.cms.gov/OpenPayments/Explore-the-Data/Data-Overview (*accessed* Sept. 9, 2020).

"knowingly and willfully solicit, receive, offer, or pay any remuneration to induce or reward, among other things, referrals for, or orders of, items or services reimbursable by a Federal health care program." 42 U.S.C. § 1320a-7b(b)(1)-(2). According to the OIG, speaker programs undermine the Statute because of the "inherent fraud and abuse risks associated with the offer, payment, solicitation, or receipt of remuneration related to company-sponsored speaker programs." To that end, the OIG raised several, specific concerns about speaker programs in the Special Fraud Alert:

First, the OIG is skeptical about the educational value of speaker programs. It explains that government investigations often reveal that "HCPs receive generous compensation to speak at programs offered under circumstances that are not conducive to learning to speak to audience members who have no legitimate reason to attend." (*Id.*) Further, the OIG states there are several other ways for HCPs to obtain information about medical products that do not involve remuneration to HCPs. (*Id.* p.4). For this reason, the OIG concludes there is a strong suggestion that speaker programs are primarily intended to induce or reward referrals.

Second, the OIG believes all speaker programs potentially implicate the Anti-Kickback Statute. In the Alert, the OIG reiterates its long-standing concern with providing anything of value to HCPs in a position to make or influence referrals to a company's products. In stating this concern, OIG relies upon its 2003 Compliance Program Guidance for Pharmaceutical Manufacturers, which explained that remunerative relationships between medical product companies and HCPs, whether directly or indirectly related to marketing and sales activities, potentially implicates the Anti-Kickback Statute: "when a drug or device company engages in 'entertainment, recreation, travel, meals or other benefits in association with information or marketing presentations,' such arrangements may potentially implicate the anti-kickback statute." (*Id.* p. 4).

Finally, the OIG believes speaker programs actually induce HCPs. In the Alert, the OIG expresses its concern that speaker programs are merely an unlawful inducement and cautions HCPs by warning that "a consultant or speaking arrangement with a drug or device company could be an improper inducement 'to prescribe or use [company] products on the basis of . . . loyalty to the company or to get more money from the company, rather than because it is the best treatment for the patient,'" and subject the individual HCP to personal liability. (*Id.* pp. 4-5).[3]

Despite the OIG's fears, speaker programs can be an important tool to educate HCPs about the benefits, risks and appropriate uses of new drugs and devices. ***More importantly, speaker programs may be lawful under the Anti-Kickback Statute based upon the facts and circumstances of the program, the intent of the parties, and if properly structured through the advice of counsel***. (*See id.* p.5) As a result, medical product companies must ensure their speaker programs are appropriately designed to ensure compliance under the Anti-Kickback Statute. ***To that end, the OIG identified several characteristics in the Alert that may indicate Anti-kickback violations and must be avoided to remain lawful.***

Additionally, and in response to the Alert, the national trade associations for medical product companies updated their codes of conduct to address OIG's guidance and the increasing scrutiny of speaker programs. ***MDMA (the Medical Device Manufacturers Alliance), for example, provided revised guidance on speaker programs based on the Special Fraud Alert.*** MDMA's updated guidance focuses on ensuring there is a legitimate business need for the program, that attendees are invited based on their professional interests in the program, and that a speaker is selected based upon qualifications and not as a reward or inducement for using a company's product. ***AdvaMed also revised its Code of Ethics to recommend updated practices for speaker programs.*** One updated practice concerned additional

[3] Additionally, the OIG expressed concern about in-person speaker programs as compared to virtual meetings that proliferated during the COVID-19 pandemic. (Special Fraud Alert p. 7).

controls for the provision of alcohol at programs: "Companies also may consider adopting controls around the provision of alcohol at Company-Conducted Programs and Meetings. For example, considering government guidance, Companies may adopt per-person drink limits, per-drink spend limits, limitations on the types of alcohol permitted (e.g., beer and wine only), or disallow alcohol at certain events." (*See* AdvaMed Code p.12, FAQ #9.)[4] ***Finally, the Pharmaceutical Research and Manufacturers of America (PhRMA) also updated its Code on Interactions with Health Care Professionals to provide additional guidance in response to the OIG's Alert.***

The ramifications of the Special Fraud Alert will continue to unfold as speaker program violations are enforced. For example, and most recently, Biogen, Inc. agreed to pay $900 million to settle a qui tam action based on allegations concerning its speaker programs. *See United States ex rel. Bawduniak v. Biogen Idec, Inc.*, No. 12-cv-10601-IT (D. Mass.). In that suit, it was alleged Biogen paid illegal kickbacks through sham speaker programs to the largest prescribers of its multiple sclerosis drugs to induce additional prescriptions. In fact, Biogen allegedly engaged in several of the practices the OIG cautioned against in the Alert, including paying excessive fees, providing lavish meals, and free alcohol, and paying speakers above fair market value (i.e., for travel time not incurred), among other practices.

As evidenced by the Biogen example and the Alert, it remains critical for medical product companies to ensure their compliance policies and speaker programs are lawfully structured. ***Companies should implement appropriate controls, evaluate existing practices, and conduct an annual compliance assessment to develop appropriate programs that mitigate compliance risks.*** Otherwise, as Pink Floyd warned, "Money, It [may be] a crime."

[4] Similar to AdvaMed's guidance, MDMA does not prohibit the provision of alcohol at programs, but suggests only modest meals and refreshments be provided.

Industry Survey v.2.0 and the 510(k) Experience

Bryan Feldhaus, J.D., LL.M, VP of Legal-Regulatory & Compliance

Ten years ago, DuVal & Associates and Introworks completed an industry survey to obtain feedback and share insights on industry experience working with the FDA on the 510(k) program. That survey was entitled the ***510(k) Pathway Med-tech Industry Survey***, and was intended to measure the industry's perception of the FDA's performance in managing 510(k) submissions. A lot has changed over the past ten years and, due to such changes, DuVal and Introworks completed the survey again. And this time NAMSA joined our sponsorship for the completion of the **Industry Survey v.2.0.**

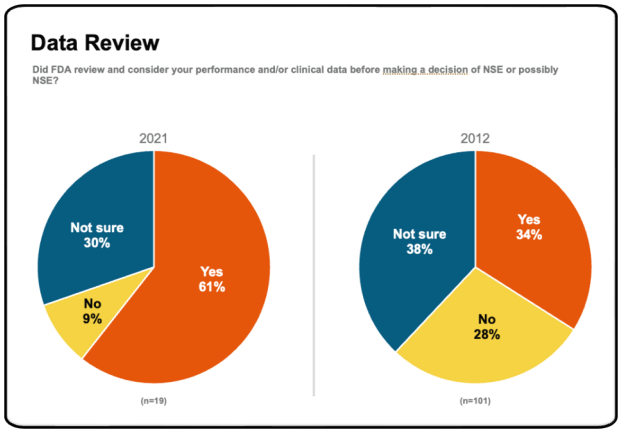
The results from the Industry Survey v.2.0 show encouraging improvements and also chronicle nagging opportunities for FDA. Mostly, the survey confirms FDA does not always follow the definitional elements of the 510(k) program, continues to escalate data requirements, and struggles with truly being Least Burdensome, which often necessitates the involvement of our firm, as legal and regulatory counsel, to negotiate a resolution with the Agency or utilize the administrative process on behalf of our clients, such as through a Section 517A appeal under the Food, Drug & Cosmetic Act. *See also* 21 CFR § 10.75; 21 CFR § 800.75.

In other areas, the Agency has substantially improved its operations. For example, the Agency has released helpful guidance documents, increased institutional opportunities for feedback and dialogue through pre-

submission meetings, and developed new pathways, such as Breakthrough Designation.[5]

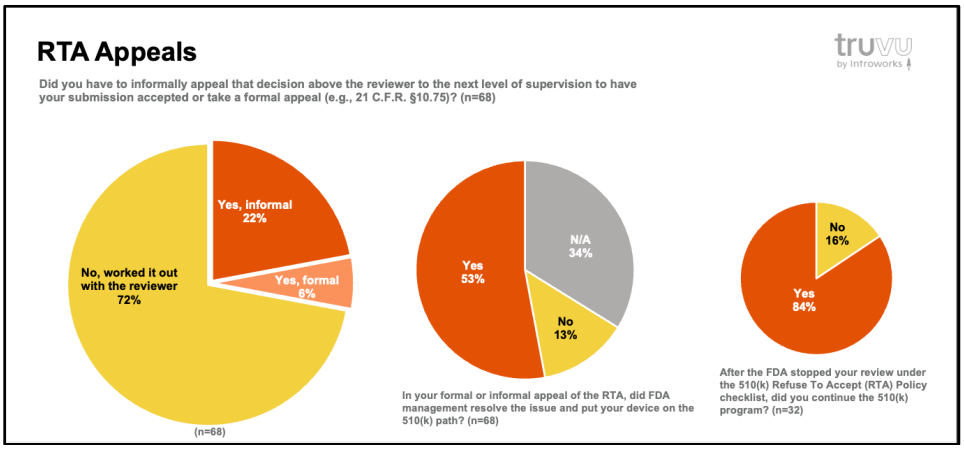
The **Industry Survey v.2.0** addressed several topics, including the 510(k) RTA Policy, the issuance of AINE/NSE Letters, Pauses and Rejections of 510(k) submissions, De Novo submissions, and Overall Industry Satisfaction. And the results of the Industry Survey are consistent with our professional experiences working with medical device companies. There are a few important takeaways to highlight that weigh upon the industry's evaluation of the Agency's 510(k) performance.

First, FDA has increased its reliance on performance and clinical data as it relates to device submissions. Of the survey respondents, approximately 44% had a 510(k) submission stopped under the Agency's RTA process due to a lack of adequate performance or clinical data. Survey respondents also acknowledged the Agency has substantially increased the frequency of its review of performance and clinical data before making a decision as compared to industry experience ten years ago:

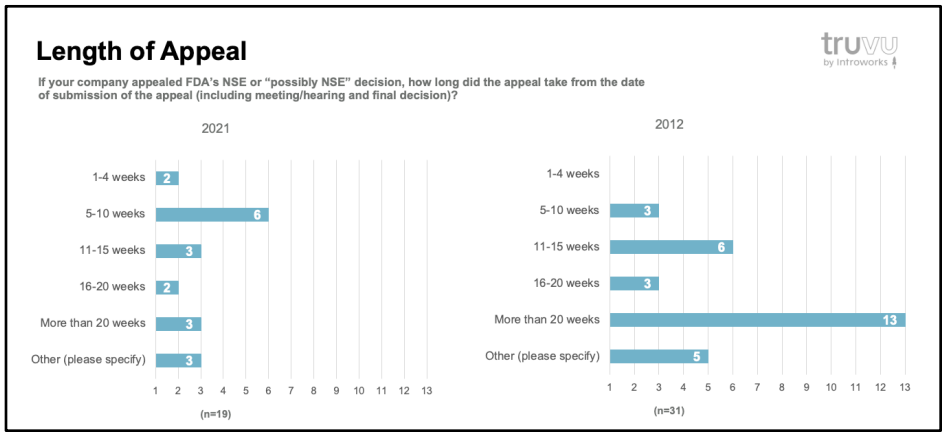


[5] We also must also commend the Agency for its management of the COVID-19 pandemic, which disrupted the Agency's normal work flow, increased the need for virtual meetings, and forced the Agency to divert resources to manage the pandemic instead for reviewing industry submissions.

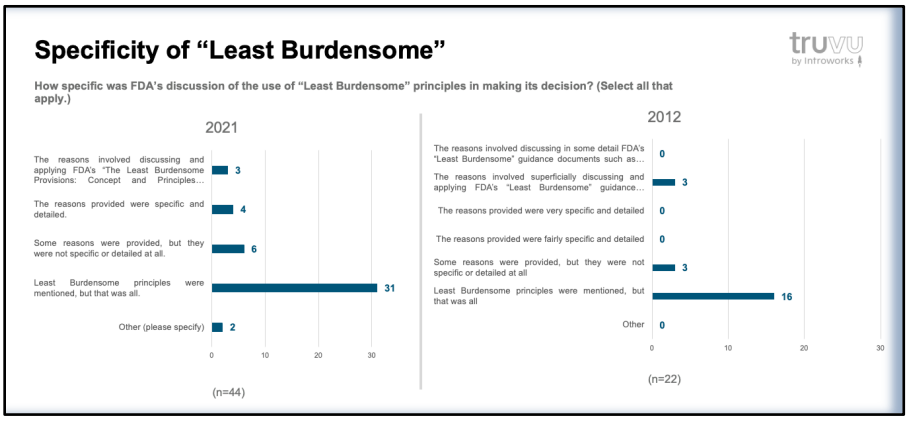
Second, many adverse decisions by FDA were successfully resolved through negotiation or appeal. For example, of the adverse RTA decisions, more than ninety-four percent (94%) were successfully negotiated with the FDA reviewer or appealed and the submission returned to the 510(k) pathway. This illustrates a commitment to collaboration for which FDA should be applauded:



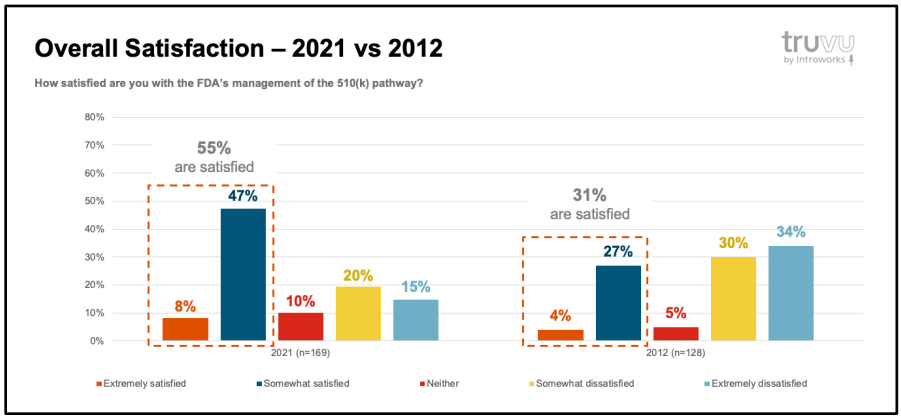
Third, the Agency has substantially reduced the delay associated with administrative appeals. Indeed, of the appeals filed with the Agency after an adverse decision, the length of the appeal was reduced by several weeks as compared to 2012:



Fourth, FDA has improved transparency regarding its application of Least Burdensome Principles. For example, between 2012 and 2021 there was a 20% increase in FDA mentioning the use of Least Burdensome principles in making its decisions, which illustrates a marked improvement over the past ten years. However, while FDA is more frequently referencing Least Burdensome principles in its decisions, its reliance on Least Burdensome principles appears generic rather than specific to the device on review.



Finally, there has been a substantial increase in industry's satisfaction with FDA's management of the 510(k) pathway. Specifically, there was a 24% increase in overall satisfaction and a nearly 30% decrease in respondents that were somewhat or extremely dissatisfied with FDA's management. This confirms FDA has improved its 510(k) management over the past ten years.



But while FDA has improved its management since 2012, we continue to experience trends that undermine the reliability of the 510(k) pathway. For example, because we serve as legal and regulatory consultants and counsel to more than 1200 clients, we are frequently engaged to assist with appeals concerning 510(k) and De Novo submissions. *Through those experiences, it is apparent that many of the appeals we have handled for our clients arise from the same OHTs within the Office of Product Evaluation and Quality*. While the frequency of appeals from a specific OHT may be a random occurrence, we believe it results from the specific performance observations and trends identified in the Industry Survey v.2.0 within certain OHTs. These trends include, without limitation, increased requests for performance and clinical data from some OHTs as compared to others, confusion regarding the criteria for substantial equivalence within certain groups, the lack of clear application of the Least Burdensome principles within specific OHTs, and the untimely issuance of AINE letters by some offices. Whether these observations are merely anecdotal or not, *we believe the different approaches by the OHTs undermine the uniformity required in the 510(k) process and provide several opportunities for improvement:*

First, FDA should increase training for review staff on the legal and regulatory issues critical to the 510(k) pathway. This includes, without limitation, the criteria required for a substantially equivalent determination, the legitimate grounds for an NSE determination, and the role and use of the Agency's own guidance documents. Doing so will help mitigate the discrepancies experienced in the 510(k) review process between different OHTs and provide the consistency required of the 510(k) program.

Second, FDA should improve the transparency of how Least Burdensome principles are applied to submissions. As evidenced by the responses to the Industry Survey v.2.0, FDA is more frequently referencing Least Burdensome principles in its review decisions, but some review groups are doing so in a generic and non-specific manner. This undermines the transparency

necessary in the administrative review process and should be standardized among review groups.

Finally, FDA should improve its performance relating to the timing and issuance of AINE letters. The Agency should ensure AINE letters are issued early in the review process and not after months of review and rounds of AINN questions. After all, delaying the issuance of an AINE letter until late in the review process can drain the financial resources of companies and delay the review of other submissions before the Agency. A more consistent approach to the use of AINE letters would provide a welcome improvement for the Agency's management of the 510(k) process and mitigate the variation currently experienced by industry.

Over the past ten years, FDA has made substantial and serious strides in improving its management of the 510(k) program. This is evident not only from the overall satisfaction results from the Industry Survey but also from the anecdotal experiences we've had as legal and regulatory professionals. *For that reason, FDA should be commended for its improvement and is deserving of praise.* Nonetheless, further improvement is also possible and recognizing such opportunities for improvement is not intended as a criticism of the Agency. *Instead, that recognition is intended to identify opportunities for improvement that will drive industry satisfaction and provide a more consistent, uniform and reliable 510(k) process.*

DuVal & Associates
Drug, Device and Food Law

DuVal & Associates is a boutique law firm located in Minneapolis, Minnesota that specializes in FDA regulations for products at all stages of the product life cycle. Our clientele includes companies that market and manufacture medical devices, pharmaceuticals, biologics, nutritional supplements and foods. Our clients range in size from Global Fortune 500 companies to small start-ups. As one of the only dedicated FDA regulatory law firms in the United States, our mission and absolute focus is providing our clients appropriately aggressive, yet compliant, guidance on any FDA related matter. We pride ourselves not only on our collective legal and business acumen, but also on being responsive to our client's needs and efficient with their resources. DuVal & Associates understands the corporate interaction between departments like regulatory affairs, marketing, sales, legal, quality, and clinical, etc. As former industry managers in the drug and device spaces, we have been in your shoes. Our firm has extensive experience with government bodies. We understand what it takes to develop and commercialize a product and bring it successfully to the market and manage its life cycle. Impractical or bad advice can result in delays or not allow for optimal results; while practical, timely advice can help companies succeed.

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