



Better health through
laboratory medicine.

**Statement of the American Association for Clinical Chemistry
FDA Public Workshop - Regulatory Oversight of
Laboratory Developed Tests
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My name is Catherine Hammett-Stabler, I am a Professor of Pathology and Laboratory Medicine at the University of North Carolina where my clinical responsibilities include serving as one of the directors of the McLendon Clinical Laboratories within the UNC healthcare system. I am here today on behalf of the American Association for Clinical Chemistry – which has more than 8,000 professional clinical laboratory scientists working in hospitals, independent laboratories and the diagnostics industry worldwide.

I would like to offer AACC's perspective on the Food and Drug Administration's proposals to regulate laboratory developed tests. We applaud the agency's willingness to enter into a public dialogue with the health care community on this important issue and commend the FDA on its continuous efforts to ensure the effectiveness and safety of medical devices. Safe and effective patient care is a goal which we all share.

AACC agrees that the increase in the number and complexity of LDTs warrants a new assessment on the part of the government and private sector accrediting bodies regarding the appropriate level of regulatory and professional oversight. Although we agree some adjustments may be necessary, we believe that the current oversight structure is generally adequate and that a major change in FDA policy is unwarranted.

It's important to note that LDTs of the 21st century benefit patients of all ages, from babies still in their mother's womb who undergo fetal lung maturity testing to newborns who are screened for myriad genetic diseases or conditions. LDTs also aid children who must undergo follow-up testing if indicated by the results of newborn screening tests, as well as subsequent monitoring if a genetic disorder is detected. Bacterial speciation to determine appropriate antimicrobial drug therapy, as well as therapeutic drug monitoring, may help both children and adults who have bacterial infections. These are but a few of the many LDTs that have become critical components of modern patient care.

Current Regulatory System

There appears to be a misconception that because the FDA is using its “enforcement discretion” in regards to LDTs that these tests are unregulated. This belief is inaccurate. LDTs are currently subject to a variety of oversight mechanisms at the federal and state levels and by professional accreditation organizations. Expanding oversight to include another federal agency will, in many instances, add to the regulatory burden and costs of performing LDTs, possibly resulting in many laboratories discontinuing these tests.

Currently, all laboratories performing LDTs are regulated under the Clinical Laboratory Improvement Amendments of 1988. These testing facilities are categorized as high complexity laboratories, subject to stringent personnel, quality control and proficiency testing requirements as well as regular inspections. Many of these same facilities also actively participate in the New York, Joint Commission, College of American Pathologists or other oversight programs. Under this current structure, clinical laboratories continuously evaluate the analytical and clinical performance of all tests performed by their staff. It is through the use of robust quality practices and tools that laboratories identify shortcomings, allowing them to take steps to avoid failure and errors – regardless of the source of a test.

We feel it is important to remember that that FDA regulatory structure is designed for medical device manufacturers, not clinical laboratories. Manufacturers provide invaluable test kits and instrumentation that assist laboratories in providing accurate test results. Laboratories that occasionally modify FDA cleared or approved tests do so to meet specific clinical needs. The laboratory providing this service is not a medical device manufacturer, but an organization of health care professionals engaging in the practice of laboratory medicine to provide safe and effective testing. The results from these tests are used to diagnose and treat patients. To apply FDA regulatory requirements to all hospitals and independent laboratories utilizing LDTs would be misguided and counterproductive to excellent patient care.

Clinical Validity

AACC agrees that clinical laboratories using LDTs should demonstrate the analytical and clinical validity of the test prior to its use. Laboratories should continue to use multiple approaches to establishing the predictive value of a test, including reviews of the scientific literature, independent assessments of patient outcomes, and use of guidelines and clinical protocols. Those laboratories subject to New York, CAP or Joint Commission oversight already meet this objective.

Categories for Continued Enforcement Discretion

There are many medical conditions for which it is not cost-effective for an IVD manufacturer to develop a commercial assay. Clinical laboratories have traditionally filled this void through LDTs. A comprehensive list of such laboratory tests would be quite lengthy and include categories such as testing for rare diseases, newborn screening, emergency testing, and testing involving world health issues, such as the recent Ebola virus outbreak. Rather than focusing on

those categories for enforcement discretion, we suggest the FDA should direct its attention towards identifying the narrow group of high risk tests that should be subject to joint FDA and CMS oversight.

Public Process for Classification and Prioritization

AACC agrees with the proposed risk-based classification approach for determining the level of oversight for LDTs. This regulatory scheme should include three categories: high, moderate, and low. We recommend that professional laboratory associations, such as AACC, medical societies, medical device manufacturers and other stakeholders work in collaboration with the FDA to identify criteria and categorize LDTs prior to finalizing the guidance.

AACC believes that following criteria should be considered for designating tests as high risk:

- the accuracy of the test cannot be independently verified;
- there is a lack of transparency regarding the underlying data to support claims made about the test; and
- the absence of professional consultation/interpretation could lead to serious patient harm.

Examples of high risk tests include IVDMIA and direct-to-consumer genetic tests.

Reporting Testing Errors

Clinical laboratories work diligently to provide quality laboratory tests. When a laboratory identifies a testing error it should report that mistake to the appropriate oversight body. Adverse events involving high risk tests should be reported to the FDA and CMS or the appropriate accrediting organization. Errors involving low to moderate risk tests that effect patient management should be documented and reported by the laboratory to CMS and/or relevant accrediting bodies.

Conclusion

In summary, AACC believes the current regulatory structure for LDTs is adequate. Joint FDA and CMS oversight should be limited to a narrow group of high risk tests determined by the government agencies and a broad cross-section of the stakeholder community. We are concerned that duplicative, costly federal oversight will stifle test innovation and hinder patient care. Prior to moving forward, however, AACC suggests that the FDA use the rulemaking rather than the guidance process. This regulatory path would ensure greater transparency, including the underlying rationale behind the agency's decisions. On behalf of AACC, I would like to thank you for the opportunity to participate today.