COGR

Council On Governmental Relations

An Association of Research Institutions

HHS and NIH Research Regulatory Reform

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Concerns about the growth and impact of federal research regulations and reporting requirements have been raised in a number of reports over the years, among them, the 1999 *NIH Initiative to Reduce Regulatory Burden;* 2005 and 2012 Federal Demonstration Partnership Faculty Workload Survey Reports; the 2012 National Academies report *Research Universities and the Future of America;* the 2014 National Science Board report *Reducing Investigators' Administrative Workload for Federally Funded Research;* the 2016 National Academies report *Optimizing the Nation's Investment in Academic Research;* and the 2016 Government Accountability Office report *Federal Research Grants: Opportunities Remain for Agencies to Streamline Administrative Requirements*. Several of these reports were requested by Congress, but to date few if any of the recommendations contained in these reports have been implemented and the number of new federal regulations, policies and reporting requirements continues to grow.

Recent legislation, including section 2034 of the 21st Century Cures Act (Cures Act), *Reducing Administrative Burden for Researchers*, which incorporates a number of recommendations from the National Academies and other reports may provide opportunities for reform. The following are recommendations for research regulatory reform. If implemented these actions would reduce the amount of time investigators and agency and institution staff spend on administration, increasing efficiencies in the use of federal research dollars and focusing investigators' time on the conduct of research.

Financial Conflict of Interest Reform

21st Century Cures Act language:

Not later than two years after the date of enactment, the HHS Secretary shall:
"lead a review by research funding agencies of all regulations and policies related to the disclosure of financial conflicts of interest, including the minimum threshold for reporting financial conflicts of interest."

Issue: There is a lack of harmonization in agency policies with respect to how conflict of interest is defined, managed and reported.

Recommendation:

- Any agency that funds academic research through grants or contracts and has a separate COI policy should be included in the review mandated by the Cures Act. Major research funding agencies include HHS/NIH (PHS), NSF, DOD, NASA, DOE, and USDA. Additional agencies or departments with separate (and administratively burdensome) COI policies that provide funding for research should be included in a review, among them, the Department of Justice, EPA and CMS.

Harmonize and make less burdensome existing policies: *"Make revisions, as appropriate, to harmonize existing policies and reduce administrative burden on researchers while maintaining the integrity and credibility of research findings and protections of human participants."*

Issue: As indicated above, most agencies have different definitions, management, enforcement, and reporting requirements for conflict of interest.

Recommendations: Harmonization is needed for the following key areas:

- Harmonize the definition of conflict of interest/financial conflict of interest with that of the NSF definition, as well as key actions, definitions and terms (e.g., use of the terms apparent, perceived and potential; and actual, real and identified) across agencies.
- Harmonize federal agency and departmental disclosure thresholds with that of the National Science Foundation (NSF), and raise the threshold to $15,000 across agencies.
- Who has to disclose - We suggest the investigator as defined by PHS
- How immediate family is defined – We suggest the investigator's (as defined by PHS) immediate family (spouse and dependent children).
- Timing of review and disclosure (addressed below)
- Who makes the COI determination – We believe the applicant institution should.
- Reporting requirements – Reporting should occur only if there is a conflict of interest that meets the regulatory definition and should only include those conflicts of interest that cannot be eliminated, reduced or managed by the institution, consistent with NSF policy.
- Consider as a long-term strategy a uniform reporting system for collecting required reports.
- Consider replacing the term "financial interest" with "significant financial interest" throughout the revised policies, after the term "significant financial interest" is defined.
- Eliminate PHS's disclosure requirement for travel.
- Eliminate the PHS retrospective review and mitigation report required when an investigator does not disclose activities. It is intended to identify whether there is bias, however, bias cannot be proven or disproven. If an investigator hasn't disclosed, the institution should instead have a process to determine what might need to be done to address non-disclosure (e.g., amending informed consent documents).
- Eliminate the PHS Requirement to include financial interests related broadly to institutional responsibilities in researchers' conflict of interest reporting to their institutions.
- Some agencies are now moving research awards to contracts and requiring organizational COI review. This practice is not one that PHS and NSF engage in for their research awards or cooperative agreements. Review for organizational COI should be restricted to procurement as intended by section 200.112 of the Uniform Guidance and addressed by OMB in COFAR FAQ 200.112-1.
- Policies should be explicit concerning whether they are intended to promote objectivity in research or to promote fair procurement and contracting processes.

Supporting Background Data:

In 2011, the Department of Health and Human Services amended the PHS regulations on conflict of interest (42 CFR Part 50 and 45 CFR Part 94). This action was taken largely in response to growing Congressional concerns driven largely by one specific high profile case of non-disclosure.

Among other changes, the revised PHS rule, which took effect in August 2012, lowered the *de minimis* threshold to $5,000 and required disclosure of travel as well as payments from non-profits. AAU, APLU and COGR findings from a survey of members suggest that the costs and negative impacts of the new rule far exceed those anticipated by PHS and that minimal benefits have been achieved.[1] Institutions reported a significant increase in disclosures in the first year, but few additional conflicts to manage. Yet there were significant costs associated with these regulatory changes. The Association of American Medical Colleges found that "Participating institutions incurred significant costs beyond their ongoing program administration costs to fully implement the regulations. The total investment by 71 institutions was almost $23 million ($22,557,744) for an average of approximately $318,000 per institution... Institutions made 61 percent ($14 million) of these investments before implementing the rule and 39 percent ($9 million) in the year following implementation of the regulations."[2]

With respect to the *de minimis* threshold, of the 2,929 disclosures reported from 33 institutions for FY14 between $5,000 (the threshold implemented in 2012) and $10,000 (the previous PHS threshold and that maintained by NSF), only 249 resulted in some action by the institution to mitigate a potential conflict, 185 from 3 of the 33 institutions. It should be noted that these are not findings of actual financial conflict of interest but potential low dollar situations for which investigators and institutions create a plan to mitigate any risk of potential conflict. Overall, the review of disclosed conflicts results in very few reportable cases of conflict of interest. Institutions would like to see the PHS threshold returned to $10,000.

With respect to travel and income from non-profits, 35 institutions responding to the AAU, APLU, and COGR survey reported 5,784 disclosures that involved only travel and outside income from non-profits (including foreign universities). Of these only 20 disclosures warranted a management plan. Twenty-nine of the 35 schools found no potential conflicts to manage related to travel or to income from non-profits. PHS is the only agency that requires travel disclosures. Data indicate that institutions are not finding travel-related conflicts and that such disclosures provide no benefits. The increase in disclosures resulting from these changes to the regulations have required additional administrative time for universities and investigators that could be better spent on higher risk areas and on research.

Per the Cures Act, in updating the policy, the Secretary shall consider: *"Modifying the timelines for the reporting of financial conflicts of interest to just-in-time information by institutions receiving grant or cooperative agreement funding from the National Institutes of Health."*

Issue: 42 CFR Part 50 states that the institution has to have a COI disclosure on file no later than the time of application. We understand that NIH is considering proposing use of just-in-time (JIT) for

[1] AAU-COGR-Yale Survey of Compliance Costs. June 2015. Retrieved from: http://www.cogr.edu/COGR/files/ccLibraryFiles/Filename/000000000113/AAU-COGR-Yale_Survey_of_Compliance_Costs_Presentation_Thursday_Afternoon_June_2015.pdf

[2] AAMC COI Metrics Project. April 2015. Measuring the Cost and Outcomes of the NIH Rule on Financial Conflicts of Interest in PHS-Funded Research. Retrieved from: https://www.aamc.org/download/429214/data/april2015implementingtheregulationsonfinancialconflictsofintere.pdf

PHS COI disclosure filing; the time for resolution would remain the same, that is, at notice of award. NIH could release an FAQ indicating that institutions may rely on annual disclosure with institutional review at time of award and that disclosure may occur up to JIT or prior to award activation. If PHS/NIH were to set this point as the standard for when disclosure to the institution is required, and other agencies harmonized to this time point, it would significantly reduce unnecessary administrative work. This would also reduce administrative work associated with subrecipient disclosure.

Recommendation:

- Consider an FAQ indicating that institutions may use annual disclosure with institutional review at the time of award and that disclosure may occur up to JIT or prior to award activation. Apply this disclosure and resolution timing to all agencies. With reference to the underlined, we believe section 50.604(e) (1) of 42 CFR Part 50 would need to be modified.

Modification of the term "Investigator": *"ensuring that financial interest disclosure reporting requirements are appropriate for, and relevant to, awards that will directly fund research, which may include modification of the definition of the term 'Investigator.'"*

PHS FCOI regulations indicate that the term "Investigator" involves those "responsible for" the design, conduct and reporting of research, so the breadth of the disclosure requirement is not currently viewed as an issue of concern, however, harmonization with this definition across agencies is needed.

Recommendation:

- As indicated above, harmonize the definition of "investigator" across agencies with that of the PHS FCOI definition; those "responsible for the design, conduct and reporting of research."

Subrecipient Monitoring

21st Century Cures Act language:

The NIH Director "shall implement measures to reduce the administrative burdens related to monitoring of subrecipients of grants by primary awardees of [NIH] funding…which may incorporate findings and recommendations from existing and ongoing activities. Such measures may include, as appropriate—

(1) an exemption from subrecipient monitoring requirements, upon request from the primary awardees, provided
that—
(A) the subrecipient is subject to Federal audit requirements pursuant to the Uniform Guidance of the Office of Management and Budget;

Issue: Science is engendering an increasing number of collaborative projects, resulting in significant growth in the number of subawards issued and received by institutions of higher education. The Uniform Guidance has added prescriptive administrative requirements (e.g., implied need to document on a transaction-by-transaction basis the determination of subrecipient/contractor

relationship and detailed risk assessment and monitoring requirements) to an already burdensome process of issuing subawards to other universities and research organizations for collaborations on federally funded projects. With subrecipient monitoring, the "Prime" recipient is expected to monitor the business practices and internal controls of the subrecipient. This may be necessary for subrecipients that do not meet the threshold for Federal Single Audit ($750K in 2 CFR 200). It is unnecessary for subrecipients that have completed a Federal Single Audit.

Recommendations:

- NIH can address this requirement by indicating in grants policy that where a subrecipient has a current Single Audit report, and has not otherwise been excluded (e.g., debarred or suspended) from receipt of federal funding, pass-through entities can rely on the subrecipient's auditors and cognizant agency oversight for routine audit follow-up and management decisions, and thus no separate audit review or management decision by the pass-through entity is required. Such reliance does not eliminate the obligation of the prime recipient to issue subawards that conform to agency and award-specific requirements and to manage risk through ongoing subaward monitoring (e.g., monitoring of technical progress and expenditures, and adherence to award terms and conditions). Optimally, OMB should make this change to the Uniform Guidance and applicable to all federal agencies.

- With respect to the area highlighted in yellow, a formal request for case-by-case exemption from monitoring requirements is unnecessary and would only increase administrative work for both the institution and agency.

(B) the primary awardee conducts, pursuant to guidance of the National Institutes of Health, a pre-award evaluation of each subrecipient's risk of noncompliance with Federal statutes and regulations, the conditions of the subaward, and any recurring audit findings;

Recommendation**:**

- With respect to pre-award evaluation and recurring audit findings (1)(B), this is needed only for subrecipients not subject to Single Audit, and having the requirement apply across-the-board adds significant administrative burden.

(2) the implementation of alternative grant structures that obviate the need for subrecipient monitoring, which may include collaborative grant models allowing for multiple primary awardees.

Recommendation**:**

- We support the use of alternative grant structures such as cooperative agreements with multiple primes, but note that the safe harbor proposed above with respect to subrecipients subject to Single Audit would be most effective in reducing administrative burden.

Review of Animal Research Regulations

Per Cures, NIH, USDA and FDA are required, within two years of enactment, to complete a review of applicable regulations and policies for the care and use of laboratory animals and make revisions to reduce administrative burden on investigators while maintaining the integrity and credibility of

research findings and protection of research animals. On April 17, 2017, the Federation of American Societies for Experimental Biology, the Association of American Medical Colleges, and the Council on Governmental Relations, with support from the National Association for Biomedical Research, held a workshop on reforming animal research regulations. Participants included investigators and administrators engaged in animal research or oversight, including chairs of institutional animal care and use committees and directors of animal welfare programs at research institutions; accreditors; and associations whose members are engaged in animal research or oversight. A workshop report was released on October 24, 2017 and provided to HHS, NIH, FDA, USDA and other relevant federal agencies and offices. The report includes a series of recommendations for reducing regulatory burden associated with the use of animals in research while maintaining or improving research integrity and the protection of animals.

Financial Reporting Reform

21st Century Cures Act language:

The Secretary, in consultation with the Director of [the] National Institutes of Health, shall evaluate financial expenditure reporting procedures and requirements for recipients of funding from the National Institutes of Health and take action, as appropriate, to avoid duplication between department and agency procedures and requirements and minimize burden to funding recipients.

Uniform 120-Day Closeout Requirement

Issue: Federal agencies that have implemented the 120-day close-out model, rather than the 90-day model, have experienced more accurate reporting, and ultimately, more timely closeouts. The extra 30 days provides institutions the time needed to settle all invoices with vendors and subrecipients; conduct an orderly and compliant closeout process; and reduce administrative work throughout the process, particularly for faculty. Agencies that have implemented the 120-day deadline as a hard requirement have experienced improved efficiency by no longer having to manage deadline extension requests, which inherently are inefficient.

NIH and other agencies have implemented the 120-day model, but not all HHS operating divisions and federal agencies have. This lack of uniformity in implementing the 120-day model results in significant administrative work for grantee institutions that are then required to address different requirements both within and between federal agencies; this has implications for the internal control environment, training and education, monitoring, and other areas. In some cases, research is impacted because subaward dates have to be shortened arbitrarily to ensure that financial reports can be submitted in time. Additionally, warning letters for late financial and programmatic reporting are often not sent to research administrators to facilitate a timely and compliant closeout, but instead are sent to investigators creating frustration, confusion, and burden.

Recommendations:

- Implement the 120-day grant closeout model across all HHS operating divisions (and optimally all federal agencies, potentially through research terms and conditions) and for all reports (financial and programmatic).
- Send administrative action and warning letters to the institution's financial contacts.

Research Terms and Conditions

Issue: NIH has signed on to, and in fact been instrumental in developing, federal-wide research terms and conditions across multiple agencies and offices to address and implement the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance) issued by OMB. Unfortunately not all HHS operating divisions and federal agencies have signed on. This lack of uniformity in implementing the Uniform Guidance results in significant administrative work for grantee institutions that are then required to address different requirements both within and between federal agencies.

Recommendation: Implement the Federal-wide Research Terms and Conditions across all HHS operating divisions (and optimally federal grant-making agencies).

Federal Cash Transaction Report (FCTR)

Issue: Most federal agencies now have systems that support real-time grant-by-grant cash balances. Some agencies, such as the National Science Foundation, have eliminated the FCTR as a required report after making this transition as the reports become redundant. To date, HHS has not eliminated this reporting requirement, despite transitioning to real-time cash balances.

- In a survey of AAU, APLU and COGR members conducted in 2014, 46 institutions reported filing 21,627 quarterly financial reports for which cash is already drawn down on an account or document level (and reports are therefore redundant/unnecessary).

Recommendation: HHS/NIH should eliminate the FCTR.

Financial Reporting for Small Dollar Credits

Issue: The Payment Management System is configured to reconcile to the penny. That means that if a research institution receives a small dollar credit (e.g. $5, $50, etc.) from a vendor months or years after the grant was closed and the Federal Financial Report (FFR) submitted, it must open the account, post the $5, calculate F&A (if applicable), revise the FFR, return the funds and revise the quarterly FCTR. NIH and HHS (and other agencies) have to go through a similar process. In effect, we may have to spend hundreds or even thousands of dollars to return a $5 credit to the U.S. Government.

Recommendation: Eliminate the requirement to resubmit the FFR for small dollar credits (e.g. <$100 or $500 or possibly 0.1% of the award amount). Allow universities to instead accumulate all debits and credits to federal awards over a period of time (e.g., quarterly or annually) and refund net credits directly to the U.S. Treasury, or reimburse the U.S. Government through some other mechanism, which could save hundreds of dollars or more per award.

Oversight of Reporting and Technology Systems

Issue: Too often, new reporting systems are implemented without adequate input from the grantee community; those that will be directly impacted by these new systems. This is inconsistent with the intent of the DATA Act, which was meant to minimize reporting system sprawl across federal agencies. For example, CDC recently initiated a new reporting system named "Grants Solutions," which will create additional administrative burden for grantees.

Recommendation: HHS could take an active role in approving new submittal and reporting systems, and facilitating participation and input from the grantee community.

Use of a Single IRB for Multisite Research

In June 2016, NIH issued a policy on the Use of a Single Institutional Review Board (sIRB) for Multi-site Research.[3] The final NIH policy became effective January 25, 2018 and applies broadly to all NIH multisite studies with more than two sites. The HHS Secretary's Advisory Committee on Human Research Protections (SACHRP), in a written response to the draft NIH policy,[4] suggested that mandating single IRB review for domestic multi-site studies is not the appropriate solution to improve turn-around time for human subjects research, that it is premature to mandate single IRB use in NIH-funded domestic multi-center trials, and that it may result in new procedures and policies being created that will undermine the goals of the policy change and create new challenges for research institutions. Research institutions, which opposed the mandate, suggested that an initial policy should be piloted, narrowly focused, and that NIH should evaluate potential benefits and costs. Many suggested the creation of additional discipline-specific federal central IRBs (CIRBs) such as the National Cancer Institute (NCI) CIRB.

HHS, in proposed rulemaking,[5] proposed to mandate use of a single IRB for multi-site research in regulation. Of the 308 responses received in response to the proposed mandate, 51% opposed the proposed change and 42% supported it, while approximately 6% offered qualified support.[6] Support for the single IRB requirement stems from reported delays in clinical trial activation due to multiple reviews of the same protocol at different sites and the variability that can be introduced. The final rule[7], published January 19, 2017, and NIH policy are broader, however, including all studies with more than one site; engaging social and behavioral and other non-biomedical research; and, in the case of regulation, including studies where *different activities* are to be conducted at each participating site.

Advisory and related groups, including SACHRP and Public Responsibility in Medicine and Research (PRIM&R), largely opposed the Single IRB proposal. Per the Association for the Accreditation of Human Research Protection Programs (AAHRPP): "While, on its face, this may appear to be a rational approach, it is not clear whether this 'one size fits all' requirement will actually lessen institutional burden, given the infrastructure and administrative complexity of becoming or ceding to a single IRB of record. AAHRPP recommends that the choice of using a single IRB be determined on a case-by-case basis, accompanied by guidance that provides assistance in creating and using

[3] Retrieved from: https://grants.nih.gov/grants/guide/notice-files/NOT-OD-16-094.html
[4] Secretary's Advisory Committee on Human Research Protections. Recommendations Regarding the Draft NIH Policy on the Use of a Single Institutional Review Board for Multi-site Research. Retrieved from: https://www.hhs.gov/ohrp/sachrp-committee/recommendations/2015-april-24-attachment-f/index.html
[5] U.S. Department of Health and Human Services. (2015). Notice of Proposed Rulemaking (NPRM), Federal Policy for the Protection of Human Subjects Notice of Proposed Rulemaking. Federal Register Retrieved from: https://www.federalregister.gov/documents/2015/09/08/2015-21756/federal-policy-for-the-protection-of-human-subjects
[6] Analysis of Public Comments on the Common Rule NPRM. (2016). Retrieved from: http://www.cogr.edu/sites/default/files/Analysis%20of%20Common%20Rule%20Comments.pdf
[7] U.S. Department of Health and Human Services. (2017). Federal Policy for the Protection of Human Subjects. *Federal Register, 82(12)*, 7149-7274. Retrieved from: https://www.federalregister.gov/documents/2017/01/19/2017-01058/federal-policy-for-the-protection-of-human-subjects

cooperative agreements to address the complex nature of relying on a single IRB for review."[8] SACHRP has expressed the concern that "there is a significant difference between an entity like the NCI CIRB which is in the business of serving as a central reviewing IRB and the rotation of the single IRB function among institutions who will serve this role for some research protocols and not for others. It takes an enormous investment in IT resources and databases to manage the communication flows, state law and local context issues for different institutions as well as the divergent policies and processes of each institution."[9]

This is expected to be a costly endeavor, beginning with necessary changes to IT infrastructure, the hiring of additional staff and changes to policy and processes; and extending to review of individual grants. While researchers and disease advocacy groups have supported the change with respect to biomedical research, there will be far less support for smaller, non-clinical studies, particularly once the costs, both financial and administrative, are fully understood. This rule and policy change may result in fewer funds for research due to additional expenses budgeted to awards for an IRB to conduct a review for multiple sites and may not reduce the level of administrative work nor accelerate the time to study activation.

Recommendations: HHS should reconsider this rule change, and NIH its policy, or significantly narrow the scope to larger, biomedical clinical research. HHS and NIH should also consider greater use and expansion of federal central IRBs to implement this rule, such as the NCI CIRB, rather than relying on an unpredictable patchwork of institutional and independent IRBs with different policies and processes. The latter are likely to add burden for researchers when their institution is not the lead site, such as learning to use multiple software systems, completing multiple conflict of interest disclosures, and fulfilling other requirements.

At a minimum, HHS should publish a technical or other amendment clarifying that the Final Rule applies only to research in which each participating site will conduct the same research protocol. HHS and NIH should implement metrics to assess the cost and effectiveness of this policy change and a timeline for assessment.

Clinical Trials Registry

Section 2054 of Cures directs the HHS Secretary to consult with agencies and other stakeholders to receive recommendations related to enhancements to the clinical trial registry. HHS issued a final rule on Clinical Trials Registration and Results Information Submission on September 16. NIH issued its policy on clinical trials reporting the same day. Both describe applicability and requirements for submitting clinical trials results information to ClinicalTrials.gov and became effective January 18, 2017. The NIH policy applies to all clinical trials, no matter the study phase or type of intervention, funded in whole or part by NIH and regardless of whether the trials are subject to the Final Rule. This includes pilot and exploratory studies with very small sample sizes for which results may not be generalizable. The regulations extend beyond statutory requirements and the NIH policy beyond the regulations. Clinical trials reporting was already onerous due to a difficult user interface. Greater balance between benefits and costs is needed, in this instance the submission of information that is of greatest benefit to the public and research community balanced with investigators' research time and the cost of implementation to universities.

[8] AAHRPP Comments on the Common Rule NPRM. (2016). Retrieved from: https://www.regulations.gov/document?D=HHS-OPHS-2015-0008-1206

[9] SACHRP. (2016). Recommendations on the Notice of Proposed Rulemaking Entitled: Federal Policy for the Protection of Human Subjects. Retrieved from: https://www.hhs.gov/ohrp/sachrp-committee/recommendations/2016-january-5-recommendation-nprm-attachment-a/index.html

NIH Definition of "Clinical Trial"

Issue: The NIH Definition of "Clinical Trial" is "A research study in which one or more human subjects are prospectively assigned to one or more intervention (which may include placebo or other control) to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes." This revised definition was published in a notice dated October 23, 2014. In the notice, the agency indicates that "the revision is designed to make the distinction between clinical trials and clinical research studies clearer and to enhance the precision of the information NIH collects, tracks, and reports on clinical trials. It is not intended to expand the scope of the category of clinical trials."

COGR, AAMC, AAU and APLU sent a letter to Dr. Michael Lauer, NIH Deputy Director for Extramural Research, on September 17, 2017, expressing concern that NIH's definition of "clinical trial" has been significantly expanded through the set of case studies published by the agency in the summer of 2017. Earlier versions of NIH clinical trial case studies published on or after notification of the revised definition, including October 2014 and April 2015 seemed to closely adhere to what has traditionally been characterized as, or understood to be, a clinical trial, while later versions of the case studies, including September 2016 and, in particular, more recent versions, have been much more ambiguous which has raised significant concern within the research community. Designating basic health research a "clinical trial" or "mechanistic clinical trial" subjects this research to a number of additional policies and requirements including the NIH Policy on the Dissemination of NIH-Funded Clinical Trial Information, the Policy on Good Clinical Practice Training for NIH Awardees Involved in NIH-funded Clinical Trials; the NIH Policy on Funding Opportunity Announcements [FOA] for Clinical Trials and additional review criteria specific to clinical trials. Efforts to enhance rigor and reporting can be addressed in the context of NIH research, or research involving human subjects, broadly. As indicated in our letter, the research community shares the agency's goals of ensuring rigor and reproducibility and making research results more broadly available to the public.

Recommendation: NIH should utilize the "NIH Definition of Clinical Trial Case Studies" published on October 23, 2014, the date of publication of the revised definition. These case studies are consistent with the communities understanding of what constitutes a clinical trial. Federal agencies should also consider harmonizing the NIH definition of "Clinical Trial" with that of the FDA definition of "Clinical Investigation", "any experiment that involves a test article and one or more human subjects, and that either must meet the requirements for prior submission to the Food and Drug Administration under section 505(i) or 520(g) of the act, or need not meet the requirements for prior submission to the Food and Drug Administration under these sections of the act, but the results of which are intended to be later submitted to, or held for inspection by, the Food and Drug Administration as part of an application for a research or marketing permit." "Test article means any drug for human use, biological product for human use, medical device for human use, human food additive, color additive, electronic product, or any other article subject to regulation under the act or under sections 351 or 354-360F of the Public Health Service Act."

A single federal definition of "Clinical Trial" using the FDA definition of "Clinical Investigation" (trial) would be consistent with the intent of statute and regulation (e.g., section 402(j) of the Public Health Service Act (PHS Act) (42 United States Code (U.S.C.) 282(j)) as amended by Title VIII of FDAAA and including technical corrections made to FDAAA under Public Law 110-316) and would reduce unnecessary regulatory burden. The regulations regarding ClinicalTrials.gov as well as what

constitutes "Good Clinical Practice" were developed based on the FDA definition but are now being applied to a much broader group of studies under a revised set of NIH case studies. NIH and HHS should adopt the FDA definition or remove clinical trial requirements from NIH-funded studies that do not meet the FDA definition.

Streamline Proposal Requirements

Background:

The National Science Board (NSB), in its report *Reducing Investigators' Administrative Workload for Federally Funded Research* recommended that federal agencies modify proposal requirements to include only those "essential to evaluating the merit of the proposed research and making a funding determination" including use of preliminary proposals, broadening just-in-time, and simplifying budget requirements at the time of proposal. Language in the American Innovation and Competitiveness Act, signed into law in January 2017, calls for a federal interagency working group to consider: preliminary proposals, increased use of just-in-time, and simplified initial budget proposals. The National Science Foundation has been piloting preliminary proposals in a number of directorates for several years and is piloting a streamlined budget process for proposals with a full budget and justification required only if a proposal has been recommended for award.

Recommendations:

- NIH should pilot a process that allows for detailed budgets and justifications just-in-time and consider other opportunities to limit pre-award requirements.
- Eliminate any reference to 'time'/person months in current and pending/other support consistent with the Uniform Guidance and other agencies.

NIH Biosketch

Issue: Investigators responding to a National Science Board request for information (RFI) and participating in roundtable discussions suggested that having to "provide a personal statement for biosketches that are tailored to each proposal is burdensome" and that "peer reviewers will look at the researcher's publications, not the reasons they think they can do the work." Similar concerns were raised with NIH staff at a Federal Demonstration Partnership meeting prior to implementation.

Recommendation: Eliminate the requirement to include a personal statement in the NIH biosketch. Streamline the biosketch and align it with that of other agencies. Alternatively, consider optional use of the biosketch that allows investigators to opt out.

NIH Modular Budget

Issue: Per the NSB report *Reducing Investigators' Administrative Workload for Federally Funded Research*, investigators responding to the Board's RFI on reducing federal regulatory burden recommended that "NIH raise the threshold for the modular budget from the current level of $250,000 to reflect increases in salary and benefit costs" with some recommending a threshold of $350,000 or $450,000.

Recommendation: NIH should increase the threshold for the modular budget which has not changed since its implementation in 1999. Modules could be increased to $35,000 while continuing to allow up to ten modules.

NIH Best Practices for Licensing Genomic Inventions

Issue: Since 2005 NIH policy has strongly encouraged non-exclusive licensing of genomic inventions as a best practice; singling out one technology area for special treatment. Also, while NIH has disclaimed the policy as not constituting regulations or award conditions, the agency has indicated it should serve as a benchmark. The policy also raises issues of consistency with the Bayh-Dole Act. It indicates that "when significant further research and development investment is not required…best practices dictate that patent protection rarely should be sought." This is problematic. While genomic research tends to be very early stage and its commercial significance may not be immediately apparent, this may make securing patent protection particularly important. Given that this policy guidance now is 10 years old and the field has progressed significantly, the purpose and need for it are even more questionable.

Recommendation: Withdraw the NIH Best Practices for Licensing Genomic Inventions.

NIH Genomic Data Sharing Policy

Issue: The Common Rule definition of "human subject" does not cover research with non-identified biospecimens. In contrast, the NIH Genomic Data Sharing Policy, effective January 25, 2015, treats de-identified data as human subjects data and requires IRB review and certification, including for data collected prior to the implementation of the policy, and study specific informed consent, resulting in significant administrative work for institutions and researchers. The policy far exceeds necessary protections and has the potential to hinder scientific progress.

Recommendation: The NIH Genomic Data Sharing Policy should be harmonized to comply with the DHHS definition of "human subject."