Value-Based Arrangement Exceptions and Safe Harbors Have Narrow Utility for Medical Device and Pharmaceutical Companies

 On December 2, 2020, the Department of Health & Human Services (HHS) published its long-awaited two final rules – one by the **Office of Inspector General** (OIG) and one by the **Center for Medicare & Medicaid Services** (CMS) – finalizing changes to regulations implementing the federal anti-kickback statute (AKS), the beneficiary inducement provisions of the civil monetary penalty law (CMPL), and the physician anti-self-referral law (Stark Law) and their safe harbors and exceptions. Among the most anticipated aspects of the final rules are the new value-based arrangement AKS safe harbors and Stark Law exceptions.

The two final rules, while complicated, are aligned in their definitions of value-based arrangements.

A **value-based enterprise (VBE)** is two or more participants that: (1) are collaborating to achieve at least one value-based purpose; (2) are each a party to a value-based arrangement with the other (or at least one other participant in the same VBE); (3) have an accountable body or person responsible for financial and operational oversight of the VBE; and (4) have a governing document describing the VBE and how its participants intend to achieve the VBE's value-based purpose(s).

A **value-based arrangement** is an arrangement entered into between (1) a VBE and one or more of its participants, or (2) among participants in the same VBE, for the provision of one or more value-based activities for a target patient population.

A **value-based purpose** is (1) coordinating and managing the care of a target patient population; (2) improving the quality of care for a target patient population; (3) appropriately reducing the costs to, or growth in expenditures of, payors without reducing the quality of care for a target patient population; or (4) transitioning from health care delivery and payment mechanisms based on the volume of items and services provided to mechanisms based on the quality of care and control of costs of care for a target patient population.

While the new AKS safe harbors exclude pharmaceutical and medical device manufacturers, distributors, and wholesalers; DMEPOS suppliers; laboratories; compounding pharmacies; and pharmacy benefit managers, there is a narrow exception intended to facilitate the deployment of health technologies for care coordination. These entities are eligible for protection under the care coordination safe harbor as "**limited technology participants**" that exchange "**digital health technology**" (defined broadly) with a VBE or VBE participant. The OIG Final Rule provided as an **example** "a medical technology company could partner with physician practices, to better coordinate and manage care for patients discharged from a hospital with digitally-equipped devices that collect and transmit data to the physicians to help monitor the patients' recovery and flag the need to intervene in real time (e.g., a device that monitors range of motion that could inform what

an appropriate physical therapy intervention may be). The technology company could provide the physician group with necessary digital health technology that improves the physician group's ability to observe recovery and intervene, as necessary." However, the OIG final rule requires that the exchange of digital health technology by a limited technology participant is *not* conditioned on any recipient's exclusive use of, or minimum purchase of, any item or service manufactured, distributed, or sold by the limited technology participant.

The Stark Law final rule does not exclude such entities from qualifying as VBE participants under any exception for value-based arrangements. However, because the Stark Law is focused on prohibiting self-referrals by physicians, the new Stark Law exceptions for value-based arrangements will be of limited value to medical device and pharmaceutical companies.

Is Prescription Support Software Classified as a Regulated Medical Device in Europe?

...the essential criterion for being classified as a medical device is the software's medical objective...

Background

Relying on an unregulated app or piece of standalone software to provide a diagnosis or recommend treatment could have potentially life-threatening consequences. In June 2020, the UK's medical devices regulator, the Medicines and Healthcare Products Regulatory Agency (MHRA) updated its **guidance** to help software and app developers in the medical field identify whether their products should be regulated as medical devices.

In particular, the MHRA endorsed the European Court of Justice (CJEU) ruling of **Snitem v Philips France C-329/16** from December 2017. This case considered whether prescription support software which used patient-specific data to detect drug interactions and excessive doses, constituted a medical device.

The CJEU's Judgment

The CJEU held that the prescription support software was a medical device under EU law for the following reasons:

- the software cross-referenced patient-specific data with the medicines that the prescriber had

contemplated prescribing;
- the software automatically provided the prescriber with an analysis intended to detect possible drug interactions and excessive dosages; and
- the manufacturer intended the software to be used for one of more medical objectives specified in Article 1(2)(a) of the **Medical Devices Directive 93/42/EEC** (MDD), which include the diagnosis, prevention, monitoring, treatment or alleviation of a disease.

The CJEU further held that it is irrelevant whether the software acts directly or indirectly on the human body. According to the court, the essential criterion for being classified as a medical device is the software's medical objective, examples of which are mentioned above.

Practical Implications

The MHRA guidance provides further certainty that prescription support software and other decision support software in the medical field may be classified as medical devices and thus need to comply with the requirements under the MDD.

As a final point, the MDD is due to be replaced by the Medical Devices Regulation on 26 May 2021. A key implication is that the risk classification of a significant proportion of existing medical device software could change which would mean manufacturers will soon need to obtain regulatory approval to market such software in the EU.

Are Pre-Approval and Pre-Licensure Inspections Limiting Approvals During COVID-19?

In this post, we discuss FDA's conduct of inspections of manufacturing facilities for new drugs and biologics during the COVID-19 pandemic. These inspections, known as pre-approval and pre-licensure inspections (PAIs/PLIs, respectively), are performed to give FDA assurance that a manufacturing site named in a new drug or biologics license application is capable of manufacturing the product according to current good manufacturing practices (cGMPs) and producing the product at commercial scale.

In **July**, FDA resumed limited domestic on-site inspections after temporarily postponing all domestic and foreign routine surveillance facility inspections in March. Since **June**, FDA had conducted only mission-critical domestic inspections. Currently, domestic on-site inspections are pre-announced and are prioritized on a newly developed rating scale that uses real-time data on the number of COVID-19 cases in a local area to qualitatively determine when and where it is safest to conduct

inspections. Foreign PAIs/PLIs continue to be temporarily postponed unless deemed mission-critical. FDA may deem an inspection mission-critical based on a variety of factors including, but not limited to, whether the product has received breakthrough therapy or regenerative medicine advanced therapy designation.

In response to COVID-19, FDA has used, on a limited basis, various tools to conduct alternative inspections. These tools include the use of FDA's authority under Section 704(a)(4) of the FD&C Act, which enables the Agency to request records directly from facilities "in advance of or in lieu of" drug inspections. In addition, FDA has indicated that it may also look to records of recent inspections and information shared by foreign regulatory partners through mutual recognition agreements. And while the concept of virtual inspections has been floated, it remains to be seen if video-based or other virtual inspection strategies can be used to fulfill PAI/PLI requirements and how long such proposals may take to implement.

Worryingly, FDA explains in its **August 2020 guidance** that should the Agency determine that a PAI/PLI is necessary, and such an inspection cannot be completed during the review cycle due to restrictions on travel or other COVID-19-related risks, FDA generally intends to issue a Complete Response letter or may defer action. The guidance, along with a number of concerns raised quietly by sponsors regarding delayed inspections leading or potentially leading to Complete Response letters, paints a potentially ominous picture for drug and biologic approvals and the advancement of the public health over the coming months. Sponsors submitting marketing applications in the near-term would be wise to proactively prepare for discussion of alternative inspection approaches during the review of their applications.

The Continuing Saga of Lab Developed Tests, Including for COVID-19 Testing

In August, the U.S. Department of Health & Human Services (HHS) **announced** that the FDA will not require premarket review of laboratory developed tests (LDTs), whether COVID-19 related or not, absent notice-and-comment rulemaking. Labs may voluntarily seek a premarket approval, 510(k) clearance, or an emergency use authorization (EUA) for their LDTs. Importantly, labs that do not obtain such FDA approval, clearance, or authorization would not be eligible for **PREP Act** coverage.

This announcement may have come as a surprise to FDA, which historically has asserted its medical device regulatory authority over LDTs while often subjecting them to enforcement discretion. Despite this HHS announcement, FDA's May 11, 2020 **Policy for Coronavirus Disease-2019 Tests**

During the Public Health Emergency remains in effect and has not been revised since the announcement. Importantly, this guidance offers two pathways for COVID-19 related LDTs – an EUA submission to FDA and the development of an LDT under the authorities of the State in which the laboratory resides, where the State takes responsibility for COVID-19 testing by labs in its State.

For FDA's latest statements on COVID-19 testing, see the **opinion piece** authored by CDRH Director Dr. Jeffrey Shuren and Dr. Timothy Stenzel, Director of the Office of Health Technology 7, In Vitro Diagnostics and Radiological Health, in the Hill.

The Purple Book and The Orange Book – When do Patents Expire and Regulatory Exclusivities end for FDA Approved Products?

The Food and Drug Administration (FDA) maintains two searchable online databases for approved products: the **Purple Book** (approved licensed biological products) and the **Orange Book** (approved drug products). The Orange Book provides details about an approved drug product, including the patents covering the approved drug product and the expiration dates of the patents and regulatory exclusivities, leaving investors, competitors, and the public in the dark as to when an approved biological product falls into the public domain.

For example, Sunosi® (solriamfetol hydrochloride) is a small molecule drug developed by Jazz Pharmaceuticals and was approved by the FDA on June 17, 2019 for the treatment of excessive sleepiness in adult patients with narcolepsy or obstructive sleep apnea. The NDA (new drug application) number, patents covering the product, the expiration dates of the patents, and regulatory exclusivity data are provided in the Orange Book.

Contrast this with Evenity® (romosozumab-aqqg), Amgen's monoclonal antibody approved for the treatment of osteoporosis in postmenopausal women at high risk for fracture. The Purple Book provides the approval date, proprietary name and generic name, BLA (biologics license application) number and type, date of first licensure, and a link to the product label. However, the Purple Book does not list the patents covering the product or regulatory exclusivity information. Thus, unlike patent litigation involving generic approvals for small molecule drugs, where the patents that will be involved are predictable based on the Orange Book listings, the patents that will be involved in litigation over a biosimilar approval are typically revealed for the first time during the litigation itself.

“March-In” Rights in the Era of COVID-19: An Unlikely Scenario for Remdesivir

As the total number of COVID-19 deaths in the U.S. is expected to climb to between 180,000 to 200,000 by September 5, 2020[1][2], there currently are no FDA-approved vaccines or drugs to prevent or treat COVID-19. However, the FDA has granted emergency use authorizations to some products for use in certain patients with COVID-19, including to Gilead for its investigational antiviral drug remdesivir[3].

On August 4, 2020, a bipartisan group of 34 state attorneys general (AGs) asked the U.S. government to exercise its march-in rights under the Bayh-Dole Act and license Gilead’s remdesivir to third-party manufacturers in order to scale up production and lower the price of the drug, or allow states to do so.[4] The AGs argued that the U.S. government should exercise its march-in-rights because the price of remdesivir is too high and because Gilead “has benefited from millions of dollars of public funding, including a $30-million NIH-funded clinical trial,” and “is unable to assure a supply of remdesivir sufficient to alleviate the health and safety needs of the country.”[5]

The AGs’ request that the U.S. government exercise its march-in rights under the Bayh-Dole Act, however, does not appear to be tethered to the law.

Under the Bayh-Dole Act, in specific circumstances, the U.S. government has the right to “march-in” and either grant licenses, or require the patent holder/licensee to grant licenses, to third parties under federally funded patents.[6] The U.S. government may exercise its march-in rights if it determines that action is necessary because the patent holder or licensee:

- has not taken, or is not expected to take within a reasonable time, effective steps to achieve practical application of the subject invention;
- is not reasonably satisfying health or safety needs;
- is not reasonably satisfying regulatory requirements for public use; or
- has violated the U.S. industry preference provisions of 35 U.S.C § 204.[7]

If the U.S. government decides to exercise its march-in rights, the decision may be appealed to the U.S. Court of Federal Claims, and with respect to items (1) and (3) above, march-in rights may not be exercised until all appeals or petitions are exhausted.[8]

Despite having the authority, the U.S. government has never exercised its march-in rights. In its response to a 1997 petition requesting that the NIH exercise it march-in rights, the NIH noted its unwillingness “to influence the marketplace for the benefit of a single company, particularly when

such actions may have far-reaching repercussions on many companies' and investors' future willingness to invest in federally funded medical technologies,"[9] and, with respect to drug pricing, in response to a 2004 petition, the NIH noted that "because the market dynamics for all products developed pursuant to licensing rights under the Bayh-Dole Act could be altered if prices on such products were directed in any way by NIH, the NIH agrees with the public testimony that suggested that the extraordinary remedy of march-in is not an appropriate means of controlling prices."[10]

Given the fact that: (a) march-in rights are limited to federally funded patented inventions (and it is not clear to what extent federal funds contributed to the development or remdesivir[11]), (b) the Bayh-Dole Act is not triggered by high drug prices, (c) the NIH's unwillingness to exercise its march-in rights, particularly because it does not want to disincentivize innovation and does not believe that the Bayh-Dole Act should be used to control drug prices, and (d) the patent holder/licensee has the ability to appeal the U.S. government's decision to exercise its march-in rights, and some instances march-in rights may not be exercised until all appeals or petitions are exhausted, it seems unlikely that the Bayh-Dole Act will be invoked in response to the AGs' request that the U.S. government exercise its march-in rights.

---

[1] According to the Centers for Disease Control and Prevention (CDC) COVID Data Tracker, as of August 21, COVID-19 has claimed 173,490 lives. **https://www.cdc.gov/covid-data-tracker/#cases**

[2] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/forecasting-us.html#anchor_1587397564229

[3] https://www.gilead.com/purpose/advancing-global-health/covid-19

[4] https://www.oag.ca.gov/system/files/attachments/press-docs/Remdesivir%20Letter%2020200804.pdf

[5] https://www.oag.ca.gov/system/files/attachments/press-docs/Remdesivir%20Letter%2020200804.pdf

[6] 35 U.S.C. §203(a).

[7] 35 U.S.C. §203(a).

[8] 35 U.S.C. §203(b).

[9] Harold Varmus, Director, NIH, Determination in the Case of Petition of CellPro,Inc., August 1, 1997,

http://web.archive.org/web/20070102183356/http:/www.nih.gov/icd/od/foia/cellpro/pdfs/foia_cellpro39.pdf.

[10] Elias A. Zerhouni, Director, NIH, In the Case of Norvir Manufactured by Abbott Laboratories, Inc., July 29, 2004,

http://www.ott.nih.gov/sites/default/files/documents/policy/March-In-Norvir.pdf.

[11] https://www.statnews.com/pharmalot/2020/05/08/gilead-remdesivir-covid19-coronavirus-patents/

President Trump Signs Four Executive Orders Designed To Reduce Drug Prices

President Trump recently announced four Executive Orders that direct the Secretary of the Department of Health and Human Services (HHS) to implement policy changes to reduce out-of-pocket costs and the price of prescription drugs. All but one of the Executive Orders has been issued with the remaining order on hold until August 24, 2020 pending discussions between the White House and leaders of the pharmaceutical industry. The Executive Orders include some prior policy proposals aimed at lower the cost of drugs and generating savings across the health care system. If implemented, many of these proposals will likely be challenged in court.

Most Favored Nations Policy

If issued, this Executive Order could tie the price that Medicare pays for certain drugs administered by doctors to prices negotiated by other economically comparable countries. This proposed Order is similar to a **2018 prior proposal** by the Center for Medicare and Medicaid Services ("CMS") to use its demonstration authority to test reimbursement changes for certain separately payable Part B drugs and biologicals using an international pricing index ("IPI"). The IPI model would result in lowering Medicare reimbursement for select drugs in certain geographies covered by the model to better match prices paid by similar economically situated countries. Health officials estimate this change would save Medicare $17 billion in the first five years. This order will be held until August 24, 2020 pending discussions with pharmaceutical industry leaders about alternative measures for lowering costs.

Increase Drug Importation

This **Executive Order** is designed to minimize international disparities in drug prices by increasing the trade of prescription drugs between nations with lower prices and those with persistently higher ones. The Administration argues that "reducing trade barriers and increasing the exchange of drugs will likely result in lower prices for the country that is paying more for drugs." The Administration aims to expand safe access to lower-cost importuned prescription drugs via three primary strategies.

First, the Order requests the Secretary of HHS to consider "facilitating grants to individuals of waivers of the prohibition of importation of prescription drugs" provided that it "poses no additional risk to public safety and results in lower costs to the American People" under the Federal Food, Drug, and Cosmetic Act (FDCA).

Second, it addresses "authorizing the reimportation of insulin products" where the Secretary of HHS finds that it is "required for emergency medical care" under section 801(d) of the FDCA. Section 801(d) generally places limitations on the reimportation of U.S. manufactured insulin products unless an exception is met.

Third, it requires the Secretary of HHS to complete the rulemaking process regarding a **December 23, 2019** proposed rule to import prescription drugs from Canada. The proposed rule contemplates allowing states and certain other non-federal government entities to import certain prescription drugs from Canada if the certain requirements under the FDCA are met.

Access to Affordable Life-saving Medications

This **Executive Order** is designed to help low income American's without access to affordable insulin and injectable epinephrine through commercial insurance or Federal health care programs, such as Medicare and Medicaid, to purchase these products from a Federally Qualified Health Centers ("FQHC") at a price that aligns with the cost at which the FQHC acquired the medication. FQHCs are community-based health care providers that provide primary care services in underserved areas. FQHCs receive discounted prices through the 340B Prescription Drug Program on prescription drugs.

The Order directs the Secretary of HHS to condition future grants available to FQHCs on establishing practices to make insulin and injectable epinephrine available at the 340B discounted price paid by the FQHCs, plus a minimal administration fee, to individuals with low incomes. The Order specifies that low income individuals include those who (a) have a high cost-sharing requirement for either insulin or injectable epinephrine, (b) have a high unmet deductible, or (c) have no healthcare insurance.

Lowering Prices for Patients by Eliminating Kickbacks to Middlemen

This **Executive Order** directs the Secretary of HHS to finalize a February 2019 **proposed rule** that would revise the discount safe harbor to the federal Anti-Kickback Statute ("AKS") with respect to pharmaceutical manufacturer rebates to health plans and pharmacy benefit managers ("PBMs"). Prior to finalizing the rule, the Order requires the Secretary of HHS to publicly confirm that the rule "is not projected to increase Federal spending, Medicare beneficiary premiums, or patients' total out-of-pocket costs." Specifically, the Order directs the Secretary of HHS to "complete the rulemaking process he commenced seeking to:

> (a) exclude from safe harbor protections under the anti-kickback statute, section 1128B(b) of the Social Security Act, 42 U.S.C. 1320a-7b, certain retrospective reductions in price that are not applied at the point-of-sale or other remuneration that drug manufacturers provide to health plan sponsors, pharmacies, or PBMs operating the Medicare Part D program; and
>
> (b) establish new safe harbors that would permit health plan sponsors, pharmacies, and PBMs to apply discounts at the patient's point-of-sale in order to lower the patient's out-of-pocket costs, and that would permit the use of certain bona fide PBM service fees."

The Order makes it clear the Administration view rebates as the "functional equivalent of kickbacks"

that “erode savings that could otherwise go to the Medicare patients taking those drugs. Yet currently, Federal regulations create a safe harbor for such discounts and preclude treating them as kickbacks under the law.” The policy objective of the order is to ensure that discounts offered on prescription drugs are passed on to patients. The Order states that, narrowing the safe harbor for discounts under the AKS will allow for billions in dollars of rebates in the Medicare Part D program to go patients at the point of sale.

The Administration’s policy positions and proposals in the Order and the prior proposed rule have elicited strong reactions from various stakeholders who suggested they may challenge any changes implemented as a result of this Order.

Real-World Evidence: Challenges and Opportunities During COVID-19

The urgent needs of the COVID-19 pandemic have more squarely brought into focus the role real-world evidence (RWE) can play in analyzing and informing product development and clinical and public health decisions. Specifically, the U.S. Food and Drug Administration (FDA) is participating in the COVID-19 **Evidence Accelerator**, in partnership with Friends of Cancer Research and the Reagan-Udall Foundation, to bring leading experts together to share insights and use RWE to help answer the most pressing research questions raised by the pandemic.

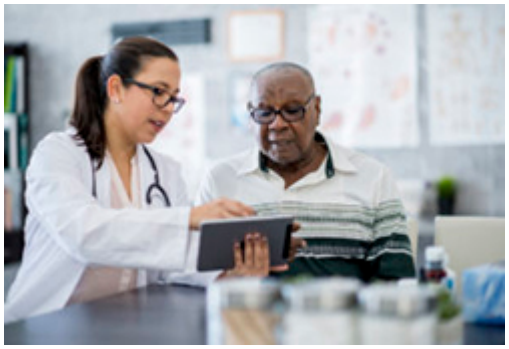
The FDA believes that RWE can play an informative role in analyzing potential therapies, vaccines, and diagnostics for COVID-19. At the recent “Establishing a High-Quality Real-World Data Ecosystem” **workshop** hosted by the Duke Margolis Center for Health Policy, Amy Abernethy, the Principal Deputy Commissioner of Food and Drugs and Acting Chief Information Officer at the FDA, highlighted the work of the Evidence Accelerator initiative, noting that RWE allows the FDA to constantly update its understanding of COVID-19 and recurrently analyze data to address changing needs. Amongst the other presenters, the general discussion focused on the many hurdles industry needs to address to establish a robust and more accurate RWE data ecosystem, including efficient capture of reliable data at the source. While internet access, smartphones, and wearable technology enable consumers and patients to keep meticulous records of their biometric data, the vast amount of collected data does not necessarily lead to efficient or fruitful analysis currently. FDA noted during the workshop that, to be more insightful, RWE stakeholders must narrowly tailor their collection to what is actually useful and relevant to clinical endpoints, fit for purpose, rather than merely what is easily accessible. Eric Perakslis, a Rubenstein Fellow at Duke University, noted that stakeholders must balance the usefulness of RWE collection against the risk of over-surveillance for each data point collected. While not discussed during the workshop, collecting massive data sets

must also be weighed against the ever-present risk of data breach. Finally, speakers also discussed patient-generated health data (PGHD) and the need for aligned stakeholders who are motivated to collect this data and understand the process for doing so, including a plan for handling outlier data which is unavoidable with PGHD.

In the context of the COVID-19 pandemic, RWE presents an opportunity for real-time learnings toward quicker identification and development of treatments and vaccines. As a result, the pandemic has only strengthened the importance of RWE in product development and, if deployed well, could help support more efficient and expedited product development plans.

*Emily Tribulski, a 2020 summer associate in Goodwin's Washington, D.C. office, contributed to this post.

What are Clinical Outcome Assessments (COAs) and Can They be Used to Support Approval and/or Labeling Claims?



The patient voice is recognized as one of the most critical sources of data in drug development, and patients play an increasingly important role in these efforts by teaching us about their experience with their condition and its impact. A common way sponsors can leverage the patient experience is by utilizing a clinical outcome assessment (COA). A COA is an assessment that describes or reflects how a patient feels, functions, or survives. Such an assessment can be a patient-reported outcome (PRO) measure, observer-reported outcome (ObsRO) measure, clinician-reported outcome (ClinRO) measure, or a performance outcome (PerfO) measure. **Alexander Varond** chaired a session on this topic in June 2020 at the Drug Information Association's Annual Meeting. Slides from his presentation can be found **here**.

FDA plans to issue a guidance that will provide patient-focused approaches and methods to consider in the selection and/or development of COAs. This future guidance, known as Patient-Focused Drug Development (PFDD) Guidance 3, is one piece of FDA's plan to develop a series of four PFDD-specific guidances for stakeholders on how to collect and utilize patient experience data in drug development. We initially discussed this plan and background on patient experience data **here**. In the meantime, FDA has described a "roadmap to COA selection/development for clinical trials" **here**. This roadmap sets forth how to obtain an understanding of the disease or condition, conceptualize clinical benefit (i.e., how a patient feels, functions and survives), and how to select, develop and modify a COA. In Guidance 4, FDA will discuss how to incorporate COAs into endpoints for

regulatory decision-making. FDA issued a discussion document related to the forthcoming Guidance 4 **here**.

As background, a COA may support approval of a product if it is a "well-defined and reliable" assessment (21 CFR § 314.126). FDA interprets this to mean that the COA must have content validity, construct validity, reliability, and the ability to detect change. But COAs can do much more. For example, COAs can be included in labeling claims, as with CRYSVITA (burosumab-twza) for X-linked hypophosphatemia linked **here**, which incorporates both PRO and ClinRO measures. COAs can even lead to a regulatory change in thinking about a particular disease or condition. For example, just over two months after hearing directly from patients with epidermolysis bullosa (EB), a rare disorder that results in serious cutaneous manifestations, at an externally-led PFDD meeting, FDA published a draft guidance for sponsors developing therapies for EB that outlined specific examples of efficacy endpoints that would show the drug provides a clinically meaningful improvement. The finalized guidance can be found **here**.

If you are considering developing or utilizing in your clinical development program a COA, or if have questions about other PFDD initiatives such as PFDD meetings, we encourage you to contact your Goodwin life sciences lawyer for assistance on how to incorporate the patient voice–the real experts on their disease or condition—in drug development.

Goodwin Webinar – Healthcare Issues + Trends: The False Claims Act and Other Government Enforcement

Healthcare companies are facing unprecedented challenges as a result of the COVID-19 crisis. This includes heightened enforcement risks. A key area of risk is the federal False Claims Act (FCA), a powerful tool for the DOJ to seek substantial penalties including three times the amount of money a company received in federal funds.

Join members of Goodwin's Healthcare team as they discuss recent enforcement developments and ways to mitigate risk from a panel of Goodwin lawyers with experience helping healthcare companies, their executives and medical professionals navigate enforcement investigations.

To register for this event, please visit the registration page **here**.