July 13, 2021

The Honorable Diana DeGette
2111 Rayburn House Office Building
Washington, DC 20515

The Honorable Fred Upton
2183 Rayburn House Office Building
Washington, DC 20515

Dear Representatives DeGette and Upton,

The Association for Clinical Oncology (ASCO) applauds your bipartisan commitment to developing cures and improving access to care for patients. The passage of the *21st Century Cures Act* was a major step forward in speeding research to create new treatments, but we know there is more work to be done to ensure those treatments can be delivered to the patients that need them most. ASCO represents nearly 45,000 clinical oncologists, researchers, and other oncology professionals who treat and study patients with cancer across the country. We are pleased to submit the following comments in response to the 21st Century Cures 2.0 Discussion Draft, which contains important policies that will improve the current state of cancer care.

Diversity in Clinical Trials

We are particularly pleased to see the inclusion of provisions to improve diversity in clinical trial participation in **Section 203 of the draft**. Improving access to and the diversity of clinical trials has long been a priority for ASCO, and we believe achieving this goal will benefit the entire cancer care continuum.

In December of last year, Congress took a critical step forward in addressing the fragmented Medicaid policies related to clinical trials by requiring that all plans cover the routine care costs associated with clinical trials participation for patients with life-threatening conditions. We thank you for including this policy in the initial Cures 2.0 white paper and are thrilled that patients experience one less barrier to care today. We support the extension of this coverage in private insurance to PCORI funded trials as outlined in **Section 205**.

Separately, ASCO published a statement devoted to making clinical trials more representative by refining eligibility criteria and continues to work with the Food and Drug Administration (FDA) and other stakeholders to implement these recommendations.

ASCO is currently partnering with the Association of Community Cancer Centers on a set of joint recommendations and practical strategies to increase participation of racial and ethnic minority populations in cancer treatment trials. Inclusion of patient experience data as addressed in **Section 204** will be a critical element of this effort.

Innovative Clinical Trial Design

Innovative trial design is essential to sustained momentum in biomedical research. The COVID-19 pandemic necessitated changes in clinical trial operations to mitigate disruptions in both care and research. Several of these changes proved successful and have now led to establishment of less cumbersome processes for patients and researchers. We believe there is an opportunity to learn from and build upon these design changes. ASCO supports grants to explore how these changes and other novel ideas, such as those proposed in **Section 302,** could continue to improve our nation's clinical trials and speed the development of treatments and cures.

Telehealth

ASCO strongly supports the *Telehealth Modernization Act,* which would permanently remove the geographic and originating site restrictions in Medicare and applauds its inclusion as **Section 403**. Since the start of the Public Health Emergency (PHE) there has been a dramatic increase in the use of telehealth. It has proven beneficial to providers and patients, as it increases access to care for patients with cancer while reducing treatment burden and disruption to patient lives.

The declaration of the PHE allowed flexibilities on the use of telehealth in Medicare, improving access to care allowing patients to access necessary services regardless of geographic location and without having to be in a doctor's office or clinic. Geographic location and site origination restrictions limited telehealth use pre-pandemic. Such restrictions, including that the patient live in a rural area and access telehealth services in limited health care settings, were required for services to be covered. Unfortunately, when the PHE ends, restrictions on telehealth that prevent access to this type of care will resume and ASCO is concerned about the impact this will have on patient's access to care.

Research

Finally, we fully support inclusion of the *Research Investment to Spark the Economy (RISE) Act* in **Sec. 502**, which would provide supplemental funds to research agencies, including $10 billion to the National Institutes of Health (NIH), to mitigate pandemic-related research disruptions. Researchers and graduate students would be able to use the funding to complete work that has been disrupted due to COVID-19, replace certain lab equipment, reconfigure laboratories to safely resume research, and cover increased construction costs resulting from the disruption from COVID-19.

***

We look forward to working with you as you craft final language and advance this important legislative package. In addition to our comments on the discussion draft, below you will find our responses to the questions posed in **Sec. 501**, the Advanced Research Projects Agency for Health (ARPA-H) request for information (RFI). Should you have any questions on the response to the discussion draft or ARPA-H RFI, please do not hesitate to contact Amanda Schwartz at Amanda.Schwartz@asco.org.

Sincerely,

Howard "Skip" Burris, MD, FASCO

Chair of the Board
Association for Clinical Oncology

***

In calling for the creation of ARPA-H, President Biden has cited the success of the Defense Advanced Research Projects Agency (DARPA) and expressed his belief that ARPA-H should be similar. Please provide specific details on which aspects of DARPA ARPA-H should replicate and why this would lead to similar success.

DARPA has been successful because it is able to do things other agencies cannot, including: supporting research at three stages (basic research, applied research, and advanced technology development); funding efforts in multiple sectors (industry, university, national labs, and consortia across these sectors); providing the critical mass of funding needed to tackle bold goals; and promoting collaboration and integration across performers. DARPA does not perform its own research. Although DARPA proposals are reviewed on a competitive basis, program managers (PM) have authority to select a portfolio of projects intended to achieve a particular program goal.

ASCO believes that this unique approach to research could be translated to the biomedical research field. Specifically, funding high-risk, high-reward research would fill a gap in our current biomedical research enterprise. The NIH is currently able to fund research at specific sites, traditionally favoring incremental, hypothesis-driven research, and often basic research. Industry then frequently tackles more translational research including projects that yield lucrative returns on investment. If nimble, a new federal agency, such as the proposed ARPA-H should be able to harness collaboration across multiple sectors, would have the ability to pursue bold ideas without concern for its bottom line and could complement efforts currently underway in our biomedical research enterprise.

Like DARPA, ARPA-H should have the flexibility to recruit and hire PMs from outside the traditional civil service hiring process and provide competitive salaries. This would serve the dual goals of recruiting people with the appropriate background and mission expertise while preventing a "brain drain" from existing agencies. ASCO supports adopting the DARPA structure of term limits for both the head of the agency and its PMs; the current proposal of 3-5 years with the possibility of extensions for special cases seems appropriate to foster a continuous influx of new ideas to the agency.

The PMs at DARPA often come to the agency with bold, ground-breaking ideas and are given both independence and sufficient resources to pursue them. Unlike DARPA, the projects conducted by ARPA-H would have additional regulatory oversight, including peer review, required for biomedical research. Therefore, the DARPA model would need to be extended to include all of the additional resources needed to meet these obligations without slowing or otherwise restricting the enterprise.

To ensure it has the biggest impact, on what activities or areas should ARPA-H focus? What activities or areas should ARPA-H avoid?

ARPA-H should not duplicate research currently funded by the NIH, NCI, or underway in the commercial sector. To protect against this, ARPA-H must collaborate with existing agencies and the private research and development sector, which is discussed in detail later in this response.

ASCO agrees with the Administration that ARPA-H should be focused on bold, transformative research. The Administration appropriately notes that bold ideas may not fit existing mechanisms because (i) the risk is too high; (ii) the cost is too great; (iii) the time frame is too long; (iv) the focus is primarily designed for academia; (v) there is a need for complex coordination among multiple parties; (vi) the near-term market opportunity is too small to justify commercial investment, given the expected market size or challenges in adoption by the health care system; or (vii) the scope is so broad that no company can realize the full economic benefit, resulting in underinvestment relative to the potential impact.

Examples of projects appropriate for a potential ARPA-H could include development of vaccines to prevent cancers; development and expansion of the use of CAR-T and other precision-based, cell, or gene-based therapies; creating drugs that target specific tissues and cell types or very rare cancers; or developing computerized organ models.

Additionally, there are certain cancer patient cohorts that do not typically benefit as much from current research endeavors, including pediatric cancer and rare cancer patients. Focusing on strategies to screen, test, and treat these patient populations—who are often left out of current research—would be incredibly beneficial within the cancer space.

Equity considerations (including race, ethnicity, gender/gender identity, sexual orientation, disability, and income level) must be woven throughout the projects ARPA-H funds. Research and clinical trials funded by ARPA-H should ensure patient populations are representative of the diversity of patients in the United States and prioritize access to the clinical trials, treatments, tools, and technologies that result from this investment for populations that have been historically excluded. Additionally, health insurance coverage and cost should not be a barrier to clinical trial participation and equitable care. This new agency should implement strategies to encourage broad inclusion criteria, decentralization of clinical trials, eliminate barriers to inequities in research, and advance the research on disparities.

Some assert ARPA-H's ability to operate independently and transparently will be essential to its success. Do you agree? If so, what is the best way to design ARPA-H in order to accomplish this?

First and foremost, it is critical the new agency be transparent about its selection criteria and decision-making process for its broad strategic investment goals and selection of individual research projects. It should establish clear metrics to ensure funds are being used to advance public health. All funded projects should be held accountable for clearly stated deliverables and timelines.

The success of ARPA-H will rely on its ability to maneuver in ways traditional Institutes and Centers (IC) at the NIH are not.

In addition to the proposed hiring and tenure processes noted above, ARPA-H should have key flexibilities from Congress on how it can spend appropriated funding. It is important that agency metrics be carefully calibrated

so as not to discourage high risk research. PMs should have ability to fund high-risk projects, even though there is a chance they can fail. ARPA-H must be able to pivot to the next good idea; failed projects should not translate into reduced yearly appropriations.

ASCO believes that any research funded by ARPA-H should be peer-reviewed. However, to truly be nimble, the agency will likely need an established exemptions process from existing proposal review processes, which can take years to clear.

Whether APRA-H is ultimately housed within or outside of the NIH is ultimately a decision for Congress and the Administration. If it resides within the NIH, the new agency will be able to draw on the vast range of knowledge, expertise, and activities at NIH. Housing ARPA-H within NIH would also ease collaboration and assist in avoiding unproductive duplication of scientific and administrative effort. However, ARPA-H will need to be granted specific flexibilities the other ICs currently do not possess in order to be successful at approaching research in a bold and nimble way. While successful in their missions, current ICs within the NIH are subject to time-consuming administrative and other requirements in implementing research, which would not be conducive to the stated ARPA-H mission.

How should ARPA-H relate to, and coordinate with, existing federal entities involved in healthcare-related research and regulation?

Within HHS, it will be important for ARPA-H to collaborate with other key agencies—such as the FDA, the CDC, BARDA, CMS, and the other ICs within the NIH—to identify critical unmet needs and opportunities and to collaborate on complex projects. ARPA-H should have appropriate trans-agency authority to coordinate translational research, product development, manufacturing, distribution, regulatory approval, and reimbursement to deliver the novel products and technologies as quickly as possible to patients.

Collaboration is key for several reasons. First, ARPA-H will need the ability to work across other healthcare agencies to avoid administrative duplication. Additionally, ARPA-H should work closely as a partner with the other ICs at NIH, learning from their processes and identifying possible research projects that these ICs might be receiving applications for, but are unable to fund. As noted below, the NCI, for example, is only able to fund about 10% of R01 grants it receives. Collaboration with NCI staff and the investigators submitting the unfunded grants could yield a wealth of ideas for ARPA-H to pursue.

It will be essential that ARPA-H and the other research agencies maintain an environment of two-way collaboration, rather than competition – both in terms of research projects, funding, and staff. Dedicated funding for this new agency should include an increase in investment in the training of diverse physician-scientists to ensure our Nation's scientific progress accelerates both within and beyond ARPA-H. Otherwise, there is a very real concern about potential brain-drain within other agencies and academia.

What is the best way to ensure ARPA-H has a mission, culture, organizational leadership, mode of operation, expectations, and success metrics that are different than the status quo?

It will be imperative that ARPA-H be granted specific flexibilities and implement certain processes not seen in other federal research institutions, including:

- Ability to quickly hire staff at competitive salaries
- Implementation of "term limits" for PMs and the head of ARPA-H (ideally 3-5 years)
- PMs should be recruited from industry, academia, and other sectors based on demonstrated scientific vision, judgment and management skills, and have broad autonomy to drive transformational change
- Clear and transparent metrics for success for each project should be created with input from various stakeholders
- Authority for PMs to act quickly and nimbly on the selection of projects and the decision to discontinue projects that are not yielding desired results
- Ensuring the agency and its projects can "fail" without fear of the agency losing annual appropriations
- Increased flexibility to utilize its annual appropriations, and guaranteed funding through 3-5 year increments for projects
- Appropriate trans-agency authority to coordinate translational research, product development, manufacturing, distribution, regulatory approval, and reimbursement to deliver novel technologies as quickly as possible in areas of high unmet need
- Mandate to collaborate closely with other research agencies, academia, industry and stakeholders to ensure projects are working towards unmet needs

How should ARPA-H work with the private sector?

To be successful, ARPA-H should leverage a diverse collaboration between the private market, biotech, health care companies, academic institutions, and government and regulatory agencies. Fostering public/private partnerships and standardization to accelerate discovery to clinically impactful solutions that help patients is vital.

ARPA-H's efforts should directly and routinely engage patients, clinicians, and researchers to inform organization and function of the new agency. This can occur through establishment of advisory bodies or other mechanisms that allow for meaningful stakeholder input, which can enrich dialogue and avoid unintended consequences during implementation. Specialty organizations, like ASCO, should be utilized for their collective knowledge and expertise both during the creation and implementation of ARPA-H and as regular consultants on projects.

Finally, any new therapeutics and treatments coming from ARPA-H funded research should be affordable and accessible to all patients. To that end, ARPA-H should clearly set out the intellectual property rights related to any eventual therapies developed through its investment at the outset, with consideration for cost and access.

What is the appropriate funding level for ARPA-H? How do we ensure ARPA-H funding does not come at the expense of traditional funding for the National Institutes of Health?

Efforts to establish a new agency or reform the biomedical research enterprise and health innovation will require sustained and dedicated funding to achieve impactful translational research with demonstration of patient benefit.

President Biden's fiscal year (FY) 2022 Budget proposed $6.5 billion to be appropriated to support the establishment of ARPA-H within the NIH. Creating and staffing a new agency, and beginning meaningful transformative research, will take time. To that end, ASCO supports the proposal within the Administration's

ARPA-H "Fact Sheet" to allow ARPA-H three years to allocate and spend the appropriations provided to the new agency in FY 2022.

Perhaps more crucial to the amount allocated to ARPA-H in FY 2022 and beyond will be ensuring that Congress continues to make meaningful, reliable annual funding increases for the NIH's baseline, and specifically regarding cancer, NCI's baseline budget, especially with the Beau Biden Cancer Moonshot's annual funding expiring in FY 2023.

The NCI is the largest funder of cancer research in the world, with most of its funding directly supporting research at NCI and at cancer centers, hospitals, community clinics, and universities across the country. While the NCI has received modest funding increases over the last few years, funding has not kept up with the growth of research grant applications as compared to other NIH ICs. In fact, over the last five years R01 grant applications submitted to the NCI rose by 50%, while funding only grew by 20%. This means NCI is funding a smaller proportion of grant applications compared to previous years. Only 10% of viable applications received funding in 2020 compared to 28% in 1997. Even after accounting for Cancer Moonshot funding, NCI's budget has not kept up with scientific opportunity.

While we strongly believe in the stated mission of ARPA-H and the innovative and expedited way its establishment could bring treatments and cures to patients, it is critical that Congress ensure NIH and NCI's baseline budgets continue to grow in a strong and meaningful way annually to continue the groundbreaking science already underway and increase the percentage of viable grants that receive funding.