

21st Century Cures Act: Key Provisions (Title III - Development)

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Pharma and Biotech, Medical Devices

On December 13, 2016, President Obama signed [H.R. 34, the 21st Century Cures Act](#), which became Public Law No. 114-255 (“the Act”). Its enactment represents the culmination of a multi-year bipartisan legislative process spearheaded on the House side by Energy and Commerce Committee Chairman Fred Upton, Ranking Member Frank Pallone, and Rep. Diana DeGette and on the Senate side by Committee on Health, Education, Labor and Pensions Chairman Lamar Alexander and Ranking Member Patty Murray. The Act amends the Federal Food, Drug, and Cosmetic Act (“FDCA”) and Public Health Service Act (“PHSA”), among other laws, with the aim of accelerating the discovery, development, and delivery of new medicines and medical technologies. This alert summarizes Title III of the Act on drug and device development.

Significant features of Title III include the following:

- Reauthorization of the priority review voucher program for certain drugs intended to treat rare pediatric diseases;
- Creation of a new priority review voucher program for drug applications determined to be material threat medical countermeasure applications;
- Establishing a statutory “breakthrough” designation and review pathway for medical devices;
- Broadening the safe harbor created by section 114 of the Food and Drug Administration Modernization Act (“FDAMA”) for communication of health care economic information by drug sponsors to payor audiences;
- Significantly revising the FDCA provisions on combination product regulation with the aim of streamlining review of combination product applications;
- Carving out of FDA’s jurisdiction certain health software, including certain clinical decision support functions that make patient-specific recommendations to providers;
- Requiring FDA to create a program to evaluate the potential use of “real world evidence” to help support approval of new indications for approved drugs and satisfy post-approval study requirements;
- Expanding the size of the patient population that may be served by a “Humanitarian Use Device;”
- Providing a new “limited population” approval pathway for antibiotic and antifungal drugs intended to treat serious or life-threatening infections; and
- Creating a process for FDA to designate a drug as a “regenerative advanced therapy,” which is eligible for the same actions to expedite the development and review of a

marketing application as breakthrough-designated drugs and may be eligible for priority review and accelerated approval (with certain modifications for drugs with the new designation).

The enacted bill adopts some provisions of the House-passed 21st Century Cures Act (H.R. 6, passed by the House on July 10, 2015), which our previous alerts on [key provisions related to drugs](#) and [key provisions related to medical devices](#) described.

Subtitle A - Patient-Focused Drug Development

Sec. 3001 Patient Experience Data

Section 569C of the FDCA requires FDA to develop and implement strategies to solicit and incorporate the views of patients during the medical development and review process. The Act amends section 569C to require FDA—after approval of each New Drug Application (NDA) or Biologics License Application (BLA) (beginning 180 days after enactment of the Act)—to make public a brief statement regarding “patient experience data and related information” submitted and reviewed as part of the application. “Patient experience data and related information” includes “patient experience data” and “information on patient-focused drug development tools.” “Patient experience data” includes data collected and intended to provide information about patients’ experiences with a disease or condition, such as the impact of a disease, a condition, or a therapy on patients’ lives and patient preferences with respect to treatment.

Sec. 3002. Patient-Focused Drug Development Guidance

No later than six months after enactment of the Act, FDA must develop a plan to issue, over a period of five years, one or more guidance documents regarding the collection of patient experience data and use of such data in drug development. FDA must issue at least one draft guidance document on the subject no later than 18 months after enactment. Then, not later than 18 months after the public comment period closes on the initial draft guidance, FDA must publish a revised draft guidance document or final guidance document.

The required guidance must address methodological issues associated with collecting, analyzing, measuring, managing, and reporting on patient experience data. The guidance also must outline the process for interested parties to submit proposed draft guidance regarding patient experience data for FDA’s consideration, including the required format and content of submissions and the agency’s process for responding to submissions. Finally, FDA must describe its plans for utilizing relevant patient experience data to inform regulatory decision-making.

Sec. 3003. Streamlining Patient Input

The section exempts FDA from complying with the Paperwork Reduction Act when requesting information from the public under section 569C of the FDCA (discussed above) when a response to the agency’s request is voluntary. The Paperwork Reduction Act—known as the “PRA”—requires that federal agencies obtain Office of Management and Budget (OMB) approval before requesting most types of information from the public.

Sec. 3004. Report on Patient Experience Drug Development

By June 1 of 2021, 2026, and 2031, FDA must publish a report on its website assessing how the agency used patient experience data in regulatory decisions, including how FDA reviewed patient-focused drug development tools as part of approved NDAs and BLAs.

Subtitle B - Advancing New Drug Therapies

Section 3011. Qualification of Drug Development Tools

This section adds section 507 to the FDCA, which requires FDA to establish a qualification process for “drug development tools.” The term “drug development tool” includes a biomarker, a clinical outcome assessment (including a patient reported outcome), and any other method, material, or measure that FDA determines aids drug development and regulatory review.

The “requestor” seeking qualification of a drug development tool initiates the process by submitting a letter of intent to the agency. If FDA accepts that letter, the requestor may then submit a “qualification plan” that, if also accepted by the agency, may be followed by a “full qualification package.” In determining whether to accept each type of qualification submission, FDA may consider factors such as the scientific merit of the submission.

FDA may prioritize review of a qualification package based on factors including the severity, rarity, or prevalence of the involved disease or condition; the availability or lack of alternative treatments for the disease or condition; and the identification of the tool and its proposed context of use as a public health priority. Section 3011 also authorizes FDA to consult with biomedical research consortia for purposes of reviewing qualification submissions and to consider their recommendations on qualification plans and packages.

FDA must conduct a comprehensive review of an accepted full qualification package and determine whether the drug development tool is qualified for its proposed “context of use,” i.e., “the circumstances under which the drug development tool is to be used in drug development and regulatory review.” This determination will be based on the package’s “scientific merit,” which is not defined in the section. FDA may rescind or modify a qualification determination—based on new information or otherwise—if the agency determines that the drug development tool “is not appropriate” for the context of use.

If FDA qualifies a drug development tool, any person may use that tool in its context of use, including to support or obtain approval or licensure of a drug or biological product or to support the investigational use of a drug or biological product. FDA must make publicly available on its website, among other things, information on the status of qualification submissions, the submissions themselves (including data and evidence submitted), and FDA’s qualification determinations and summary reviews. FDA’s disclosures of this information are considered a disclosure authorized by law for purposes of the Federal Trade Secrets Act. Nothing in section 507 may be construed as authorizing FDA to disclose trade secret or confidential commercial information submitted in an application under section 505 of the FDCA or section 351 of the PHS Act, however.

To implement FDCA section 507, FDA must establish a taxonomy for the classification of biomarkers and related concepts through a public comment process. The agency also must publish guidance that specifies standards and scientific approaches for the development of

biomarkers and that outlines procedures and timelines for the qualification process. FDA must issue draft guidance within three years of enactment and issue final guidance not later than six months after comment period for the draft guidance closes.

Section 3012. Targeted Drugs for Rare Diseases

Under new section 529A of the FDCA, the sponsor of a full NDA or full BLA for a “genetically targeted drug” or a “variant protein targeted drug” may rely on certain data and information previously submitted in an approved full NDA or full BLA. Namely, this section recognizes the permissibility of reliance on data and information that were previously developed by the same sponsor (or another sponsor who has granted the current sponsor the contractual right of reference for the data) for a drug that incorporates or utilizes the same or similar genetically targeted technology or that is the same or incorporates or utilizes the same variant protein targeted drug as the previously approved drug. A rule of construction clarifies that the section does not confer any rights to rely on a full NDA or BLA beyond those in place before enactment.

“[G]enetically targeted drug” is defined as a drug that is the subject of a full NDA or full BLA for the treatment of a rare disease or condition that is serious or life-threatening, may result in the modulation of the function of a gene or its associated gene product, and incorporates or utilizes a genetically targeted technology. “[G]enetically targeted technology” is defined as a technology comprising non-replicating nucleic acid or analogous compounds with a common or similar chemistry that is intended to treat one or more patient subgroups (including subgroups with different mutations of a gene) with the same disease or condition, including a disease or condition due to other variants in the same gene. “[V]ariant protein targeted drug” is defined as a drug that is the subject of a full NDA or full BLA for the treatment of a rare disease or condition that is serious or life-threatening, modulates the function of a product of a mutated gene where such mutation is responsible in whole or in part for a given disease or condition, and is intended to treat one or more patient subgroups (including subgroups with different mutations of a gene) with the same disease or condition.

Section 3013. Reauthorization of Program to Encourage Treatments for Rare Pediatric Diseases

This section extends the sunset of FDA’s authority to issue rare pediatric disease priority review vouchers from December 31, 2016 to September 30, 2020. Section 3013 also authorizes FDA to award these vouchers after September 30, 2020 for a drug that was designated for a rare pediatric disease by September 30, 2020 and approved by September 30, 2022. Finally, section 3013 strikes Section 3 of the Advancing Hope Act of 2016, which required a Government Accountability Office (“GAO”) study on the effectiveness of the rare pediatric disease priority review voucher program (although see the GAO report required by section 3014, below).

Section 3014. GAO Study of Priority Review Voucher Programs

This section requires the Comptroller General to conduct a study addressing the “effectiveness and overall impact” of priority review voucher programs for rare pediatric diseases, neglected tropical diseases, and medical countermeasures. The study report is due to the Senate Health, Education, Labor and Pensions Committee and to the House Energy and Commerce Committee by January 31, 2020. Among other things, the report must analyze (1) the resources used by FDA to review drugs for which vouchers were redeemed; (2) whether any improvements to the voucher programs are needed to appropriately target incentives for “development of drugs that would likely not otherwise be developed, or developed in as timely a

manner,” and (3) whether the sunset provisions for the rare pediatric disease and medical countermeasures programs have affected the programs and had “unintended consequences.”

Section 3015. Amendments to the Orphan Drug Grants

This section expands FDA’s authority to award grants and contracts to defray costs of developing orphan drugs, *including* “qualified testing expenses.” Before this amendment, FDA’s authority was limited to providing these awards to defray costs of “qualified testing expenses.” Further, the definition of “qualified testing” is broadened to include “prospectively planned and designed observational studies and other analyses conducted to assist in the understanding of the natural history of a rare disease or condition and in the development of a therapy,” including those to develop drug development tools for orphan conditions and define disease manifestations, including genotypic and phenotypic variability and distinct subpopulations.

Section 3016. Grants for Studying Continuous Drug Manufacturing

This section authorizes the Secretary of Health and Human Services (“HHS Secretary”) to award grants to higher education institutions and nonprofit organizations “for the purpose of studying and recommending improvements to the process of continuous manufacturing of drugs and biological products and similar innovative monitoring and control techniques.”

Subtitle C - Modern Trial Design and Evidence Development

Section 3021. Novel Clinical Trial Designs

This section requires FDA to update or issue guidance on use of complex adaptive and other novel trial designs in the development, regulatory review, and approval of medicines. The guidance must address use of these trial designs to help satisfy the substantial evidence standard for drug effectiveness, recommended analysis methodologies, the types of information that should be submitted for review, and mechanisms for sponsors to obtain feedback from FDA on technical issues related to modeling or simulations. Prior to updating or issuing the guidance required by the section, FDA must hold a public meeting to obtain input from stakeholders, and a draft version of the guidance must be issued not later than 18 months after such public meeting. FDA must finalize the guidance not later than one year after the public comment period closes on the draft guidance.

Section 3022. Real World Evidence

Under new section 505F of the FDCA, FDA must create a program to evaluate the potential use of “real world evidence” to help: (1) support approval of new indications for approved drugs; and (2) satisfy post-approval study requirements. “[R]eal world evidence” is defined as “data regarding the usage, or the potential benefits or risks, of a drug derived from sources other than randomized clinical trials.” FDA must establish a framework for the program in collaboration with stakeholders and implement that framework within two years of enactment. Within five years of enactment, FDA must issue draft guidance on the conditions under which real world evidence may be relied upon for the above purposes and appropriate standards and methodologies for collection and analysis of such evidence. The draft guidance must be revised or finalized within 18 months of the close of the comment period on the draft guidance.

Section 3023. Protection of Human Research Subjects

This section provides that the HHS Secretary must, to the extent practicable and consistent with other statutes, harmonize the HHS and FDA human subject regulations. This harmonization must be complete within three years of enactment.

Specifically, the HHS Secretary must, “as appropriate,” modify the HHS and FDA human subject regulations and vulnerable population rules as may be necessary to: (1) reduce regulatory duplication and unnecessary delays; (2) modernize the rules in the context of multisite and cooperative research projects; (3) protect vulnerable populations, incorporate local considerations, and support community engagement; and (4) ensure that human subject research may undergo joint or shared review, review by an independent IRB, or “similar arrangements to avoid duplication of effort.”

Section 3024. Informed Consent Waiver or Alteration for Clinical Investigations

Under this provision, FDA need not require that informed consent be obtained from subjects in clinical testing of drugs and devices that poses “no more than minimal risk to [human subjects]” and that includes “appropriate safeguards” to protect the subjects’ rights, safety, and welfare.

Subtitle D - Patient Access to Therapies and Information

Section 3031. Summary Level Review

This section amends section 505 of the FDCA and section 351 of the PHSA to allow FDA to rely upon “qualified data summaries” to support approval of a supplement for a “qualified indication” for an approved drug or biologic. A “qualified data summary” is a summary of clinical data that demonstrates the safety and effectiveness of a drug with respect to a qualified indication. A “qualified indication” is an indication that FDA determines to be appropriate for summary level review. A supplement is eligible for summary review if: (1) there are existing data available and acceptable to FDA demonstrating the drug’s safety; and (2) all data used to develop the qualified data summary are submitted as part of the supplement.

Section 3032. Expanded Access Policy

Under new section 561A of the FDCA, a manufacturer or distributor of an investigational drug for the diagnosis, monitoring, or treatment of a serious disease or condition must make available its policy for evaluating and responding to requests for individual patient access to the investigational drug under section 561(b) of the FDCA. The policy must be made public and readily available, such as by posting on the Internet, and may be generally applicable to all of the manufacturer’s or distributor’s investigational drugs.

The policy must include: (1) contact information for the manufacturer or distributor; (2) procedures for making the requests; (3) the general criteria the manufacturer or distributor uses in evaluating and responding to such requests; (4) the anticipated time needed to acknowledge receipt of such requests; and (5) a hyperlink or other reference to the clinical trial record containing expanded access information for the drug on ClinicalTrials.gov.

Posting a policy does not guarantee access to an investigational drug by any individual patient, and the manufacturer or distributor may revise the policy at any time. This section applies to a manufacturer or distributor with respect to an investigational drug beginning on the later of:

(1) 60 days after enactment; or (2) the first initiation of a phase two or phase three study with respect to the investigational drug.

Section 3033. Accelerated Approval for Regenerative Advanced Therapies

New section 506(g) of the FDCA defines a “regenerative medicine therapy” and establishes an accelerated approval pathway for a drug that qualifies as a “regenerative advanced therapy.”

A “regenerative medicine therapy” is defined as including “cell therapy, therapeutic tissue engineering products, human cell and tissue products, and combination products using any such therapies or products”—except for those products regulated solely under section 361 of the PHSA and 21 C.F.R. Part 1271.¹

Under section 506(g), a drug that is designated as a regenerative advanced therapy is eligible for the same actions to expedite the development and review of a marketing application that are available to drugs that receive breakthrough therapy designation, including early interactions with FDA to discuss any potential surrogate or intermediate endpoint to support accelerated approval. The designated regenerative advanced therapy also “may” be eligible for priority review and accelerated approval (with modifications as described below). A drug is eligible for designation as a “regenerative advanced therapy” if:

- The drug is a “regenerative medicine therapy,” as defined above;
- The drug is intended to treat, modify, reverse, or cure a serious or life-threatening disease or condition; and
- Preliminary clinical evidence indicates that the drug has the potential to address unmet medical needs for such disease or condition.

A sponsor may submit a request for designation of a drug as a “regenerative advanced therapy” upon submission of an investigational new drug application or any time thereafter. FDA must make the designation determination within 60 calendar days of receipt of the request. If FDA determines that the drug does not meet the criteria, FDA must provide a rationale for that determination.

Under the accelerated approval pathway, the regenerative advanced therapy may receive approval based on, “as appropriate”: (1) surrogate endpoints or intermediate clinical endpoints; or (2) data obtained from a “meaningful number of sites, including through expansion to additional sites, as appropriate.” This differs from the accelerated approval pathway for other drugs under section 506(c), which does not state that approval may be based on data obtained from a “meaningful number of sites, including through expansion to additional sites, as appropriate.”

The accelerated approval pathway under section 506(g) also differs from the accelerated approval pathway under section 506(c) with regard to postapproval requirements. Under section 506(g)(7), sponsors of regenerative advanced therapies qualifying for accelerated approval

¹ Generally, the excepted products are human cell and tissue products (HCT/Ps) that meet a four-part test specified in FDA’s regulations, including that they are minimally manipulated and intended for homologous use only. See 21 C.F.R. § 1271.10.

may, “as appropriate,” meet applicable postapproval requirements by: (1) submitting clinical evidence, clinical studies, patient registries, or other sources of real world evidence, such as electronic health records; (2) collecting larger confirmatory data sets; or (3) postapproval monitoring of all patients treated with the therapy prior to its approval. Under section 506(c), applicable postapproval study requirements may only be met through “appropriate post-approval studies to verify and describe the predicted effect on irreversible morbidity or mortality or other clinical benefit.” It is unclear how this difference in statutory language will be interpreted. On its face, the additional language in section 506(g)(7) could be seen as affecting the kinds of postapproval confirmatory evidence that FDA may require; however, section 3033 contains a rule of construction stating that nothing in section 3033 shall be interpreted “to alter the authority of [FDA] to require postapproval studies”

Section 3034. Guidance Regarding Devices Used in the Recovery, Isolation, or Delivery of Regenerative Advanced Therapies

Within one year of enactment, FDA must issue draft guidance clarifying how FDA will evaluate devices used in the recovery, isolation, or delivery of regenerative advanced therapies. The guidance must address: (1) how FDA intends to streamline regulatory requirements for combination device and cell or tissue products; (2) what, if any, intended uses or attributes would result in a device used with a regenerative therapy product to be deemed a class III device; (3) when FDA considers it necessary, if ever, for the intended use of a device to be limited to a specific intended use with only one particular type of cell; and (4) application of the least burdensome approach to show how a device may be used with more than one cell type. FDA must finalize the guidance within 12 months of the close of the comment period.

Section 3035. Report on Regenerative Advanced Therapies

This section requires FDA to annually report to Congress on: (1) the number and type of applications for regenerative advanced therapies filed, approved, withdrawn, or denied in the previous calendar year; (2) how many of such applications or therapies were granted accelerated approval or priority review.

Section 3036. Standards for Regenerative Medicine and Regenerative Advanced Therapies

Within two years of enactment, FDA, in consultation with stakeholders and the National Institute of Standards and Technology, must facilitate an effort to develop standards and consensus definitions of terms to support the development, evaluation, and review of regenerative medicine therapies and regenerative advanced therapies, including with respect to the manufacturing processes and controls of such products. Within one year of development of such standards, FDA must review relevant regulations and guidance and update them as appropriate.

Section 3037. Health Care Economic Information

This section amends section 502(a) of the FDCA on drug manufacturers’ dissemination of health care economic information. Under the revised provision, the audience for this information is “a payor, formulary committee, or other similar entity with knowledge and expertise in the area of health care economic analysis, carrying out its responsibilities for the selection of drugs for coverage or reimbursement.” (The prior provision referred to “a formulary committee, or other similar entity, in the course of the committee or the entity carrying out its responsibilities for the selection of drugs for managed care or other similar organizations.”) Under amended section 502(a), health care economic information is not considered false or misleading if it “relates”

(rather than “directly relates”) to an approved indication for a drug or biological product, among other things. If the health care economic information materially differs from the approved labeling, a “conspicuous and prominent statement” describing the differences must be included.

The definition of “health care economic information” is broadened to mean “any analysis (including the clinical data, inputs, clinical or other assumptions, methods, results, and other components underlying or comprising the analysis) that identifies, measures, or describes the economic consequences, which may be based on the separate or aggregated clinical consequences of the represented health outcome, of the use of a drug. Such analysis may be comparative to the use of another drug, to another health care intervention, or to no intervention.” Any analysis “that relates only to” an unapproved indication is not considered health care economic information, however.

Section 3038. Combination Product Innovation

This section substantially revises section 503(g) of the FDCA regarding combination products. First, in determining the primary agency center for review of a combination product, FDA may not determine that the product’s primary mode of action (PMOA) is that of a drug or biological product solely because it has any chemical action within or on the human body.

Second, FDA is directed to conduct premarket review of a combination product under a single application “whenever appropriate,” although sponsors may choose to submit separate applications for constituent parts of a combination product unless FDA determines one application is “necessary.”

Third, if a combination product sponsor disagrees with FDA’s PMOA determination, the sponsor may request, and FDA must provide, a substantive rationale for the determination that references scientific evidence relied upon by FDA. The sponsor then may propose one or more studies (which may be clinical, nonclinical, or both) to establish the relevance, if any, of chemical action in achieving the PMOA of the combination product. If the sponsor and FDA agree on the study design and the sponsor conducts such studies, then FDA must consider the data in reevaluating the PMOA.

Fourth, if a combination product sponsor submits a written meeting request, FDA generally must meet with the sponsor within 75 calendar days. This meeting may address the standards and requirements for market approval or clearance, postmarket modifications, and applicable good manufacturing practices for the combination product. FDA may, however, defer addressing issues if scientific or other information is not available or agreement is not feasible when the meeting is requested. Any agreement reached in the meeting must remain in effect except upon: (1) the written agreement of FDA and the sponsor; or (2) a decision by the director of the review division of the primary agency center (or someone more senior) that an “issue essential to determining whether the standard for market clearance” or another applicable statutory standard is met was identified after the agreement or that deviating from the agreement is “otherwise justifiable based on scientific evidence, for public health reasons.”

Fifth, FDA may require that the sponsor of a combination product containing an “approved constituent part” submit only those data and information that FDA deems necessary to meet the statutory standard for marketing authorization. FDA must consider any incremental risks and benefits posed by the product, “using a risk-based approach and taking into account” prior

findings of safety and effectiveness or substantial equivalence for the relied-upon “approved constituent part.” “Approved constituent part” means:

- A drug constituent part that is an “approved drug” and that is part of a combination product being reviewed in a device marketing submission (510(k), premarket approval application (PMA), or *de novo* classification request). “Approved drug” is defined as an active ingredient that “was in” a previously-approved NDA on which the combination product applicant relies and which contained full reports of safety and effectiveness to which the applicant has no right of reference;
- A device product approved under a PMA that is “available for use,” i.e., that is no longer subject to the six-year exclusivity for PMAs;
- Any constituent part that was previously approved, cleared, or classified pursuant to a NDA, abbreviated NDA, 510(k) notification, *de novo* classification request, or PMA and for which the sponsor has a right of reference; or
- Any constituent part that is a nonprescription drug that is not subject to approval under section 505 of the FDCA.

Notably, “approved constituent part” does not include biological product constituent parts.

Device submissions that rely on an “approved drug” constituent part must include patent certifications or statements as are required for section 505(b)(2) applications and comply with the notice provisions regarding paragraph IV certifications. The timeline for approval of these applications will depend on the type of patent certification made by the applicant. Approval of the combination product also must await expiry of any blocking new chemical entity exclusivity, three-year Hatch-Waxman exclusivity, pediatric exclusivity, qualified infectious disease product (“QIDP”) exclusivity, and orphan drug exclusivity applicable to the “approved drug.”

Section 520(h)(4) of the FDCA currently authorizes FDA to rely on data in a PMA six years after its approval in approving a subsequent device or reclassifying a device. This section is amended to provide that no information in a PMA may be used to approve or clear another device submission for a combination product containing an approved drug constituent part unless the submitter complies with the patent certification and notice requirements that would apply to a section 505(b)(2) applicant, and that the subsequent device submission is subject to the exclusivity rights applicable to the approved drug.

Sixth, section 3038 also amends the duties of the Office of Combination Products (“Office”) in section 503(g). The Office now must oversee the alignment of feedback regarding reviews involving multiple agency centers. The Office also must ensure that there is a designated primary point of contact in the lead center for a combination product sponsor, that meetings between FDA and a combination product sponsor are attended by each agency center involved in the review “as appropriate,” and that each consulting center follows applicable guidance. And the Office must ensure that each consulting center completes its premarket review and provides the results to the lead center “in a timely manner.” Communications from the primary agency center shall be considered communications from the FDA on behalf of all agency centers involved in the review “to the extent consistent with other provisions of law and the requirements of all affected agency centers.”

Seventh, within four years of enactment and after public comment, FDA must issue final guidance addressing: (1) the structured process for managing pre-submission interactions with

sponsors developing combination products; (2) best practices for ensuring that agency feedback in such interactions represents FDA's best advice based on the information provided; and (3) procedural matters for the meetings described above and agreements reached therein.

Finally, eighth, within 18 months of enactment, FDA must publish a proposed list of combination products and manufacturing processes for which GMP requirements may vary from 21 C.F.R. section 4.4 or for which the requirements of section 4.4 can be satisfied through alternative or streamlined mechanisms. After a public comment period, FDA must publish a final list in the Federal Register and then periodically review it.

Subtitle E - Antimicrobial Innovation and Stewardship

Section 3041. Antimicrobial Resistance Monitoring

Section 3041 adds new subsections (f) through (k) to section 319E of the PHSA, which relates to programs aimed at combatting antimicrobial resistance (while moving existing subsections (f) and (g) to (l) and (m)).

Subsection (f) requires the HHS Secretary to encourage federal health care facilities to report on aggregate antimicrobial drug use and resistance to antimicrobial drugs and to implement antimicrobial stewardship programs. Subsection (g) requires the HHS Secretary annually to prepare and make publicly available data and information on (1) national and regional trends of antimicrobial resistance in humans, including with respect to drugs approved under the new Limited Population Pathway (see discussion on section 3042 below); (2) antimicrobial stewardship, including summaries of state efforts to address antimicrobial resistance; and (3) coordination between the Centers for Disease Control and Prevention ("CDC") and FDA on antimicrobial resistance monitoring, including with respect to monitoring of drugs approved under the new Limited Population Pathway.

Subsection (h) requires the HHS Secretary to disseminate guidance, educational materials, and other materials to help medical facilities implement antimicrobial stewardship programs and practices. Subsection (i) encourages the HHS Secretary to work with state and local public health departments to identify patterns of antimicrobial resistance and prevent the spread of antimicrobial resistant infections. Subsection (j) requires the HHS Secretary to utilize existing networks to provide a way for medical facilities to report data related to their antimicrobial stewardship activities, antimicrobial resistance, and trends in utilization of drugs approved under the new Limited Population Pathway. All data collected under this section will be publicly available unless they are trade secret or confidential commercial information.

Section 3042. Limited Population Pathway

Section 3042 adds subsection (h) to section 506 of the FDCA to establish the Limited Population Pathway, a new FDA approval pathway for certain antibacterial and antifungal drugs. Use of the Limited Population Pathway is voluntary for drug sponsors. If the Limited Population Pathway is utilized, FDA may approve an antibacterial or antifungal drug if: (1) the drug is intended to treat "a serious or life-threatening infection in a limited population of patients with unmet needs"; (2) the drug meets the standards of approval for an NDA or a BLA; and (3) FDA receives a written request from the sponsor to approve the drug under this pathway.

FDA's determination of the safety and effectiveness of an antibacterial or antifungal drug approved through the Limited Population Pathway must reflect the benefit-risk profile in the intended limited population, taking into account the "severity, rarity, or prevalence of the infection the drug is intended to treat and the availability or lack of alternative treatment." The Act notes that a drug approved for a limited population may not have a favorable benefit-risk profile in a broader population; however, a rule of construction makes clear that nothing in section 506(h) alters the standards of approval for a drug or FDA's authority to monitor drugs. As such, the Limited Population Pathway does not represent a significant change to FDA's existing authorities to approve new drugs; instead, the Limited Population Pathway represents a strong signal that Congress recognizes the need for antimicrobial drugs for patients with serious or life-threatening infections, even where the risk-benefit profile has not been established for a broader population.

A drug approved under the Limited Population Pathway is subject to a number of requirements. All labeling and advertising must contain the statement "Limited Population" in a prominent manner and adjacent to the proprietary name of the drug (or if no proprietary name exists, the established or proper name of the drug). The prescribing information must also include the statement, "This drug is indicated for use in a limited and specific population of patients." The sponsor of a drug approved under the Limited Population Pathway needs to submit copies of all promotional materials related to the drug to FDA at least 30 days prior to dissemination (similar, but not identical, to the requirements under accelerated approval). FDA may remove these additional requirements if the agency approves the drug for a broader population at a later date.

Section 3042 requires FDA to issue, within 18 months after enactment of the Act, draft guidance describing the criteria, processes, and other considerations for demonstrating safety and effectiveness under the Limited Population Pathway. FDA may approve drugs under the Limited Population Pathway prior to issuing guidance. FDA also must report to Congress at least once every two years on the number of requests for approvals and number of approvals under the Limited Population Pathway. By December 2021, GAO must report to Congress on the effectiveness of the Limited Population Pathway, including whether expansion of the pathway to other categories of drugs may be appropriate. Earlier versions of the legislation allowed FDA to expand the Limited Population Pathway to other categories of drugs through agency rulemaking, but this the enacted legislation does not reflect that approach.

Section 3043. Prescribing Authority

The provision reinforces that the "practice of health care" and existing prescribing authorities of health care professionals are not affected by the Antimicrobial Innovation and Stewardship subtitle of the Act. In other words, the section reiterates that nothing in sections 3041 to 3043 is intended to restrict health care professionals' ability to prescribe antimicrobial drugs, including those approved under the new Limited Population Pathway.

Section 3044. Susceptibility Test Interpretive Criteria for Microorganisms; Antimicrobial Susceptibility Testing Devices

Section 3044 adds section 511A to the FDCA. The purpose of the section is to clarify FDA's authority to:

- efficiently update susceptibility test interpretive criteria for antimicrobial drugs (commonly referred to as "breakpoints") when necessary for the public health;

- provide public notice of the availability of recognized breakpoints; and
- clear, classify, or approve testing devices using updated, recognized breakpoints.

The authority granted under this section builds on section 1111 of the Food and Drug Administration Amendments Act (FDAAA) of 2007, which required FDA to identify and periodically update breakpoints for antibacterial drug products and make those findings public.

Section 3044 requires FDA to establish and maintain an “Interpretive Criteria Website,” (“Website”) that includes antimicrobial breakpoints recognized by FDA. The Website will contain two lists: (1) new or updated breakpoints from standards-setting organizations, which have been recognized in whole or in part by FDA and (2) breakpoints “that the [FDA] has determined to be appropriate with respect to legally marketed antibacterial drugs.” Certain requirements apply to FDA’s creation and maintenance of both lists.

Within one year after the establishment of the Website, all antimicrobial drugs must reference the Website in lieu of having breakpoints listed in the drugs’ labeling. Moreover, the drug marketed before establishment of the Website should make the necessary labeling changes through documentation in the next annual report to FDA.

Section 3044 also permits FDA to authorize the marketing of antimicrobial susceptibility testing devices based on breakpoints that are recognized on the Website. The labeling for such devices must include a disclaimer that the device “provides information about the susceptibility of bacteria and fungi to certain drugs,” and the drug’s safety and effectiveness “in treating clinical infections due to such bacteria or fungi may not have been established in adequate and well-controlled clinical trials and the clinical significance of such susceptibility information is unknown.” The device’s labeling must also include a statement that health care professionals should consult the drug labeling for the drug’s approved uses.

Subtitle F - Medical Device Innovations

3051. Breakthrough Devices

Section 3051 adds new section 515C to the FDCA to establish a new priority review program for “breakthrough” devices. This section reflects FDA guidance that was issued on April 13, 2015, establishing an “expedited access pathway” (the “EAP Program”). The EAP Program covered devices subject to premarket approval applications (PMAs) or *de novo* requests, whereas the new section 515C also covers devices subject to 510(k) premarket notifications. Given the creation of the new review program in section 515C, the Act strikes section 515(d)(5) of the FDCA, which had codified FDA’s existing medical device priority review program.

Under Section 3051, a device qualifies as a “breakthrough” device if it “provide[s] for more effective treatment or diagnosis of life-threatening or irreversibly debilitating human disease or conditions” and device meets one of four additional conditions: (1) the device represents a breakthrough technology (although not defined in the Act, FDA’s EAP Program guidance document describes this as a technology with the potential to lead to a clinical improvement over existing legally marketed technology); (2) the device has no approved or cleared alternatives; (3) the device offers the potential to, compared to existing approved or cleared alternatives, reduce or eliminate the need for hospitalization, improve patient quality of life, facilitate patients’ ability to manage their own care (such as through self-directed personal

assistance), or establish long-term clinical efficiencies; or (4) the availability of the device is in the “best interest of patients.”

This section provides a process for designating devices as “breakthrough.” A sponsor may request designation at any time prior to submission of a PMA, 510(k) notification, or *de novo* application. FDA must determine whether a device meets the criteria as a “breakthrough” device no later than 60 calendar days after a sponsor submits a request for designation. Section 3051 includes a number of actions intended to facilitate the priority review by FDA. For example, FDA must assign a team of staff and a team leader with appropriate subject matter expertise and experience for the device, provide oversight of the team by senior agency personnel, adopt an efficient process for timely dispute resolution, provide for interactive communication with the sponsor of the device during the review process, and, as applicable, expedite the review of applicable manufacturing and quality compliance. A decision by FDA on a request for designation as “breakthrough” is considered a “significant decision” for purposes of documentation and review under Section 517A(a)(1) of the FDCA.

In order to expedite the development and review of devices designated for priority review, FDA may also collaborate with the device sponsor to (1) coordinate an early agreement on a data development plan; (2) take steps to ensure that a design of clinical trials is as efficient as practicable, such as through shorter or smaller clinical trials or use of surrogate endpoints; (3) agree in writing to clinical protocols that FDA will consider binding on the sponsor and FDA; and (4) facilitate expedited and efficient development and review of the device through postmarket data collection. The clinical protocol requirements can change if the director of the office reviewing the submission decides in writing that “a substantial scientific issue essential to determining the safety or effectiveness of such device exists,” after FDA provides an opportunity for the sponsor to meet with the director to discuss the “substantial scientific issue.”

FDA is also required to publish guidance on implementation of the new section 515C not later than one year after enactment. On January 1, 2019, FDA must report to Congress on the effectiveness of the priority review program for “breakthrough” devices.

Section 3052. Humanitarian Device Exemption Application

This section expands the availability of a humanitarian device exemption (“HDE”)—an existing pathway for the development of devices for use in the treatment or diagnosis of diseases affecting small populations. Under the HDE pathway, a device may be approved by FDA upon a showing that the device is safe and provides probable benefit for the proposed intended use, along with certain conditions surrounding approval. Section 520(m) of the FDCA currently limits HDE devices to those that are intended to treat or diagnose a disease or condition that affects no more than 4,000 individuals in the U.S. per year. Section 3052 increases the limit to 8,000 individuals in the U.S. per year.

This section also requires FDA to issue draft guidance within 18 months of enactment that defines the criteria for establishing “probable benefit” to health from use of an HDE device.

Section 3053. Recognition of Standards

Section 3053 amends section 514(c) of the FDCA, which addresses the recognition of standards for devices. With the amendments made by section 3053, FDA must make a determination not later than 60 calendar days after the agency receives a request to recognize all, part, or none of a standard issued by a nationally or internationally recognized standard-

development organization. FDA must issue a written response to the requester that provides FDA's rationale for the determination and make the response and rationale publicly available.

In addition, FDA must (1) provide training to all employees who review device premarket submissions on the concept and use of recognized standards to facilitate premarket review; and (2) issue guidance identifying the principles for recognizing standards under this section.

Section 3054. Certain Class I and Class II Devices

Currently, most Class I devices and some Class II devices are exempt from the requirement to submit a 510(k) premarket notification. Section 3054 requires FDA to identify additional types of Class I devices that no longer require a 510(k) notification to FDA. FDA must identify the devices through publication in the *Federal Register* within 120 calendar days after the enactment of the Act and at least once every five years thereafter. The 510(k) exemption for these Class I devices becomes effective upon the publication in the *Federal Register*.

In addition, FDA must publish, within 90 days after enactment of the Act, a list of Class II device types that FDA believes no longer require a 510(k) notification to FDA and provide a period for public comment. After public comment and within 210 calendar days after enactment, FDA must publish a final list of Class II devices that are exempt from the 510(k) requirement.

Section 3055. Classification Panels

Section 3055 amends section 513(b) of the FDCA to update the procedures for medical device classification panels. Whenever a device is the subject of review by a classification panel, FDA must ensure that "adequate expertise" is represented on the panel, and FDA should consider the recommendations of the device sponsor regarding the expertise needed as part of this process. A panel has "adequate expertise" if it consists of (1) at least two voting members with a specialty or other expertise clinically relevant to the device under review; and (2) at least one voting member who is knowledgeable about the technology of the device. FDA will need to provide an annual opportunity for patients and medical device sponsors to nominate experts to fill the voting member positions on classification panels.

Section 3055 also amends section 513(b) of the FDCA to require FDA to provide time at the panel meeting time for a designated representative of the sponsor (who may be accompanied by experts) to address the panel, correct misstatements, or provide clarifying information, subject to the discretion of the panel chairperson. FDA must provide adequate time for initial presentations by the sponsor of the device and by the agency.

Section 3056. Institutional Review Board Flexibility

Section 3056 streamlines the clinical investigations of devices by removing the requirement for a local institutional review board ("IRB") at each site in a multi-site study to review and approve a device study. These provisions would allow sponsors to use a centralized IRB to oversee clinical research, which could help to expedite the initiation of clinical studies, simplify IRB reporting, and ensure consistency of IRB review across multiple sites.

Section 3057. CLIA Waiver Study Design Guidance for In Vitro Diagnostics

Certain home use tests and "simple" tests that have "an insignificant risk of an erroneous result" are eligible for a waiver of the requirements of the Clinical Laboratory Improvement

Amendments of 1988 (“CLIA”). In January 2008, FDA issued a guidance document describing the agency’s approach to determining that a device meets the CLIA statutory waiver criteria.

Section 3057 requires FDA to publish a new draft guidance within 12 months, including specifically to revise Section V of the 2008 guidance, which describes the agency’s recommendations on the clinical studies to demonstrate that a test is accurate in the hands of the intended operator and therefore has an insignificant risk of an erroneous result.

The new guidance also must include recommendations on the appropriate use of comparable performance between a waived user and a moderately complex laboratory user to demonstrate accuracy. FDA must issue a final guidance within 12 months after the closing of the comment period on the draft guidance.

Section 3058. Least Burdensome Device Review

Under current law, FDA must consider the “least burdensome” means of evaluating device effectiveness or substantial equivalence for purposes of approval or clearance of a device.

Section 3058 requires all FDA employees involved in the review of PMA or 510(k) submissions to receive training on the meaning and interpretation of the “least burdensome” principle. FDA must periodically assess the implementation of the least burdensome requirements. Within 18 months after the enactment of the Act, an FDA ombudsman from the Center for Devices and Radiological Health (CDRH) must conduct an audit of the training described, which should include (1) interviews of industry representatives regarding their experience in the device premarket review process; and (2) a list of measurement tools used to assess the implementation of the least burdensome requirements. FDA must summarize the findings of the audit in a final audit report to be published on FDA’s website and submitted to Congress.

In addition, Section 3058 requires FDA to consider the “least burdensome means necessary to demonstrate device safety and effectiveness” when FDA requests additional information regarding a PMA application. FDA must consider the role of postmarket information in making this determination. “Necessary” is defined as the “minimum required information that would support a determination by the [FDA] that an application provides a reasonable assurance of the safety and effectiveness of the device.”

The section also amended FDCA 517A(a) to require FDA to provide a statement of how the least burdensome requirements were considered during any significant decision regarding a 510(k), PMA, or binding determination agreement regarding data required to support a PMA.

Section 3059. Cleaning Instructions and Validation Data Requirement

On March 17, 2015, FDA issued final guidance recommending that reusable medical devices should include reprocessing instructions in their 510(k) submission. The guidance also identified a subset of medical devices for which the 510(k) submissions should include protocols and complete test reports of the validation of reprocessing instructions for FDA review.

Section 3059 codifies the principles in FDA’s guidance and adds subsection 510(q) to the FDCA. The section requires that sponsors submitting 510(k) notifications for certain reusable devices should include instructions for use and validation data regarding cleaning, disinfection, and sterilization. FDA may use this information as the agency determines substantial equivalence of the device. FDA must identify and publish a list of reusable devices that will

require this additional information within 180 days after the enactment of the Act, and may revise the list as appropriate.

Section 3059 also requires FDA to issue final guidance regarding when sponsors must submit a 510(k) notification to FDA for a modification or change to a legally marketed device. The final guidance must be issued within one year of the close of the comment period on the draft guidance.

Section 3060. Clarifying Medical Software Regulation

Section 3060 narrows FDA's authority over five categories of software functions. The term "device" in section 201(h) does not include a software function that is intended to perform one or more of the following:

- A. Provide administrative support of a health care facility (e.g., processing and maintaining financial records, claims or billing information, analyzing historical claims data to predict future utilization, laboratory workflow);
- B. Maintain or encourage a healthy lifestyle and is unrelated to the diagnosis, cure, mitigation, prevention, or treatment of a disease or condition;
- C. Serve as electronic patient records intended to transfer, store, convert formats, or display patient information, so long as the records are part of health information technology that is certified under section 3001(c)(5) of the PHS Act and meet certain other requirements (e.g., not interpret or analyze patient records, including medical image data, for the purposes of diagnosis or other functions within the definition of a "device");
- D. Transfer, store, convert formats, or display clinical laboratory test or other device data (but not interpret or analyze the test data); or
- E. For the purpose of—
 - Displaying, analyzing, or printing medical information about a patient or other medical information;
 - Supporting or providing recommendations to a health care professional; and
 - Enabling a health care professional to independently review software recommendations so that the professional does not primarily rely on the recommendations to make a decision about an individual patient.

However, even if a software function meets the criteria in (E) (for clinical decision support functions), the exclusion from FDA's jurisdiction will not apply if the software function "is intended to acquire, process, or analyze a medical image or a signal from an in vitro diagnostic device or a pattern or signal from a signal acquisition system." Moreover, a software function that is a Class III device is not exempted from FDA jurisdiction under section 3060, whether or not the function meets the criteria in categories (A)-(E) above.

When the device has multiple software functions and one or more functions meet the definition of a "device," FDA will continue to regulate the functions that fall within its jurisdiction. FDA may also assess how any non-device functions impact the medical device functions.

Section 3060 also contains a "claw back" provision for FDA. For a software function that falls within categories (C) through (E) above, FDA can reassert jurisdiction if FDA determines that the function "would be reasonably likely to have serious adverse consequences." In making

such a finding, FDA must consider: (1) the likelihood and severity of patient harm; (2) the extent the function is intended to support clinical judgment; (3) whether there is a reasonable opportunity for a health care professional to review the recommendation provided by the function; and (4) the intended user and user environment. FDA must follow certain procedures to reassert its jurisdiction over a function or functions in (C), (D), or (E) above, including by publishing a proposed notice in the *Federal Register* and providing for at least 30 days for public comment.

Every two years, the HHS Secretary must publish a report on the software functions described in this section. The report should include input from stakeholders with relevant expertise, examine the risks and benefits of software functions under this section, and summarize how the functions impact patient safety.

Section 3060 also incorporates into the statute FDA's current practice in classifying an accessory as Class I, II, or III based on the intended use of the accessory rather than the class of the accessory's parent device.

Subtitle G - Improving Scientific Expertise and Outreach at FDA

Section 3071. Silvio O. Conte Senior Biomedical Research and Biomedical Product Assessment Service

This section amends section 228 of the PHS Act (the "Silvio O. Conte Senior Biomedical Research and Biomedical Product Assessment Service" or the "SBRS") by increasing the maximum number of staff across HHS hired under the SBRS from 500 to 2,000. To ensure that FDA can fully utilize the SBRS for various review positions in its medical product centers, the Act expands the scope of the SBRS to include experts "in the fields of biomedical research, clinical research evaluation, and biomedical product assessment," while also expanding the SBRS to include experts with a doctoral or master's level degree in engineering, bioinformatics, or a related or emerging field. This section also increases the maximum pay available to members of the service, among other changes to the SBRS.

Within four years after enactment of this Act, a study on the effectiveness of these amendments to the SBRS must be submitted to Congress by HHS. The study must address the effects on recruitment and retention of experts and on the assessment of biomedical products.

Section 3072. Hiring Authority for Scientific, Technical, and Professional Personnel

This section amends the FDCA by adding new section 714A, "Hiring Authority for Scientific, Technical, and Professional Personnel." Under new section 714A, FDA is authorized to directly hire scientific, technical, or professional staff that support the "development, review, and regulation of medical products." FDA also may set the annual pay rate for these positions at up to \$400,000, whether appointed before or after passage of this Act, notwithstanding the General Schedule pay rates.

Within 18 months after enactment of this Act, FDA must submit to Congress a report that examines the extent to which FDA has a critical need for qualified individuals for scientific, technical, or professional positions. GAO must conduct a study of FDA's ability to hire, train, and retain qualified scientific, technical, and professional staff, not including contractors, and shall submit to Congress a report on such study no later than January 1, 2022.

Section 3073. Establishment of Food and Drug Administration Intercenter Institutes

This section amends the FDCA by adding new section 1014, “Food and Drug Administration Intercenter Institutes.” Under this section, FDA shall establish one or more Intercenter Institutes (“Institutes”) within the FDA for major disease areas (similar to the FDA Oncology Center of Excellence established administratively in 2016). For each Institute established, the Institute will develop and implement processes for coordinating activities related to the associated major disease area among CDER, CBER, and CDRH (the “Centers”). With respect to the major disease area, such Institute activities may include: (1) coordination of staff from the Centers; (2) streamlining the review process; (3) promotion of scientific programs within the Centers; (4) development of programs and enhancement of strategies to recruit, train, and provide continuing education opportunities for the personnel of the Centers; (5) enhancement of the interactions of the Centers with patients, sponsors, and the external biomedical community; and (6) facilitation of the collaborative relationships of the Centers with other agencies within HHS.

FDA must establish at least one such Institute within one year of enactment of this Act, and must provide a period for public comment during the time that each Institute is being implemented. FDA may terminate any such Institute upon 60 days’ public notice in the Federal Register, which must include the rationale for such termination.

Section 3074. Scientific Engagement

This section clarifies that scientific meetings that are attended by scientific or medical personnel or other professionals within HHS, for whom attendance at such meeting is directly related to their professional duties, shall not be considered conferences for the purposes of complying with federal reporting requirements or annual appropriations Acts or regulations restricting travel to such meetings. This section also requires each operating division of HHS, within 90 days of the end of each fiscal year, to prepare and post on its website an annual report on scientific meeting attendance and related travel spending for that fiscal year.

Section 3075. Drug Surveillance

This section amends section 505(k)(5) of the FDCA on the adverse event reporting system by, among other changes, requiring FDA to make available on its website guidelines on best practices for drug safety surveillance using the system and criteria for public posting of adverse event signals. This section also amends section 505(r) of the FDCA on postmarket drug safety information by striking the requirement that the FDA prepare a summary analysis of the adverse drug reaction reports received for a drug by 18 months after approval of the drug or after use of the drug by 10,000 individuals. Instead, FDA must make publicly available, on its adverse events reporting website, best practices for drug safety surveillance activities for approved drugs and biologics.

Section 3076. Reagan-Udall Foundation for the Food and Drug Administration

This section amends section 770(d) of the FDCA on the Board of Directors for the Reagan-Udall Foundation, such that there may be more than 14 voting members on the Board, as long as no more than 30 percent of the total voting members are representatives of the general pharmaceutical, device, food, cosmetic, and biotechnology industries. Additionally, under this section, “special Government employees” may be appointed to the Board, as the term is defined in section 202 of the United States Code. The additional members to the Board potentially appointed under this section will have terms that expire on a staggered basis. Finally, this

section makes changes to how the Board may fix the compensation of the Executive Director of the Reagan-Udall Foundation.

Subtitle H - Medical Countermeasures Innovation

Section 3081. Medical Countermeasure Guidelines

This section amends section 319F-2 of the PHSA on the Strategic National Stockpile and Security Countermeasure Procurements. Under amended section 319F-2, the HHS Secretary must ensure timely and accurate utilization guidelines for qualified countermeasures, qualified pandemic and epidemic products, and security countermeasures, including for such products in the stockpile.

Additionally, the subsection on the special reserve fund is amended such that the HHS Secretary must submit a report to Congress no later than March 1 of each year in which the HHS Secretary determines that the amount of funds available for procurement of security countermeasures is less than \$1.5 billion. (Under current law, the HHS Secretary must submit such a report “Not later than 30 days after any date on which the Secretary determines” that less than \$1.5 billion is available in the special reserve fund). The report must detail the amount of funds available for procurement and the impact such “amount” (rather than “reduction”) will have in meeting security countermeasure needs and on the annual Public Health Emergency Medical Countermeasures Enterprise and Strategy Implementation Plan.

Section 3082. Clarifying BARDA Contracting Authority

This section also amends section 319F-2 of the PHSA to clarify the Biomedical Advanced Research and Development Authority’s (“BARDA”) contracting authority. As amended, section 319F-2 authorizes the Director of BARDA to carry out the programs funded by the special reserve fund, including the execution of procurement contracts, grants, and cooperative agreements pursuant to this section. Section 319L of the PHSA is also amended to reflect the Director’s contracting authority. BARDA previously relied on the Office of Acquisitions Management, Contracts, and Grants under the Office of the Assistant Secretary for Preparedness and Response for such matters.

Section 3083. Countermeasure Budget Plan

This section amends the responsibilities of the Assistant Secretary for Preparedness and Response in section 2811 of the PHSA. As amended, section 2811(b)(7) requires the Assistant Secretary to update, before March 1 of each year (whereas there was previously no March 1 deadline), the coordinated five-year budget plan based on the medical countermeasure priorities, “including with respect to chemical, biological, radiological, and nuclear agent or agents that may present a threat to the Nation, including such agents that are novel or emerging infectious diseases, and the corresponding efforts to develop qualified countermeasures, security countermeasures, and qualified pandemic or epidemic products for each such threat.”

This section requires that by March 15, the five-year budget plan must be submitted to particular committees of Congress (rather than “the appropriate committees”), and made publicly available in a manner that does not compromise national security.

Section 3084. Medical Countermeasures Innovation

This section amends section 319L of the PHSA on BARDA by adding new subsection 319L(c)(4)(E), “Medical Countermeasures Innovation Partner.” Under this new subsection, the Director of BARDA may enter into an agreement (including through the use of grants, contracts, cooperative agreements, or other transactions) with an independent, nonprofit entity to:

- Foster and accelerate the development of innovation of medical countermeasures and technologies, including through the use of strategic venture capital practices and methods;
- Promote the development of new and promising technologies that address urgent medical countermeasure needs;
- Address unmet public health needs that are directly related to medical countermeasure requirements; and
- Provide expert consultation and advice to foster viable medical countermeasure innovators.

Entities eligible to enter into such an agreement must meet multiple requirements, including that they:

- Are an independent, nonprofit entity;
- Have a demonstrated record of being able to create linkages between innovators and investors;
- Have experience promoting novel technology innovation;
- Are problem-driven and solution-focused based on the needs, requirements, and problems identified by the Director of BARDA;
- Demonstrate the ability, or the potential ability, to promote the development of medical countermeasure products;
- Demonstrate expertise, or the capacity to develop or acquire expertise, related to technical and regulatory considerations with respect to medical countermeasures; and
- Are not within the Department of HHS.

This section states that in selecting an eligible entity for an agreement, the Director of BARDA will place a high value on the entity’s demonstrated experience in partnering with the federal government to meet identified strategic needs.

The Director of BARDA, when entering into such an agreement, shall:

- Communicate the medical countermeasure needs and problems to be addressed by the entity;
- Develop a description of work to be performed by the entity;
- Provide technical feedback and oversight for work performed by the entity; and
- Ensure fair consideration of products developed under the agreement.

Additionally, as a condition of the agreement, the Director of BARDA will ensure that the entity:

- Has in place a comprehensive set of policies that demonstrate a commitment to transparency and accountability;
- Protects against conflicts of interest through a comprehensive set of policies;
- Provides monthly accounting on the use of funds provided under such agreement; and
- Provides, on a quarterly basis, reports regarding the progress made toward meeting the identified needs set forth in the agreement. Upon request, the Director of BARDA shall provide these quarterly reports to Congress.

Not later than four years after the date of enactment of this Act, an independent evaluation shall be conducted and submitted to Congress, concerning the partnership activities described in this section. Such report shall include recommendations with respect to any agreement or activities carried out pursuant to this subparagraph. This subparagraph sunsets on September 30, 2022.

Section 3085. Streamlining Project Bioshield Procurement

This section amends section 319F-2(c) of the PHSA on procurement of countermeasures. As amended, section 319F-2(c) allows the Secretaries of Homeland Security (“DHS”) and HHS to make available the special reserve fund for the procurement of a countermeasure, subject to the availability of appropriations. Previously, the Secretaries were required to make a recommendation to the President and await Presidential approval before the special reserve fund could be made available for procurement of a countermeasure. As amended, Presidential approval is no longer required, but the Secretaries must still notify Congress explaining their decision to make available the special reserve fund.

Section 3086. Encouraging Treatments for Agents That Present a National Security Threat

Under new section 565A of the FDCA, the sponsor of a “material threat medical countermeasure application” shall receive a priority review voucher upon approval of the application. A priority review voucher entitles the holder of such voucher to priority review of a single human drug application submitted under section 505(b)(1) of the FDCA or under section 351(a) of the PHSA.

A “material threat medical countermeasure application” is:

- A human drug application for a drug intended for use:
 - to prevent, or treat harm from a biological, chemical, radiological, or nuclear agent identified by the Homeland Security Secretary as a material threat sufficient to affect national security; or
 - to mitigate, prevent, or treat harm from a condition that may result in adverse health consequences or death and may be caused by administering a drug or biological product against such agent; and
- FDA determines is eligible for priority review;
- Is approved after enactment of this Act; and

- Is for a human drug, no active ingredient (including any ester or salt of the active ingredient) of which has been approved in any other application under section 505(b)(1) or section 351(a) of the PHSA.

A priority review voucher awarded for a material threat medical countermeasure application is transferable (including by sale) without limitation on the number of times the voucher may be transferred before use. No sponsor of a material threat medical countermeasure application may receive more than one priority review voucher issued under any section of the FDCA with respect to such drug; however, this result presumably would follow from the requirement—common to all voucher programs—that the drug earning the voucher contain no previously approved active ingredient.

FDA may not award any vouchers under section 565A after October 1, 2023.

Section 3087. Paperwork Reduction Act Waiver During a Public Health Emergency

This section amends section 319 of the PHSA by adding new subsection 319(f) to allow HHS to waive Paperwork Reduction Act (“PRA”) requirements during a public health emergency. Under new subsection 319(f), the HHS Secretary may waive the requirements of the PRA with respect to voluntary collection of information if, after consultation with other public health officials, certain criteria are met related to the emergency. The waiver will be effective: (1) during the immediate investigation of, and response to, such public health emergency; (2) during the time necessary to determine if a disease or disorder will become a public health emergency; and (3) during the immediate postresponse review. HHS must post certain information regarding any such waivers on its website.

Section 3088. Clarifying Food and Drug Administration Emergency Use Authorization

This section amends section 564 of the FDCA with regard to emergency use authorization (“EUA”) for medical products during public health emergencies so that it also applies to animal drugs. Thus, under the existing criteria for issuing EUAs under FDCA section 564, FDA may authorize for emergency use animal drugs that are neither approved nor conditionally approved, or that are not approved or conditionally approved for a particular use. Corresponding edits are made throughout FDCA section 564 to account for the inclusion of animal drugs, such as FDA authority to waive or limit the prescription requirements for animal drugs during an emergency, and for continued use of an EUA drug in animals treated during the emergency when determined necessary by the veterinarian caring for the animal. This section also makes conforming amendments to FDCA sections 512, 564A, and 564B.

Subtitle I - Vaccine Access, Certainty, and Innovation

Section 3091. Predictable Review Timelines of Vaccines by the Advisory Committee on Immunization Practices

Upon the licensure of any vaccine or new indication for a vaccine, the Advisory Committee on Immunization Practices (“ACIP”) must “as appropriate” consider the use of the vaccine at its next regularly scheduled meeting. If ACIP does not make recommendations for use of the vaccine at that meeting, ACIP must “provide an update on the status” of its review. ACIP must make recommendations “in a timely manner, as appropriate” for vaccines that are designated as breakthrough therapies or that could be used in a public health emergency, among others.

Section 3092. Review of Processes and Consistency of ACIP Recommendations

The Director of the CDC must review ACIP's processes for formulating and issuing vaccine recommendations. The review must assess the criteria used to evaluate new and existing vaccines, the Grading of Recommendations, Assessment, Development, and Evaluation ("GRADE") approach to analysis of scientific and economic data, and the extent to which the processes used by ACIP working groups are consistent among groups. The Director must solicit input from vaccine stakeholders, and the Director's report to Congress on the results of the review and recommendations to improve consistency of ACIP processes is due within 18 months of enactment.

Section 3093. Encouraging Vaccine Innovation

Within one year of enactment, the HHS Secretary, in collaboration with NIH, CDC, FDA, and BARDA, must report to Congress on ways to promote innovation in the development of vaccines that minimize the burden of infectious disease. The report must review the current status of vaccine development, consider the optimal process to determine which vaccines would be beneficial to public health, assess whether obstacles exist that inhibit the development of beneficial vaccines, and recommend steps for removing any such obstacles.

The HHS Secretary must revise the Vaccine Injury Table to include vaccines recommended by the CDC for routine administration to pregnant women. For purposes of petitions for compensation under Section 2111 of the PHS Act, both a woman who received a covered vaccine while pregnant and any child who was in utero at the time will be considered persons to whom the covered vaccine was administered and persons who received the covered vaccine.

Subtitle J - Technical Corrections

Section 3101. Technical Corrections

Section 3101 makes numerous technical amendments to the FDCA and other laws. Among those changes referred to as "technical" is an amendment to section 524A of the FDCA, on automatic priority review for QIDP applications. Before the amendment, this section provided that, if FDA designated a drug as a QIDP, then FDA "shall give priority review to any application submitted for approval for such drug." As amended, only "the first" application for the drug must receive priority review. In another "technical" amendment, the Pediatric Research Equity Act is amended to require that the Pediatric Review Committee consult on "any significant amendments" to agreed initial pediatric study plans before approval of an application or supplement for which a pediatric assessment is required.

Section 3102. Completed Studies

This section removes provisions in the FDCA requiring completion of certain studies by the Institute of Medicine and FDA.

If you have any questions concerning the material discussed in this client alert, please contact the following members of our Pharma and Biotech practice or Medical Device practice:

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