MEDEC brief submitted for public consultation re: Regulations under the Health Sector Payment Transparency Act, 2017 (Bill 160)

March 2018
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Summary

“MEDEC supports the Ontario government’s objectives towards greater transparency in health care. We look forward to our continued collaborative work with the government to ensure that these objectives are achieved, while at the same time increasing patient access to innovations through initiatives such as shifting to value-based procurement in health care.”

- Brian Lewis, President and CEO, MEDEC

MEDEC is the national association representing the medical technology industry in Canada. We represent over 100 medical technology companies who are committed to providing safe and innovative products and solutions that help save the lives of patients by improving the accuracy of diagnoses, enhancing treatments options, reducing long-term disabilities and helping to provide better medical care.

Covering a wide range of clinical arenas – medical technology examples include pacemakers, artificial heart valves, hip implants, synthetic skin, scalpels and medical laboratory diagnostic technologies. Medical technologies help save lives, enable better patient outcomes, and help contribute to health system savings and the sustainability of our health care system.

MEDEC recognizes the importance of ensuring transparency and accountability in Ontario’s health care system. MEDEC is committed to ensuring fairness, transparency and supporting ethical behaviour in interactions between the medical technology industry and health care providers.

As such, MEDEC is committed to working collaboratively with provincial and federal governments to ensure confidence in the integrity of the healthcare system and in supporting an open, collaborative and innovative medical technology sector in the best interest of patients.

MEDEC Submission and Recommendations – BY THE NUMBERS

- 120 Regulations Proposed by the Ontario Government
- 10 Key Areas Identified by MEDEC for recommended changes
- 17 Amendments to Specific Regulations Proposed by MEDEC
- 1 Additional Regulation Proposed by MEDEC
- 4 Points of Clarification Needed

We believe we are submitting a very reasonable and achievable number of recommendations given the total number of regulations. As you can also see, we are supportive of the majority of the proposed regulations.
MEDEC would like the government to consider our recommendations, which we believe would continue to strengthen the public trust in our health care system, and are aligned with the spirit of Bill 160 which seeks to enhance transparency and accountability over individuals and organizations that work hard every day to improve patient care, enhance patient safety and provide greater value to Ontarians. At the same time our amendments could both greatly reduce the administrative burden on the government and on medical technology companies, would provide the appropriate transparency over group purchasing organizations, and would continue to best serve the public interest related to transparency over health system transfers of value from industry.

About MEDEC

MEDEC is the national association representing the medical technology industry in Canada. We represent over 100 medical technology companies who are committed to providing safe and innovative products and solutions that help save the lives of patients by improving the accuracy of diagnoses, enhancing treatment options, reducing long-term disabilities and helping to provide better medical care.

For over 40 years, MEDEC has worked and collaborated with governments, health care providers and patients to improve the health of Canadians and create a sustainable health care system.

MEDEC members provide devices, instruments, equipment, supplies, applications and many other innovations that are used every day to diagnose, treat and enhance the quality of life of patients in Canada and around the world. These technologies translate into many benefits, including early diagnosis and more accurate and less invasive procedures, which lead to faster recovery, reduced hospital stays, better treatment options, and decreased wait times. In addition to providing better health outcomes, these technologies also provide substantial value and make significant contributions to the development of Canada’s health care system.

We want to improve the performance of health care to ensure patient well-being, and we strive to promote the growth of our industry in Canada and Ontario. To do so, we focus on access to proven and safe technology and medical innovations, which are often developed in Canada by our member companies.
Summary of Key MEDEC Proposals

Please find below – in priority order – the summary of our key MEDEC proposals.

1. SSOs and GPOs Should Be Both Recipients and Payors, Not Just “Intermediaries” (CATEGORY: Recipients)
   - SSOs and GPOs should not only be listed as recipients but they should also be listed as payors. Key reasons:
   - Transfers of value to these groups aren’t always linear or transparent ie: one amount goes to SSO but that exact amount doesn’t then usually go back to the hospital.
   - The SSO keeps a portion of the money and then may send a portion of the rebate, or the remainder of rebate funds on to the hospital.
   - Vendors are not involved in this process, and do not have visibility to any details once the rebate is paid to the SSO/GPO.
   - SSO’s don’t share this data with vendors, nor do they provide transparency to the hospitals. They often require vendors to not disclose the total rebate paid to them.
   - Some SSO’s insist they will only provide limited product tracing information for a large cost to companies.
   - Given that the rebate amount is considerably altered, and that much of the value of it is retained by the SSO/GPO, the portion that is provided to the hospitals should be separately disclosed and accounted for as a value from the SSO/GPO to the hospital.
   - MEDEC members are not comfortable being responsible for collecting customer rebate information back from the SSO/GPO given there has been absolute resistance or refusal in obtaining any transparency back from SSO’s and GPO’s. If this does in fact become a requirement as currently stated, industry vendors would require clear and defined support from legislators requiring SSO’s and GPO’s to provide this information back to the vendors in a timely manner.
   - There would be nothing to legally stop them from continuing to charge for this information and companies are not in a strong position to put that requirement into a contract (ie: the SSO can just tell companies if they don’t agree to pay for the data, they can’t bid on the contract).
   - Also, many companies are already in 5-6 year contracts that would be unable to be amended.
   - SSOs and GPOs should be included in Section 4 as a “Payor” or – alternatively – a section should be added after Section 11 entitled “When Intermediary to be Treated as Payor, Conditions” and there it should state “When the intermediary is an SSO or GPO”
2. Rebates and Cash Value-Adds Should be Included, But Discounts and Other Value-Adds Should Not Be Included (CATEGORY: Transfers of Value)

- Only rebates should be included, not discounts.
- Discounts that are declared within the commercial agreement be excluded.
- For example: discounts for early payment of a contract are not relevant in terms of impact on patient care, nor could they be construed as an inducement.
- Rebates are monies that are sent from companies back to SSOs or hospitals based on product that the hospitals purchase.
- This is a cash transaction and easy to quantify.
- “Discounts” on the other hand, are impossible to quantify as there isn't a “retail” price for medical technologies (other than in the case of discounts for standard commercial practices such as early payments on a contract, etc)
- Items that are provided on a value-added basis in connection with a procurement should be changed to “cash value-adds that are provided in connection with a procurement”
- Other value adds, like training, etc – are impossible for a company to quantify as they generally don’t “sell” these services and don’t have a retail price for them
- Example: industry may be requested to train institution’s staff on safe and effective use of products included in an RFP.
- Most times, this is a customer expectation associated with the sale of medical products.
- How shall we value that? On which basis is the value determined?
- These changes are very key for our sector

3. Timelines to Begin This Process Should be Moved by 1 Year to Allow Government and Payors Enough Time to Prepare (CATEGORY: Manner and Frequency of Reporting)

- With the current deadline to begin reporting to the Ontario Government in 2019, there is simply not enough time to prepare.
- Roughly 7 months after the final regulations are passed is not enough time for companies to hire staff, change internal systems, and prepare to begin tracking the data – especially given the extensiveness of the regulations which are more extensive and excessive than any other jurisdiction in the world.
- We need one more year.
- We should be targeting for this process to begin in 2020, not 2019
4. Threshold is Too Low  
(CATEGORY: Exceptions to Reporting Requirements)  
- The threshold is too low. We suggest $50  
- Please consider also an aggregate threshold of $100  
- In simple terms: The lower the threshold, the higher the burden on all parties.  
- Manufacturers have to track more data; the government has to process more data and the general public has to sort through more data to come to any meaningful conclusion.  
- We have learned in the US that the majority of data will be of a very low dollar amount.  
- For example, for payments reported in CY2014 (in the US) "... the majority of the payments in the general database (66 percent) were for transfers of value of $20 and below. Eighty-seven percent of payments were for transfers of $100 or less. We also found that almost 150,000 transactions were under a dollar..."  
- Ideally the reporting threshold would be higher than a $10 transfer of value.  
- Keep in mind the administrative burden and the public's ability to easily draw meaningful conclusions from the data.  
- Threshold should be changed to transactions that have a dollar value of less than $50 and an aggregate threshold of $100

5. Confidentiality for Competitive Reasons Should be Maintained in Relation to Research  
(CATEGORY: Recipients)  
- With regards to clinical research specifically, in the US payments in relation to research & development get reported to the government, but are not reported publicly until the technology is either licensed by Health Canada, or for 4 years (whichever comes first).  
- This is called “Delayed Reporting”  
- We should follow the US rules for “Delayed Reporting”  
- Below is the text for the US Sunshine Regulation that outlines the requirements for research delayed disclosure. This text starts on page 280 of the legislation. We’ve also included the link to the final legislation for reference:  

6. Some In-Kind Services Such as Training and Medical Equipment Servicing Should Not Be Considered a Transfer of Value  
(CATEGORY: Transfers of Value)  
- Training for medical devices is functional in nature.  
- Medical devices training/service functions by company employees should be excluded.  
- Product specific training for the purposes of the safe and effective use of the medical device should be excluded.  
- In-kind services should not include training for how to use and operate medical devices and the ongoing servicing of medical devices
7. US System Should be Used in Relation to How to Facilitate Corrections  
(CATEGORY: Corrections)  
- For notifying recipients, we should be using the same system as the US.  
- In the US, the payor reports to the government then recipients can log into the portal to check.  
- Recipients have time to make an “objection”  
- This is far less burdensome for all parties than to have payors send notices to recipients in advance of the report submission  
- Please review language and processes in the US and use the same process.

8. Unnecessary/Unintended Capturing of industry Trade Associations  
(CATEGORY: Recipients/Transfers of Value)  
- Seems unnecessary to capture industry trade associations in this legislation.  
- Industry Trade Associations are clearly advocating in the interest of their industry – this is open and transparent by the nature of their structure  
- They do not treat patients, nor do they influence purchasing decisions  
- Membership fees for industry trade associations such as MEDEC seem to have been captured by the regulations (likely unintentionally?) and should be excluded

9. Royalties Should Not Be Included  
(CATEGORY: Transfers of Value)  
- Royalties have nothing to do with “inducements”.  
- Royalties are paid for intellectual property.  
- Should be removed.

10. A Simple Language Change Can Make Some Data Capturing Processes Less Burdensome and Still Remain Effective  
(CATEGORY: Information re: Parties to Transactions)  
- In Section 7 – in relation to how we report the business name, changing the word “and” to “or” will capture all of the necessary information and make reporting less burdensome  
- The two specific areas are:  
  o 7 (a) the business name of the business, and its business identification number; and (b) the legal name of a business that is a corporation, and its Ontario or Canadian corporate number.  
  o Change “and” to “or” – too burdensome and unnecessary  
  o So change this regulation to (a) the business name of the business, and its business identification number; or (b) the legal name of a business that is a corporation, and its Ontario or Canadian corporate number.
Points of Clarification

Please find below 4 questions that MEDEC has re: points of clarification.

1. Recipients
   • For Section 1.31. An immediate family member of an individual prescribed under this section, except where the transfer of value is provided to the family member for reasons unrelated to the individual’s role in the health care system. For this purpose, without restricting the ordinary meaning of the term, an “immediate family member” includes a spouse, parent, child, sibling, grandparent, grandchild, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, daughter-in-law, son-in-law, brother-in-law, or sister-in-law.

   • Can you please provide clarity in the definition of “except where the transfer of value is provided to the family member for reasons unrelated to the individual’s role in the health care system”
   • Examples would help to clarify

2. Transfers of Value
   • For Section 2 (1) (I) payments to cover marketing and advertising costs;

   • Need a clarification – is this recipient advertising or industry advertising ie: is this an ad in a newspaper or journal? Or is this money given to physicians to support their own advertising practices?
   • Please clarify.
   • Please ensure same as US definition.

3. Date of the Transfer of Value
   • There can be a difference between the date a payment is made and the event date. Payments tend to follow after events requiring such.

   • Please clarity whether this means the date that payment is made or the event date?

4. Duplication of Transfers of Value
   • Duplications in payments can easily occur such as SSO, hospital and physician in the case of a single procurement process situation as many physicians are not employees of the hospital.
   • If duplication of interactions is not removed then the reporting will be excessive and not provide a clear, fair view for the public.

   • Please clarify how duplication of transfers of value will be avoided in situations where there is one transfer involving several categories of recipients.
**Chart – Key MEDEC Recommendations**

Below is a chart that aligns our key proposals against the actual regulations, in an effort to provide greater clarity and streamline the feedback process for the Ontario Government.

<table>
<thead>
<tr>
<th>Current Proposed Regulation</th>
<th>MEDEC Feedback</th>
<th>Recommended Action</th>
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<tbody>
<tr>
<td><strong>RECIPIENTS</strong></td>
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<tr>
<td>1. The following persons and entities are prescribed as recipients for the purposes of the Act:</td>
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<td>21. An association that advocates for the interests of health care professionals, health care organizations, or a sector within the health care system.</td>
<td>Why would industry associations be included in this? They do not treat patients.</td>
<td>Change to: 21. An association that advocates for the interests of health care professionals, health care organizations, or a sector within the health care system, excluding however not-for-profit industry trade associations</td>
</tr>
<tr>
<td>24. A group purchasing organization, shared service organization, or other corporation controlled by one or more persons or entities prescribed under this section that exists solely or primarily for the purpose of purchasing goods or services for the persons or entities.</td>
<td>SSOs and GPOs should not only be listed as recipients but they should also be listed as payors. Key reasons:</td>
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<td></td>
<td>- Transfers of value aren’t always linear or transparent ie: one amount goes to SSO but that exact amount doesn’t then usually go back to the hospital.</td>
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<td></td>
<td>- SSOs don’t easily share this data, sometimes they charge companies to get data on which hospitals are using/purchasing their technologies, which hospitals the rebates go to, etc. There would be nothing to legally stop them from continuing to charge for this information and companies are not in a strong position to put that requirement into a contract (ie: the SSO can just tell companies if they don’t agree to pay for the data, they can’t bid on the contract). Also, many companies are already in 5-6 year contracts that would be unable to be amended.</td>
<td>There might be one of two ways to handle this:</td>
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<td>1) Include SSOs and GPOs in Section 4 as a payor</td>
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<td></td>
<td>2) Add a section (after Section 11) entitled “When Intermediary to be Treated as Payor, Conditions” and then state 1. When the intermediary is an SSO or GPO</td>
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<td>29. An individual who is employed, contracted or otherwise retained by a person or entity prescribed under this section to conduct research.</td>
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| **Re: Clinical Research**  
- In the US, payments in relation to research & development get reported to the government, but are not reported publicly until the technology is either licensed by Health Canada, or for 4 years (whichever comes first).  
- This is called “Delayed Reporting” |
| Follow the US rules for “Delayed Reporting”  
Below is the text for the US Sunshine Regulation that outlines the requirements for research delayed disclosure. This text starts on page 280 of the legislation. We’ve also included the link to the final legislation for reference: [https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-02572.pdf](https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-02572.pdf)  
And here is how the regulations in the US are written:  
**403.910 Delayed publication for payments made under product research or development agreements and clinical investigations.**  
(a) General rule. Certain research payments or other transfers of value made to a covered recipient by an applicable manufacturer under a product research or development agreement may be delayed from publication on the website. Publication of a payment or other transfer of value is delayed when made in connection with the following instances:  
(1) Research on or development of a new drug, device, biological, or medical supply, or a new application of an existing drug, device, biological, or medical supply.  
(2) Clinical investigations regarding a new drug, device, biological, or medical supply.  
(b) Research or development agreement. The research or development agreement must include a written agreement, a research protocol, or both between the applicable manufacturer and covered recipient.  
(c) Date of publication. Payments or other transfers of value eligible for delayed publication must be reported to CMS (in the manner required in 403.904(f)) on the first reporting date following the year in which they occur, but CMS does not publicly post the payment until the first annual publication date after the earlier of the following: |
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<tr>
<td><strong>(1)</strong> The date of the approval, licensure or clearance of the covered drug, device, biological, or medical supply by FDA.</td>
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<td><strong>(2)</strong> Four calendar years after the date the payment or other transfer of value was made.</td>
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| **(d) Notification of delayed publication.**  
(1) An applicable manufacturer must indicate on its research report to CMS whether a payment or other transfer of value is eligible for a delay in publication. The absence of this indication in the report will result in CMS posting all payments publicly in the first year of public reporting. |   |
| (2) An applicable manufacturer must continue to indicate annually in its report that FDA approval, licensure, or clearance of the new drug, device, biological or medical supply to which the payment or other transfer of value is related, is pending. |   |
| **(3)** An applicable manufacturer must notify CMS during subsequent annual submissions, if the new drug, device, biological or medical supply, to which the payment is related (or the new application of the existing drug, device, biological, or medical supply), is approved by the FDA. |   |
| **(4)** Failure to notify CMS when FDA approval occurs may be considered failure to report, and the applicable manufacturer may be subject to civil monetary penalties. |   |
| **(5)** If, after 4 years from the date of a payment first appearing in a report to CMS, there is an indication in a report that the payment is subject to delayed reporting, it is reported regardless of the indication. |   |
| **(e) Confidentiality.** Information submitted and eligible for delayed publication is considered confidential and will not be subject to disclosure under 5 U.S.C. 552, or any similar Federal, State, or local law, until on or after the date on which the information made available to the public as required in this section. |   |
31. An immediate family member of an individual prescribed under this section, except where the transfer of value is provided to the family member for reasons unrelated to the individual’s role in the health care system. For this purpose, without restricting the ordinary meaning of the term, an “immediate family member” includes a spouse, parent, child, sibling, grandparent, grandchild, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, daughter-in-law, son-in-law, brother-in-law, or sister-in-law.

Can you please provide clarity in the definition of “except where the transfer of value is provided to the family member for reasons unrelated to the individual’s role in the health care system”

None

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<tr>
<th>TRANSFER OF VALUE</th>
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<tr>
<td>2. (1) Without limiting the generality of the definition set out in section 2 of the Act, and subject to subsection (2) of this section, “transfer of value” includes,</td>
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| (a) in-kind items or services; | • Training for medical devices is functional in nature.  
• Medical devices training and service functions by company employees should be excluded.  
• Product specific training for the purposes of the safe and effective use of the medical device should be excluded. | Change to (b) In-kind items or services; not including training from company employees for how to use and operate medical devices and the ongoing servicing of medical devices |
| (h) membership fees; | • Membership fees for industry associations should be excluded | See Section 1.21. where we have proposed new language to exclude not-for-profit industry trade associations |
| (i) rebates and discounts; | • This should only include rebates, not discounts.  
• Discounts that are declared within the commercial agreement should be excluded.  
• Ie: discounts for early payment of a contract are not relevant in terms of impact on patient care.  
• Rebates are monies that are sent from companies back to SSOs or hospitals based on product that the hospitals purchase. This is a cash transaction and easy to quantify.  
• “discounts” on the other hand, are impossible to quantify as there isn’t a “retail” price for medical technologies (other than in the case of discounts for standard commercial practices such as early payments on a contract, etc) | Change to (j) rebates |
| (j) items that are provided on a value-added basis in connection with a procurement; | • This should be changed to “cash value-adds that are provided in connection with a procurement”
• Other value adds, like training, etc – are impossible for a company to quantify as they generally don’t “sell” these services and don’t have a retail price for them
• Example: industry may be requested to train institution’s staff on safe and effective use of products included in an RFP. How shall we value that? On which basis is the value determined?
• This change is very key for our sector | Change to (k) items that are provided on a cash value-added basis in connection with a procurement |
| (k) royalties; | • Royalties have nothing to do with “inducements”.
• Royalties are paid for intellectual property. | Should be removed. |
| (l) payments to cover marketing and advertising costs; | Need a clarification – is this recipient advertising or industry advertising ie: is this an ad in a newspaper or journal? Or is this money we give to physicians to support their own advertising practices? | Please clarify. Please ensure same as US definition. |

### ADDITIONAL PAYORS

5. The following persons and entities are prescribed as payors for the purposes of paragraph 6 of section 3 of the Act:

| IMPORTANT: NEED TO ADD SSOs and GPOs | SSOs should be added as an additional payor | Please see our earlier comments in Section 1.24 |

### EXCEPTIONS TO REPORTING REQUIREMENTS

6. For the purposes of section 4 of the Act, a payor is not required to report the following transactions:

| 1. Transactions that have a dollar value of less than $10. | Threshold is too low. Suggest $50. Please also consider an aggregate threshold of $100.
• In simple terms: The lower the threshold, the higher the burden on all parties.
• Manufacturers have to track more data; the government has to process more data and the general public has to sort through more data to come to any meaningful conclusion.
• We have learned in the US that the majority of data will be of a very low dollar amount.
• For example, for payments reported in CY2014 (in the US) "... the majority of the payments in the general database (66 percent) were for transfers of value of $50 and below. Eighty-seven percent of payments were for transfers of $100 or less. We also found that almost 150,000 transactions were under a dollar..."
• Ideally, the reporting threshold would be significantly higher than $10 per transfer of value.
• Keep in mind the administrative burden and the public's ability to easily draw meaningful conclusions from the data. | 1. Transactions that have a dollar value of less than $50 and an aggregate threshold of $100. |
### INFORMATION RE PARTIES TO TRANSACTIONS

7.(1) For the purposes of subparagraph 1 i of subsection 4 (5) of the Act, the legal and operating names of a business include,

(a) the business name of the business, and its business identification number; and  

(b) the legal name of a business that is a corporation, and its Ontario or Canadian corporate number.

Change “and” to “or” – too burdensome and unnecessary

Change to (a) the business name of the business, and its business identification number; or (b) the legal name of a business that is a corporation, or its Ontario or Canadian corporate number

### TRANSFER OF VALUE, DESCRIPTION

8.(1) In describing the transfer of value under paragraph 6 of subsection 4 (5) of the Act, the payor must describe the transfer of value as taking one of the following forms:

1. In-kind items or services.  
   - Training for medical devices is functional in nature.  
   - Medical devices training and service functions by company employees should be excluded.  
   - Product specific training for the purposes of the safe and effective use of the medical device should be excluded.

   Change to (b) In-kind items or services; not including training from company employees for how to use and operate medical devices and the ongoing servicing of medical devices

   SAME FEEDBACK AS 2.(1)(b)

5. Royalties, memberships and subscriptions, with the following subcategories:  
   i. Royalties paid to a recipient in respect of intellectual property.  
   ii. Royalties paid on behalf of a recipient in respect of intellectual property.  
   iii. Membership fees paid on behalf of a recipient.  
   iv. Subscription fees paid on behalf of a recipient.  
   
   - Royalties have nothing to do with “inducements”.  
   - Royalties are paid for intellectual property.

   Remove the word “Royalties”  
   Remove i.  
   Remove ii.
6. Research, with the following subcategories:
   i. Clinical trial.
   ii. Research agreement.
   iii. Research grant

   Re: Clinical Research
   - In the US, payments in relation to research & development get reported to the government, but are not reported publicly until the technology is either licensed by Health Canada, or for 4 years (whichever comes first).
   - This is called “Delayed Reporting”

   Follow the US rules for “Delayed Reporting”

   Below is the text for the US Sunshine Regulation that outlines the requirements for research delayed disclosure. This text starts on page 280 of the legislation. We’ve also included the link to the final legislation for reference:

7. Rebates, discounts and items that are provided on a value added basis in connection with a procurement, with the following subcategories:
   i. Rebates.
   ii. Discounts.
   iii. Other value adds.

   Discounts should not be included. Value-Adds should be only “cash” value adds
   - see earlier feedback – Section 2 (1) (j) and 2 (1) (k)

   Change to 12. Rebates and items that are provided on a cash value added basis in connection with a procurement, with the following subcategories:
   i. Rebates.
   ii. Other cash value adds.

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**MANNER AND FREQUENCY OF REPORTING**

10. (1) Every payor shall report to the Minister, no later than June 30 in any year after 2019, all transfers of value from the previous calendar year.

   Not enough time to prepare. Need one more year.

   Change to 10. (1) Every payor shall report to the Minister, no later than June 30 in any year after 2020, all transfers of value from the previous calendar year.

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**CORRECTIONS**

12. (1) For the purposes of section 7 of the Act, the following are prescribed as persons who may request that the Minister correct the information reported under the Act, as long as they have complied with the applicable requirements under this section:

   (2) A payor shall, no later than March 31 in any year after 2019, (a) notify each recipient in writing of the information it intends to report to the Minister relating to each transfer of value it provided to the recipient during the previous calendar year; and (b) ensure that the recipient has a minimum of 45 days to review the information before it is reported to the Minister.

   Not enough time – need to extend deadlines.

   Also – should be the same as the US. Payor reports to the government then recipients can log into the portal to check. They have time to make an “objection”. Should follow this system.

   Please move deadlines to 2020.

   Please review language and processes in the US and use the same process.
Conclusion

MEDEC is supportive of the Ontario governments’ push for greater transparency in health care and we look forward to working collaboratively with the government on the implementation of the initiatives put forth in the Health Sector Payments Transparency Act.

This legislation is providing an excellent opportunity for the government to also significantly enhance the transparency of critical players (GPOs and SSOs) who bear the responsibility of the majority of medical technology purchases in Ontario. However, the regulations need to be written in a way that is achievable and conducive to the ultimate goal – which is to increase transparency over the critical health care dollars that flow through Ontario group purchasing and shared services organizations in our province.

The current consultation period provides an opportunity for the medical technology industry and the Ontario government to work closely together to ensure that best practices and lessons learned from other jurisdictions are incorporated into the regulations of this legislation with regards to health sector payments and transparency initiatives.

MEDEC would like to thank the Ontario government for taking the time to consider our recommendations, and for the strong, collaborative positive relationship the government continues to foster with the medical technology industry.

Enhancing transparency and accountability in Ontario’s health care system has the potential to improve patient care, enhance patient safety and provide greater value to Ontarians. MEDEC looks forward to our continued work and partnership with the Ontario government to achieve these common goals.