Submitted via email OASHPrimaryHealthCare@hhs.gov

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Admiral Rachel L. Levine, MD, Assistant Secretary for Health
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 716G
Washington, DC 20201

RE: Primary Health Care RFI

Admiral Levine:

Haystack Project is pleased to respond to the Office of the Assistant Secretary for Health's "**HHS Initiative To Strengthen Primary Health Care"** request for information.

Haystack Project (Haystack) is a 501(c)(3) non-profit organization enabling rare and ultra-rare disease patient advocacy organizations to coordinate efforts to address systemic value and access barriers. We strive to amplify the patient and caregiver voice in disease states where unmet need is high, and treatment delays and inadequacies can be catastrophic. Our core mission is to evolve health care payment and delivery systems to make innovation and quality treatments accessible to all Americans living with or caring for someone with a rare or ultra-rare condition.

Approximately 7,000 rare diseases have been identified to date, 95% of which have no FDA-approved treatment.

- 80% of rare diseases are genetic in origin, and present throughout a person's life, even if symptoms are not immediately apparent
- Approximately 50% of the people affected by rare diseases are children
- 30% of children with a rare disease will not live to see their 5th birthday
- Approximately half of identified rare diseases do not have a disease-specific advocacy network or organization supporting research and development.

Cumulatively, rare diseases affect approximately 1 in 10 individuals in the U.S., most (if not nearly all) of whom begin their diagnostic and treatment journey in primary care. Initiatives to strengthen awareness of rare diseases in primary care are, therefore, the "tip of the spear"

toward reducing the multi-year, multi-specialist struggle rare disease typically face before a definitive diagnosis is obtained. Primary care clinicians remain at the forefront of care as patients and their families face the day-to-day challenges of accessing care from specialists at distant health centers. The diagnostic and treatment access challenges common to rare disease patients generally are particularly onerous for people of color and other underserved populations, including rural communities. Our comments focus on leveraging and augmenting existing governmental infrastructures to empower patients and their primary care providers in securing a timely diagnosis and accessing the health care services and familial support resources needed to obtain the best possible outcome for ALL rare disease patients.

Newborn screening is crucial to ensuring that infants with rare diseases receive the therapeutic interventions they need to live to their full potential.

The Health Resources and Services Administration (HRSA) maintains the Recommended Uniform Screening Panel (RUSP) - a list of disorders that the Secretary recommends for inclusion in state newborn screening (NBS) programs. The RUSP update process is supported by recommendations from the Advisory Committee on Heritable Disorders in Newborns and Children. Unfortunately, state variability in breadth of NBS programs, testing protocols, and costs to families varies considerably.

Spinal Muscular Atrophy, for example, is a genetic disease affecting the central nervous system, peripheral nervous system, and voluntary muscle movement. It is the most common genetic cause of mortality in infants. The first disease-modifying therapy (Spinraza (nusinersen)) received Food and Drug Administration (FDA) approval on December 26, 2016; in May 2019, FDA approved Zolgensma (onasemnogene abeparvovac-xioi), the first gene-replacement therapy for a neuromuscular disease. Both treatments have demonstrated potential to slow, stop, or even reverse the devastating symptoms of SMA and can be given in individuals who are not yet symptomatic. HRSA did not include testing for SMA on the RUSP until 2018; the majority of state NBS programs continue to exclude SMA testing despite the fact that two disease modifying therapies are now available.

States also vary considerably in their testing protocols. Most simply specify that the NBS testing is performed before discharge. Maryland, however, specifies that one NBS blood sample be collected when the baby has had 24 hours of feeding. A second sample is collected when the baby is between 10 and 14 days old. The website outlining Maryland's NBS program notes that "the two screen system has been supported by the fact that about 10% of congenital hypothyroidism is identified by testing the second (subsequent) screen." The two-screen system is also necessary for accurate testing for cystic fibrosis (CF).

Haystack recommends that HHS:

- Consider implementing a "carrots and sticks" approach to allocating funding from the Centers for Disease Control and Prevention (CDC) based on the extent to which state NBS programs

    - include all RUSP tests,
    - expand NBS testing to a larger set of conditions for which treatments, including dietary regimens, can reduce disease symptoms or progression, and
    - conduct testing in a manner likely to secure valid results for all tests on the panel (e.g., timing of sample, subsequent testing).

- Consult with the rare disease advocacy community on development of a supplemental informed consent document that would give new parents of infants diagnosed with a condition the option of being connected with an advocacy organization or other entity sponsoring a patient registry and/or connecting patients with care and support resources.

- Develop, in consultation with disease-specific experts, a uniform set of disease-specific "next steps" for both primary care physicians and families. Haystack Project members have noted that pediatricians vary with respect to instructions provided to families, with some families noting that their child's primary care physician suggested that a condition detected in an infant was likely a "false positive."

- Require that states disclose to new parents any tests listed on the RUSP but not included in the state NBS program, as well as testing and treatments available for those conditions.

- For states that do not include the full set of RUSP tests, require state disclosure of any newborn screening variability, including existence of differential testing for newborns covered by Medicaid, employer-sponsored coverage, ACA plans, and other payers.

- Convene an HHS Health Equity Task Force to examine and make recommendations regarding the conditions included on the RUSP list, state NBS panel variability on included tests, specimen collection, patient/payer costs, and follow-up. Evidence from state NBS programs that include testing for metabolic disorders suggests that mandatory screening can reduce health disparities. (Brosco JP, Grosse SD, Ross LF. Universal state newborn screening programs can reduce health disparities. JAMA Pediatr. 2015 Jan;169(1):7-8.) A task force modeled on the COVID-19 Health Equity Task Force within the HHS Office of Minority Health would be well-positioned to provide recommendations on refinements to NBS panels and the RUSP that would both reduce health disparities and inequities, and improve health outcomes for all U.S. children with treatable rare diseases and conditions.

<u>Undiagnosed rare disease patients fail to receive appropriate treatment and may receive care that worsens their condition.</u>

Individuals with rare disease and conditions often suffer from disease symptoms for 5-9 years and see an average of 7 specialists before obtaining a diagnosis. Primary care clinicians are on

the front line for these patients, making referrals to specialists based on the patient's symptoms, assessing progression or changes in symptoms, and sharing their patients' frustration. Clinicians and patients often focus on managing symptoms without considering the possibility of a rare or ultra-rare disease.

Haystack urges HHS to focus on primary care outreach strategies that emphasize the fact that 1 in 10 U.S. patients suffers from a rare disease and outlines actionable recommendations that primary care clinicians should follow based on symptom persistence, combinations of symptoms, and other factors. In addition, HHS should increase provider-level awareness of initiatives like the Common Fund's Undiagnosed Diseases Network (UDN). This National Institutes of Health initiative is operated through the Office of Strategic Coordination as a research study to improve the level of diagnosis of rare and undiagnosed conditions.

The UDN nationwide network of clinicians and researchers should be a known, go-to resource for primary care clinicians unable to identify the cause of chronic, persistent, or episodic patient symptoms. In particular, Haystack urges HHS to assess the extent to which UDN participants to date are representative of patient populations with respect to racial, ethnic, sex/gender, socioeconomic, and geographic factors. We also HHS should engage primary care providers, including those practicing in rural and underserved urban areas, to facilitate increased participation in UDN.

Conclusion

Once again, Haystack Project appreciates the opportunity to respond to the RFI with recommendations to strengthen primary care resources for individuals with rare and ultra-rare diseases. We look forward to a continuing dialogue to increase the effectiveness of primary care clinicians in facilitating timely, equitable diagnosis and treatment access for our patients.

If you have any questions or would like to discuss our response, please contact me or M. Kay Scanlan, JD, at 410-504-2324.

Best regards,

Deanna Darlington
CEO and Ex Officio Board Member
Haystack Project