Palmetto_GBA_MolDX9.18

0:45
Good afternoon.

0:46
It is now 2:00 PM Eastern.

0:48
And so welcome to the Moldex Open meeting.

0:51
My name is Doctor Magdalena Yerkowitz.

0:52
I'm one of the Medical Directors at Moldex and will be moderating this session.

0:57
As we have a busy agenda, we can get started with some housekeeping issues.

1:01
Welcome and thank you to all of our presenters for joining us this afternoon.

1:06
We look forward to your presentations.

1:08
Please remember to mute your microphone if you are not actively speaking in order to reduce any background noise.

1:15
We would also like to remind you that Palmetto GPA requires all presenters at the open meeting to also submit their oral comments through the formal comment process.

1:24
The proposed local coverage determination released for comment is entitled Moldex Molecular Testing for Solid Organ Allograph Rejection and can be found in the online Medicare coverage database.

1:36
This is a reconsideration of existing policy wherein revision was conducted for clarity of the coverage criteria section stand for an inclusion of the CAC session held on November 16th and 17th of 2022.

1:49
There's no change in coverage from the current effect currently effective policy.

1:54
Please note that Palmetto GB A consents to and will be recording this meeting which will be subsequently published on the Palmetto GB A website Okay.

2:03
Let's get started with the notice that this meeting will be recorded in accordance with PIM Chapter 13, Section 13.2, Point 4.4.

2:12
We are going to make an audio recording of this open meeting and as part of the LCD record assure the recording is maintained on our Palmetto GB a website on behalf of Palmetto GB A I consent to recording of this meeting and I will now start the recording.

2:44
I have just started the recording of this open meeting in compliance with CMS for the record.

2:50
Prior to doing so, I announced that Palmetto GB A would make an audio recording of the open meeting and consented on behalf of Palmetto GB A.

2:58
We have 16 speakers this afternoon with 10 minute presentations and one additional speakers with 5 minutes.

3:05
Our first speaker is Doctor Kiran Kush, who is a Professor of Medicine, the Director of Heart Transplant Research and Program Director of Advanced Heart Failure Transplant Cardiology at the Stanford School of Medicine.

3:17
Doctor Kush, you may share your presentation.

3:22
I think you're on mute.

3:25
Thank you very much for allowing me to join and to share my presentation today.

3:33
Let me see if I can show my slides.

3:37
This worked perfectly, of course, in the technical check earlier today, Today.

3:45
Here we go.

3:46
Okay, can you see my slides?

3:50
Yes.

3:51
All right.

3:51
Thank you very much again.

3:53
So there are three issues that I would like to address today in the current proposed LCD.

3:58
The first has to do with molecular diagnostic test frequency must be no more frequent than the OPTN center specific surveillance biopsy schedule.

4:08
The second issue is that molecular testing should not be performed in conjunction with endomyocardial biopsies.

4:14
And the third is that for a given patient encounter, only one molecular test for assessing allograph status may be performed.

4:22
So to start with the first issue and that has to do with the timing of molecular diagnostic testing only to correspond with the surveillance biopsy schedule.

4:31
I would say that molecular surveillance is critical for patient management and should not be limited to instances where surveillance biopsy would have been performed.

4:40
Specifically, molecular testing facilitates the precision medicine that has evaded cardiac transplant recipient management.

4:48
Because of the difficulties and impracticalities of biopsy surveillance, one of the holy grails in transplantation is to individualize or personalize immunosuppressive therapy, and to do so, we may want to perform more frequent rejection surveillance in younger patients who are at high risk of rejection, such as African American patients or Allo sensitized patients.

5:11
On the other hand, we may want to do more frequent surveillance in older patients.

5:15
We're at low risk of rejection and high risk of toxicities.

5:19
And then this may actually help us wean immunosuppression faster in patients who do not need it.

5:25
And This is why I believe that our surveillance should really be individualized to particular patient based on their clinical risk profile.

5:33
Dr.

5:33
Krish, sorry to interrupt.

5:35
Sorry to interrupt you.

5:36
We're seeing the title slide.

5:38
The slides are not progressing, if that was your intent.

5:44
You do not see me advancing my slides.

5:49
No, it's sort of stuck on the slide show.

5:51
And we see the title slides and then we see the small slides on the corner.

5:56
That's odd.

5:59
You're still seeing just my title slide.

6:02
Yes.

6:04
Huh.

6:04
I'm wondering.

6:05
Ohh, there we go.

6:06
OK now we have, now we have, now we're on.

6:08
We see slides.

6:09
Maybe I'll just do it in this view then if that works better.

6:12
Yeah, it's advancing now.

6:14
OK, good.

6:14
Sorry about that.

6:16
No problem.

6:16
So I also think that molecular testing is really crucial because it enables us to detect graft injury very early before we see graft damage on biopsies.

6:28
As you may know, by the time we see graft damage on biopsies, there's cell death.

6:33
And this is, this reflects the fact that immune activation and graft injury has probably been going on for at least days two weeks.

6:42
So the advantages of molecular testing is that it's a very sensitive marker for early graft injury and can detect very early immune activation with tests such as gene expression profiling or donor Dr.

6:54
cell free DNA.

6:56
And this is an abstract from last year's ATC meeting which showed that donor Dr.

7:00
cell free DNA levels start to rise about two months prior to rejection on biopsy.

7:06
So by using these very sensitive noninvasive assays, we can actually detect graft injury much earlier than we could on biopsy.

7:14
And so frequent surveillance could then enable us to titrate immunosuppression and hopefully augment maintenance therapy to prevent a fullblown rejection event from ultimately occurring and thereby personalize the care of our patients.

7:29
Now this slide shows that patients who have rejection but no hemodynamic compromise have much improved outcomes to patients with mild or severe hemodynamic compromise.

7:40
And so that's why it's important that we do early rejection surveillance so that we can detect rejection early before hemodynamic compromise occurs.

7:52
We also know that most centers only do biopsies up till 1 or maybe 2 years post transplant because these are invasive procedures that carry risk.

8:02
But unfortunately registry studies such as this one have shown that rejection may occur years post transplant, especially antibody mediated rejection.

8:12
And This is why it's really important to continue rejection surveillance beyond the usual biopsy schedule and non invasive surveillance offers us the opportunity to do so.

8:23
And so This is why the new is HLT guidelines which came out several months ago state that routine tests and clinic visits are crucial for this excessive heart transplant.

8:34
The importance of lifelong follow up by the transplant center is essential and the purpose of the follow up visits is to monitor for rejection and screen for adverse events.

8:44
And so the reassurance of negative surveillance in this context is actually very helpful because it allows us to back off to reduce immunosuppression over time and prevent these longterm toxicities of our therapies.

8:57
And I'd like to mention that the guidelines are not in the bibliography for the proposed LCD longterm biopsy surveillance is harmful.

9:07
As we all know, more biopsies cause tricuspid regurgitation, which can cause graft dysfunction and graft failure.

9:14
And also late biopsies often just yield scar tissue and are not helpful.

9:19
We also know that biopsies can be very inaccurate.

9:22
It's really quite a poor gold standard.

9:24
This study shows that pathologists disagree almost half of the time on whether acute rejection is even present on biopsy.

9:32
So biopsy is becoming less and less of a standard of care over time.

9:38
And finally, our patients are very far away.

9:40
At Stanford, for instance, we follow patients from all over California, Oregon, Nevada, Alaska and Hawaii.

9:48
And so it's quite impractical for patients to come into the Center for biopsy.

9:53
And this is really where the value of noninvasive surveillance lies.

9:57
It's so helpful in being able to do remote draws to assess for rejection.

10:02

So in summary, I think molecular testing is a suitable candidate to replace most surveillance biopsies and to allow surveillance testings and biopsies were not particularly were not typically performed.

10:15
An extended surveillance with molecular testing is very reasonable not only to detect late rejection, but also to enable clinicians to personalize immunosuppression and to wean it over time and prevent longterm adverse events.

10:31
So the second point I'd like to address is that molecular testing should not be performed in conjunction with biopsy.

10:36
We now know that molecular tests are more sensitive than biopsy and can detect graft injury even when the biopsy is negative.

10:44
And this is a figure from the D or registry showing patients who presented with graft dysfunction who had a negative biopsy but elevated donor Dr.

10:53
cell free DNA levels reflecting graft injury.

10:56
And these patients were then treated for rejection.

11:00
Cases such as antibody mediated rejection can be very difficult to diagnose.

11:05
Often the biopsies are negative and we look at adjunctive data such as donor specific antibodies, non HLA antibodies, graft function et cetera.

11:14
But really where non invasive surveillance can be very helpful is by doing assays such as self free DNA testing and gene expression testing to see whether it is graft injury.

11:25
And if there is we may go ahead and commit the patient to treatment.

11:30
And with a Mr.

11:31
this is at least a two week treatment course which can be highly toxic.

11:35

And so we really rely on these adjunctive tests to help us since the diagnosis and commit to this intensive form of therapy.

11:45
We also know that molecular testing can indicate the success of treatment of rejection.

11:51
These are two studies that showed patients with acute rejection had a dramatic decline in their donor Dr.

11:57
cell free DNA levels after treatment was started.

12:00
And what we typically do is transplant centers is we repeat a biopsy after two weeks to see if our rejection treatment was successful.

12:08
But we could actually perform a donor Dr.

12:11
cell free DNA assay at the time of rejection and then several days or a week later to see if the rejection treatment was successful and therefore avoid repeat visits and further biopsies.

12:23
And finally, I'd like to address the point that for a given patient encounter, only one molecular test for assessing allograft status may be performed.

12:32
This is a recent review article that we just published in Circulation discussing all the different noninvasive tests that are available or in development and their clinical utility.

12:42
Some of these assays detect immune activation, some detect graft injury, some detect cellular rejection, some detect antibody mediated rejection and we may one day have noninvasive tests to screen for Cav.

12:55
And I really think that these tests can be quite complementary and can provide data on different aspects of the immune response and different post transplant complications simultaneously.

13:07
And that's really where their value may lie.

13:09
And so I don't think that we should be limited to only performing one assay at a particular time.

13:15
So in summary, these are my requested considerations for changes to the draft proposed LCD.

13:22
The first point is that molecular diagnostic test frequency must be no more frequent than our center specific biopsy schedules.

13:30
And I would contend that molecular surveillance is critical for patient management and should not be limited to instances where surveillance biopsy would have been performed.

13:40
I gave several examples of how more frequent molecular testing can really help detect rejection earlier, can help wean immunosuppression and thereby really personalized immunosuppressive therapy for our patients.

13:53
The second point is that molecular testing should not be performed in conjunction with biopsy.

13:58
And I would contend that there are some cases where simultaneous biopsy molecular testing may improve the diagnosis in patients presenting with graft dysfunction and may help us monitor the efficacy of our treatment of acute rejection.

14:12
And the final point is that for a given patient encounter, only one molecular test for assessing graft status may be performed.

14:19
And as I just showed, I believe that multiple that molecular assays are complementary and can provide data on multiple aspects of the L immune response and graft injuries simultaneously and this is where their value will lie.

14:33
So with that, I'd like to end my presentation and I thank you very much for the opportunity to present today.

14:42
Thank you, Dr.

14:42
Kush.

14:43
Our next speaker is Dr.

14:44
Steven Potter, who is a professor of surgery and neurology and director of pancreas transplantation at the MedStar Georgetown Transplant Institute and the Georgetown University School of Medicine.

14:55
Dr.

14:55
Potter, you might share your presentation.

15:00
Thanks for having me.

15:01
Is my volume OK for you?

15:03
Yes, we can hear you.

15:10
I'm just looking to share my screen now.

15:16
The share button should be at the top right corner.

15:21
We can see my first slide now.

15:31
Yes, if you see just the first slide, okay, we see.

15:35
Yeah, the.

15:35
Yeah.

15:37
So thanks very much for the opportunity to present today on behalf of the American side of transplant surgeons.

15:44
I'll be commenting on proposed revisions to molecular testing for solid organ and allograph rejection disclosures.

15:52
Care, DX, Eurofans and the Terra have provided financial support to our society over the years.

16:00
So local coverage determination is the proper process in the appropriate venue for changes to coverage.

16:07
In March, ASTS requested delay of the revised building article in favor of a revised LCD process.

16:14
And we thank you for engaging in this LCD revision process with its attendant opportunity to provide public comment.

16:21
Proposed LCD revisions were issued in August and we're appreciative of your admission that a billing article is not the correct mechanism to introduce substantive or significant changes to an LCD.

16:33
The revised billing article, however, is still in effect and is at odds both with transparency and public process.

16:40
Our comments today regard the proposed LCD and the existing constraints to optimal patient care imposed by the billing article.

16:50
So the molecular diagnostic tests in question are an emerging standard of care and solid organ transplantation.

16:56
Some of the proposed LCD changes are inconsistent with the input provided by subject matter experts at the Clinical Advisory Committee or CAC meeting in November 2022.

17:07
Some of the points made at the CAC meeting, there is significant evidence of the clinical validity of these tests.

17:13
There is widespread acceptance for the utility in clinical decision making of these tests and the CAC support an expansion rather than limitation of Medicare coverage for these tests.

17:26
These molecular tests may provide the ability to improve long term patient and allograft survival, which is a strategic pillar of those of us in the transplant community that care for these patients.

17:36
The proposed changes to the LCD substantively change coverage, and the proposed coverage changes are not supported by evidence that's abundant in the peer reviewed literature.

17:49
So the proposed LCD would restrict the surveillance use of these tests to direct replacement of existing surveillance biopsy protocols.

17:58
Surveillance biopsies used to detect kidney subclinical rejection, But surveillance biopsies are only performed by a minority of centers.

18:05
Guidelines recommend treating kidney subclinical rejection, recognizing its association with e.g.

18:11
Fr decline, chronic allograft injury, and graft loss.

18:15
But the conundrum is that those same guidelines don't advocate for surveillance biopsy, leaving us in something of a quandary.

18:23
However, there's strong correlation between a covered molecular test and the diagnosis of kidney subclinical rejection, which gives us a potential valuable solution for our patients.

18:36
We heard an eloquent presentation about the issues specific to heart transplant recipients.

18:42
Heart transplant centers have dramatically reduced the frequency of surveillance biopsy by utilizing molecular testing and acknowledge the importance of rejection surveillance using these tests in their guidelines.

18:54
Molecular testing is not subject to interobserver variability or the sampling errors that are inherent in particularly cardiac biopsies and may have superior sensitivity and specificity to those biopsies.

19:07
The proposed LCD conflates to risk benefit calculations for a noninvasive blood test with an interventional procedure that has significant risks of patient harm and it carries with it significant healthcare expenditures.

19:20
Molecular testing allows surveillance testing when biopsies were not typically performed or planned due to its more favorable risk benefit ratio.

19:28
Transplant professional should retain the ability to determine the frequency of molecular surveillance testing in partnership with the patients under their care based on the immunologic and other risks faced by those particular patients.

19:45
The proposed LCD would restrict molecular testing based on timing relative to biopsy.

19:50
Levels of DONOR Dr.

19:51
self free DNA obtained concurrently with biopsies demonstrate that low grade cellular rejection can be diagnosed and that that diagnosis carries prognostic utility.

20:03
Improvement in DONOR Dr.

20:05
self free DNA after treating rejection is well documented in both kidney and heart transplant patients.

20:11
Therefore, a DONOR Dr.

20:12
self redunate level that's obtained at the same time as a biopsy can evaluate the adequacy of response and preclude the need for follow up biopsies to document successful treatment.

20:23
Information from concurrently obtained molecular and histologic testing can help clinicians make decisions about immunosuppression management, individualization of that immunosuppression, longterm prognostication, and need for or timing of repeat biopsies.

20:41
The proposed LCD would prohibit the concomitant use of multiple genetic gene expression profiling and selfre DNA tests.

20:51
The definitive diagnosis of disease frequently requires comprehensive multimodal laboratory investigation.

20:57
Multimodal assessment utilizing donor Dr.

20:59

Self free DNA and gene expression profiling in solid organ transplant recipients provides complementary information on 2 distinct biological processes.

21:08
Allograph injury information is provided by the donor Dr.

21:11
self free DNA, whereas recipient immune activation information is provided by gene expression profiling.

21:17
Paired testing demonstrates better diagnostic performance for the detection of active rejection in both kidney and heart transplant recipients rather than or or as opposed to those tests individually.

21:30
The existing LCD includes language recognizing that quote.

21:34
Combining both donor Dr.

21:36
Self free DNA and gene expression profiling may further improve graph rejection determination.

21:41
End Quote And furthermore states that quote these molecular tests have different strengths and weaknesses and can be leveraged for different populations.

21:49
End Quote.

21:51
We feel that the coverage criteria should allow providers a latitude to determine the appropriate tests for a given patient under their care.

22:01
In the big picture, it's really all about patients and patient care.

22:05
Prior to molecular testing for allograft injury and immune activation, we in the transplant community had been performing organ surveillance in much the same way for several decades.

22:15
The results obtained with legacy surveillance techniques including urine protein assessment, serum creatinine, urine volume and tissue biopsy were and continue to be suboptimal.

22:27
The failure to meaningfully improve longterm transplant survival despite massive improvements in

shortterm patient and allograft survival remains one of the critical failure points of the transplant endeavor to date and really is one of the sole areas where we've not seen massive improvement in outcomes over the last several decades.

22:46
Molecular diagnostic testing may help us unlock significant gains in longterm patient and allograft survival and already widely used emerging standards of care in the management of our patients.

22:57
We humbly and respectfully urge you to support the utilization of these innovative tools with demonstrated clinical utility in the complex and vulnerable patient populations that we care for.

23:08
Thank you so much for letting me present today.

23:13
Thank you, Dr.

23:14
Potter.

23:15
Our next speaker is Dr.

23:16
Robert Woodward, who is a Senior Vice President of Research and Development at CARE DX.

23:21
Dr.

23:21
Woodward, you make sure your presentation.

23:30
Thank you.

23:33
Thanks for the opportunity to present today at Care DX.

23:36
We are 100% committed to transplantation with over 20 years of innovation in transplant patient care.

23:43
Our first Medicare approval was in 2006 for gene expression profiling of the immune status in heart transplantation and we led the industry with the first approved coverage of donor Dr.

23:53
Self Free DNA to measure graft injury in kidney, heart and lung.

23:57
And finally, we've been the first to approve to have approved coverage and multimodal testing.

24:03
As the first two speakers have mentioned, there's significant need for these advanced molecular tests and transplantation, which is a lifesaving treatment, but it carries A lifelong risk of immune mediated rejection of the transplanted organ.

24:15
Rejection is currently diagnosed by histopathology from an invasive biopsy.

24:20
Surveillance by biopsy, however, is invasive and therefore undesired.

24:24
While surveillance through assessment of graft function is insufficient to identify rejection early enough, molecular tests have significantly reduced dependence on biopsies, improved diagnostic capability and enabled noninvasive detection of subclinical rejection that occurs before function is impacted.

24:46
These tests have proven so valuable that they have been quickly adopted.

24:50
Just those tests that are provided by Cardiacs are used in over 90% of heart centers, 75% of kidney centers and 65% of lung centers, the latter of which this the lung transplant is within two years of launch, there's been that significant adoption.

25:05
Many physicians consider these to be standard of care and in heart transplant where there are care guidelines that have been in place since these tests were launched that clinician societies include these tests in the guidelines.

25:16
As has been mentioned, the proposed revisions to the LCD introduced changes in language that we view as actual changes to coverage.

25:25
These changes were initially introduced in the associated billing article in March of this year, a concern that was noted by physician professional societies as has been mentioned.

25:34

And our first recommendation is that these changes be rescinded immediately until the full LCD process has been completed.

25:41
That is the comments today, the written comments due this week, and all of the evaluation that is ongoing until the LCD is finalized.

25:52
The proposed revised LCD changes coverage in three major ways.

25:56
First, it restricts surveillance use.

25:59
Second, it prohibits testing close to a biopsy, and 3rd it prohibits the use of multiple tests with unique contributions at the same encounter.

26:07
The LCD itself states that these revisions are simply for clarity of coverage and are not changes to policy.

26:13
However, a question that should be asked is whether new evidence has emerged to support disturbing the longstanding coverage of policy which has not.

26:21
The evidence that has emerged supports the established use of these tests, and this evidence has even increased in the past three years.

26:31
The first of these major changes that we will comment on is the restriction on surveillance use.

26:36
Since the first LCD that covered Alisher, which is our test for donor Dr.

26:40
cell free DNA, the Lcds have always provided a broad coverage for surveillance that is not tied to a biopsy.

26:47
In fact, on that first LCD, Iridian replied to a comment with an official statement that Alistair may be performed at a frequency established for other noninvasive tests four to six times in the first year, two to four times in subsequent years.

27:01
More recently, in the initial draft of the current foundational LCD included the language in lieu of

biopsy, but that was subsequently removed after public comment and Maldex and Iridium's response to those comments that they were not tying its used to the need for a biopsy.

27:18
The proposed LCD text now states that for surveillance use, the testing frequency must know must be no more frequent than the center's surveillance biopsy schedule.

27:27
The accompanying billing article states that surveillance testing is only compliant if the patient would otherwise receive a surveillance biopsy.

27:36
However, this change was not made based on the evidence, but despite the evidence that these tests have a demonstrated ability to identify subclinical rejection.

27:43
Early detection of rejection, that is before the rejection impacts function, allows for earlier therapy and can lead to improved outcomes.

27:52
As has been mentioned, the kidney guidelines, which hasn't have not been updated since these tests have become available, recommends treating subclinical rejection despite not recommending the invasive surveillance biopsy procedure.

28:05
As mentioned, the heart guidelines acknowledge the importance of surveillance.

28:08
With these tools in lungs, surveillance biopsies have the most significant complication rates, further limiting use for surveillance.

28:15
Despite the great need for lung transplant patients, limiting the use of molecular tests to biopsy frequency is flawed because of the risk profile of a noninvasive blood test is fundamentally different from an invasive procedure.

28:29
We recommend maintaining coverage for surveillance use, possibly even memorializing its use consistent with prior official comments.

28:37
The second major change is restriction of this is a restriction based on time of the biopsy.

28:43
There are no limits in the current LCD in this regard.

28:46

However, the proposed LCD states that these tests are not covered by Medicare if the patient has undergone a recent biopsy with a definitive diagnosis or has a planned upcoming biopsy.

28:57
The proposed billing article also states that the molecular test and the biopsy cannot be performed simultaneously.

29:05
Published evidence supports the use of these tests concurrent with biopsy for several reasons.

29:09
In kidneys, cell free DNA has been demonstrated to inform on outcomes.

29:13
In patientsists.

29:14
Biopsy diagnosed low grade T cell mediated rejection.

29:17
In both heart and kidney, there are publications demonstrating the ability to use cell free DNA to monitor treatment response.

29:25
This use requires comparison to the level of cell free DNA at the time of the biopsy confirmed rejection.

29:30
We recommend this new restriction be removed in favor of physician directed evidence based use of these tests alongside biopsy.

29:39
The third major change is the prohibition of multimodality, that is the use of the at the same visit of different tests that offer complementary information.

29:49
This is enabled in the current LCD.

29:51
However, the proposed LCD strikes the phrase unless the 2nd test meeting all of these criteria is reasonable and necessary as an adjunct to the first Test.

30:01
This leaves the sentence to end with the phrase only one test may be performed.

30:06

The use of two complementary tests has been validated in both heart and kidney and has evolved to the standard of care in heart transplantation and is specifically mentioned in the latest guidelines.

30:17
Paired testing offers better diagnostic performance.

30:19
For active rejection, we recommend the current language or similar be retained to enable physicians judgment to choose the appropriate test or tests for a given transplant recipient based on the evidence and on the need.

30:34
There have been four other changes we wish to mention.

30:36
First, added language regarding the frequency of kidney surveillance.

30:40
Biopsy fails to recognize the risk profile as discussed earlier, but also fails to recognize that surveillance protocols may be used by only a subset of physicians at a center or in only a subset of patients.

30:51
In fact, the source of this 18% as is mentioned in the proposed LCD also included the fact that at this was for the centers that did this in every patient.

31:02
But in a that 40% of centers did surveillance and at least a subset of patients and even that publication didn't survey the difference with it within a center by physician of individual physicians assigning a surveillance for one patient or another or even all of their patients.

31:20
Second, the added language about serological and laboratory markers in the summary of evidence section may be confused with the pretest definition.

31:27
So we recommend adding the actual definition of pretest that was put in the billing article, taking that and adding it to the LCD as there is a new section on definitions.

31:38
3rd The classification system for his pathology of biopsies is proposed to be limited to the most current classification system in the in the in the proposed revisions, due to the fact that the Banff classification is updated every two years.

31:52
This puts an undue burden on the evidence.

31:54
A large multicenter real world evidence study may be only slightly out of date two years later, but it would be essentially impossible or only with inordinate hardship to gather all of the pathology images from a large multicenter study just to remead them based on minor updates to the requirements.

32:10
More nuanced wording about impactful changes may better accomplish the goal in this unique situation where the field changes the definitions every two years.

32:19
And lastly, for similar concerns of consistency as mentioned in on the second one in the prior slide, we suggest updating the definition of for cause to match the language used for the pretest as was done in the second revision to the billing article this year.

32:35
In summary, the proposed LCD changes coverage in ways that limit physician judgment and negatively impact patient patient impact care for organ transplant recipients that require lifelong monitoring to achieve longterm graft survival.

32:50
Revision to the LCD is the correct process to introduce such changes, but this process is compromised by the earlier implementation of these same changes in a billing article, which did not go and does not go through public comment.

33:02
We recommend rescinding the billing article changes if this process is to proceed.

33:07
Ultimately, the longstanding coverage for these molecular tests should be maintained to allow physician judgment based on evidence and patient need for surveillance for use concurrent with biopsy and for multi modality use of complementary tests.

33:22
The data support these uses covered by the existing policy and no new data supports the proposed changes.

33:28
Thank you for the time and for the opportunity to to to present today.

33:32
The evidence referenced is all listed here in this slide and we will of course include the all the these references when we submit this information in the form of a comment letter later this week.

33:43
Thanks again.

33:45
Thank you, Doctor Woodward.

33:47
Our next speaker is Tiffany Archibald, who is the founder and executive director of Community Kidney Care.

33:55
Oh, Tiffany, I think you're on mute.

34:00
Hello, everyone.

34:01
Thank you so much for having me here to share my testimony journey.

34:05
My name is Tiffany Archibald.

34:07
I'm a kidney transplant recipient and my journey started over 20 years ago.

34:13
As an active athlete with the healthy lifestyle all my life, I never could imagine the health challenges that I would experience And where I am today.

34:23
After three kidney transplants and several failed biopsies, I'm speaking now to shed light on the invaluable role that noninvasive molecular diagnostic testing plays for post transplant surveillance and the overall health of transplant patients.

34:41
I believe that the access to this testing is a large part of the reason why I'm here today.

34:47
Strong, healthy and able to share my story.

34:52
So I play collegiate basketball and I also played a little bit overseas while undergoing a low risk procedure on my toe of having a corn removed.

35:04
My post surgical labs showed that I was in kidney failure and that I only had 26% functioning.

35:12
My only option was a transplant.

35:14
That's where my journey began in 2005.

35:18
My mother was able to be my kidney donor.

35:21
I was able to give a second chance at life, and that was the time that I was first exposed to the rally tea of a biopsy.

35:29
Biopsies are not just routine medical procedures.

35:33
They're also very traumatic for the patient and they are very risky.

35:38
After 8 1/2 years with my first transplant, I required another one in 2013.

35:45
My husband was a donor at the time, and that process actually moved very quickly.

35:51
I was fortunate enough at that point that I did not have to undergo dialysis while waiting for a kidney.

35:57
My life transplant patient changed forever, and then I had another traumatic biopsy.

36:07
I learned that there would be a better way moving forward to monitor my kidney for rejection.

36:13
Going into that biopsy, I'm going to be honest, I was incredibly scared and traumatized.

36:19
After my first difficult experience, I learned that unfortunately the biopsy did not successfully connect any pieces of the kidney, only the medulla, despite invasively prodding and moving through the kidneys during the procedure.

36:36
Admittedly, I was frustrated, scared, confused.

36:40
I do get emotional talking about it because I never could have imagined an option like that would be failed.

36:49
So I was given the opportunity to start the self free DNA test by Alice Shore after that unsuccessful biopsy.

36:59
You know, it amazes me that at a simple blood draw like a routine labs I was already doing anyway that this could monitor my kidney health successfully and potentially detect signs of rejection earlier.

37:11
I was fortunate that if I needed to, I have the resources and support necessary to inpatient medical care for surveillance and biopsies.

37:21
Not everyone has the luxury though, and the convenient of a blood test at home is a games changer for so many patients and giving them their best chance at preserving their transplant function and the ability to live a healthy life.

37:39
Fast forward Just five months ago, I received my third kidney transplant.

37:44
This was my first time on dialysis, among other health challenges that caused me to be hospitalized.

37:52
Now that I'm on the other side of that transplant, I continue to be grateful for the access to the noninvasive testing that monitors my transplant.

38:01
I couldn't imagine what it would be like to have restrictions on access to our shore test, not knowing if I'm being tested frequently enough.

38:09
Or would I have to shoulder the burden of the cost of that test?

38:13
I'm here sharing my story because I don't think it could be stated enough just how much uncertainty transplants patients have to endure.

38:22
As you've now heard from me, it's often times not just one transplant, 2 transplant and noun 3, even 4 if we are lucky enough to receive the precious gift of donation.

38:34
The advent of noninvasive testing is called a game changer, and as I see it, it was one of the most important ways that some of the uncertainty of the post transplant journey can be alleviated for patients.

38:49
It is essential for doctors and patients to be able to work collaboratively to set a care path that provides patients with access to personalized, noninvasive testing that works for them.

39:03
Any restrictions on access to these tests can only hinder much needed innovation in this space.

39:10
And they have the potential to put our transplant patients at risk for rejection.

39:15
The stakes are just too high for that risk.

39:20
Thank you for considering my comments today and thank you, Miss Archibald, for sharing your story.

39:27
Our next speaker is Bill Ryan, who is the President and CEO of Transplant Games of America.

39:37
I think you're on mute.

40:08
Hello.

40:09
Yes, we can hear you now.

40:10
Hear me now.

40:11
OK.

40:11
I'm sorry.

40:12
Again.

40:12
Good afternoon, everyone.

40:13
Thank you for giving me the opportunity to speak.

40:16
My name is Bill Ryan.

40:17
I'm President and CEO of the Transplant Light Foundation.

40:21
We're A501C3 nonprofit representing almost 10,000 transplant recipients and caregivers in the United States.

40:29
Along with producing the biennial Transplant Games of America.

40:33
We published the Transplant Nation magazine, the 68 page full-featured publication dedicated to the transplant community.

40:43
Our mission in supporting the transplant community has been directly affected by the recent decision to restrict access to non invasive post transplant testing which provides early diagnosis of plant transplanted organ failure.

40:58
I'm here today to provide commentary on behalf of thousands of recipients and their families who view these changes as a step backwards in the care and treatment of transplant patients nationwide.

41:12
Post transplant patient care takes a significant toll on recipients and their families.

41:18
Noninvasive testing provides a measure of relief, at the same time providing a critical diagnostic tool for medical teams.

41:27
These tests provide an early warning system that suggests treatment options for organ preservation before significant rejection can occur.

41:36
Without the capability of early analysis, there's a possibility that the organ may go into failure, resulting in either more intense treatment options or ultimately complete organ failure.

41:50
The development of noninvasive post transplant testing has been one of the most dramatic improvements for patient care in our community.

41:58

The decision to restrict or reduce coverage for noninvasive testing is the wrong message to send to companies who are seeking to design and implement new and innovative medical care for transplant patients.

42:13
The alternative to testing is the use of biopsies for analysis of organ damage.

42:18
Biopsies are an invasive option requiring A surgical procedure.

42:23
Aside from the invasive nature of the biopsy, the patient and caregivers require time off of work for the procedure and often endure an unnecessary burden of increased travel related costs and extended recovery time frames.

42:39
These challenges often come with loss of wages and increased travel costs.

42:45
These issues are exacerbated for economically disadvantaged patients and within our rural communities.

42:51
We are here today to advise you that our patient community needs these diagnostic tools in order to maximize the health benefits that were provided when they received the gift of a transplanted organ.

43:03
Our patients deserve better.

43:05
Thank you for listening.

43:10
Thank you, Mr.

43:11
Ryan.

43:12
Our next speaker is Doctor Brian Keller, who is the Medical Director of Lung Transplantation in the Division of Pulmonary and Critical Care Medicine as well as Assistant Professor of Medicine at Harvard Medical School.

43:27
Thank you and thank you for the opportunity to to talk with you today.

43:33

As mentioned, I'm the Medical Director of Lung Transplantation here at Massachusetts General Hospital and I wanted to talk a little bit just about how we utilize these tests in our lung transplant population, which can be a little bit different than how they're utilized.

43:48
And and in another organ transplant such as kidney transplant.

43:53
So in lung transplantation, not only do our patients run the risk of rejection of their allograft, but because of the exposure of the lungs to the environment, our patients are at also high risk for infection.

44:05
And these tests such as the cell free DNA tests are great tests to look for allograft injury, but they don't specifically delineate between infection and rejection.

44:16
That said, they're they're an important part of our armamentarium and monitoring the health of these allografts.

44:21
And I look at these tests along the lines of other tests that we use to monitor to the health of these allografts such as pulmonary function tests and other blood tests.

44:31
We also do invasive biopsies and there as mentioned previously, there are quite a, there's quite a bit of variation among programs and even among providers in the approach to the frequency of biopsies.

44:44
And I think where I see these tests really standing out is they provide us the opportunity in a noninvasive fashion to more closely monitor the health of the allograft and to pinpoint times when we need to do more invasive testing such as a biopsy.

44:59
I don't see these tests eliminating the need for biopsies, but I do see these tests helping us decide when to perform an invasive biopsy which are not without risk.

45:10
There are a couple of other scenarios that these non invasive tests such as cell free DNA come in handy.

45:16
Sometimes patients are too sick to safely undergo an invasive bronchoscopy and these tests can be utilized to tell us if there is actual damage happening to the allograft or if the allograft is functioning well.

45:28
And we just need to focus on other areas of the patient's overall condition.

45:33
And the next area that I think that these tests are are beneficial is in monitoring response to therapy.

45:40
For example, when patients develop a antibody mediated rejection that's requires a treatment over the course of about two weeks followed by serial treatments with other therapies over the following months.

45:55
We have experience using this test and we monitor these cell free DNA levels and we see that these levels are elevated in settings such as AMR.

46:04
We also know that these levels tend to decrease when AMR treatment is successful and therefore are a good marker of response to therapy.

46:13
And these uses definitely fall out of the range of what's been listed in the current LCD proposal.

46:21
And so I wanted to just highlight some of these nuances as regarding use of this test and lung transplant population and to highlight the importance of reimagining how these tests are approved for use and maintaining provider independence and deciding when is most appropriate time and way to utilize these tests for monitoring patients.

46:44
Thank you for your time.

46:47
Thank you, Doctor Keller.

46:48
Our next speaker is Laurinda Gray Davis, who is the President of the Transplant Recipients International Organization.

46:56
Hi, thank you for listening to transplant patients as evidence of this public comment session.

47:03
My name is Laurinda Gray Davis and I'm the President of Transplant Recipients International Organization of 501C3 that has been around since 1987.

47:14
I'm five years post liver transplant and heading towards a kidney transplant.

47:19
Due to the lack of innovation and post transplant medication, my concerns are for the members of TRIO regarding the proposed coverage changes for post transplant test and my outline to the Mold DX March 2023 billing article.

47:38
These require patients to exhibit symptoms of rejection before being eligible for these tests and poses a threat, a significant threat to the wellbeing of transplant patients and the advancement of medical innovation.

47:53
Transplant patients are already dealing with the complexities and challenges of organ transplantation and rely on rigorous post transplant care by using biopsies to monitor health.

48:06
A biopsy are burdensome, painful, expensive, and can come with complications and can occur often too late to successfully treat the issue.

48:18
Innovative test for surveillance play a crucial role in this process by providing early warning signs of rejection and other complications even before noticeable symptoms emerge.

48:29
These restrictions risk stifling medical innovation in the field of post transplant care.

48:34
Innovative tests have the potential to revolutionize how we monitor and manage transplant patients, making care more precise, efficient and ultimately improving patient outcomes.

48:47
If access to these tests are restricted, researchers and developers may be discouraged from investing in further advancements in this area, resulting in a standstill in progress.

48:59
I urge you to reconsider these proposed restrictions to noninvasive test and prioritize the wellbeing of transplant patients, the advancement of medical science.

49:10
It is essential that we maintain an environment that fosters innovation, supports early detection, and ensures the best possible care for transplant patients.

49:21

I respectfully request that you take into account the concerns raised by transplant patients, medical professionals and advocates like myself and making your final decision on this matter.

49:32
The health and wellbeing of transplant patients should remain in B at the forefront of any policy changes in this field.

49:40
I look forward to seeing a decision that prioritizes the needs of transplant patients and encourages continued innovation and post transplant care.

49:49
And thank you for your attention and for being here today.

49:55
Thank you.

49:55
Miss Gray Davis, our next speaker is Doctor Nicole Ali of NYU Langone.

50:00
Hell, Doctor Ali, are you here?

50:19
I see.

50:19
OK, we can come back to Doctor Ali right now.

50:23
We will move on to our next speaker, which is doctor near Oryel, who is the director of NYP Heart Failure, Heart Transplant and Mechanical Circulatory Support programs at Columbia University Irving Medical Center.

50:43
Dr.

50:43
Arielle, are you here?

50:46
If not, we can come back.

50:55
Oh, he's on OK.

50:58
Or Dr.

50:58
Ali's here.

50:59
Sorry, I just joined.

51:01
Had a little.

51:01
No worries.

51:02
No problem.

51:08
Would you like me to go?

51:09
Yes, Dr.

51:10
Ali.

51:10
No.

51:11
Or you have the floor.

51:26
Shall I go or or do you want someone else to go?

51:29
Oh, no, please.

51:30
Please go ahead.

51:31
OK.

51:31
Sorry.

51:31
Thank you.

51:32
Sorry, I'm in the in and out of clinic.

51:34
So thank you for the opportunity to make some comments at this meeting.

51:37
I really appreciate the opportunity.

51:39
So I'm Nicole Alley.

51:40
I'm the assistant professor of medicine at the NYU School of Medicine, and I'm the medical director of our Kidney and pancreas transplant program here.

51:49
I'm also one of the many PI's for the kidney allograft outcomes Allo Sure registry study and I sit as the lead nephrologist on the Living donor echo hub for the National Kidney Foundation as well as I'm on the Advisory Board of the National Kidney Registry.

52:05
I've been caring for kidney transplant patients for over 12 years and have relied on donor derive cell free DNA testing to monitor for allograft injury, assessed response to rejection modulate immunotherapy, trying to minimize toxicities and also trying to reduce the use of costly invasive kidney biopsies sometimes in very complex patients to even be able to access their allograft.

52:30
The proposed LDC will I think cause harm to my patients by limiting my ability to care for them safely and effectively.

52:38
In the current proposed form, the LDC undermines the role of the clinical decision making I feel and the expertise that we have in terms of determining the appropriate frequency and indications for testing which makes it much more challenging to detect evolving allograft injury and manage immunosuppression.

52:58
I wish that you know the algorithms were straightforward to follow, but a lot of times this is really comes down to the clinical scenarios for patients.

53:07
What we've done as clinicians, the risk of the patient and it's a challenging thing to make into like a straightforward algorithm.

53:16
Routinely I use our shore to assess risk and high risk recipients and especially also patients who live very far from the transplant center.

53:27
We have a large population of patients who seek care at here at NYU because of the expertise we have in highly sensitized patients, in anatomically very complicated patients and return alograph patients.

53:38
And so you know sometimes caring for patients who are not right here is complicated and you know the use of cell free DNA helps us really keep an eye on the allograft testing in these patients at some sort of regular cadence is really essential to identifying problems early and facilitating appropriate follow up.

53:57
We've all had the experience with patients where the elevated cell free DNA prompted us to do a kidney biopsy and that allowed us to detect rejection much earlier than would have been evident looking at creatinine.

54:11
But we've also had experiences where by lowering immunosuppression in order to say try to clear a CMV virus or clear BK virus, we see the the cell for DNA goes up.

54:22
We return the immunosuppression to baseline without even doing a biopsy and we see the alosure come back down.

54:29
And in those cases we we judge that to be a success that we have prevented A rejection.

54:35
Unfortunately by the time a rejection is evident in many patients with their creatinine being elevated, you are you have significant damage that has been done to those allografts and and fibrosis is left.

54:48
So trying to get ahead of this and really increase the lifespan of allografts is important.

54:54
We do use the cell free DNA testing more frequently than surveillance biopsies, a practice that you know we here at NYU have largely eliminated because of our experience using molecular diagnostics.

55:07
You know molecular diagnostics for detecting rejection and monitoring post transplant response whether it's tapering of immunosuppression or increasing back immunosuppression has been very, very useful.

55:18
You know the the error of patients who are unfortunately as we seem to be getting into another COVID wave based on the number of COVID patients I rounded on this weekend, it can be really detrimental for our transplant patients.

55:31
And while most other people are able to take Paxilovit and and do OK, our transplant patients can't.

55:37
And so we do have to lower immunosuppression in those patients and have some way to monitor them.

55:42
The proposed LCD appears to have been drafted without consideration or or inclusion of many of the recent publications that support the use of donor Dr.

55:52
cell for the in kidney in kidney transplantation and describe the limitations of surveillance biopsies.

56:01
Another notable admission is that the most recent Cadigo guidelines on the care of transplant recipients which specifically for those making a recommendation of the use of surveillance biopsies due to uncertainties regarding risk and benefit, but do encourage the treatment of subclinical rejection.

56:18
Subclinical rejection is really where molecular diagnostics are the only non invasive way to find subclinical rejection.

56:26
And I do really believe that if you're looking to lengthen allograft life, you have to avoid these subclinical rejections because that's the rejection that's happening in the background where you really don't have a way to find unless you happen to hit it at a surveillance biopsy point and how often can you really continue to biopsy patients.

56:49
But those subclinical rejections leave a significant impact on the allograft.

56:53
They scar the allograft and and they're not reversible when they go on for too long.

57:00
You know also you know there's some references that I would think you you should try to take a look at.

57:06
There are two major publications that highlight the superior correlation between donor derived cell free DNA and molecular Histology including the ability to identify early rejection that is often missed or mischaracterized by traditional pathology.

57:20
You know, I I think that I really don't believe that this policy was authored with the best interest of patients in mind nor the most scientific data that is most current, which does support the routine use of the molecular test.

57:35
I would ask that the Mold DX, the risk team revised the proposed LDC to integrate the prevailing scientific evidence supporting the use of these diagnostics.

57:45
And I'm happy to take any feedback you have.

57:48
Thank you for your time and thanks for the opportunity to express this on behalf of our patients.

57:54
Thank you, Dr.

57:54
Ali.

57:55
Our next speaker is Dr.

57:56
Neer Oryal, who is the Director of NYP Heart Failure, Heart Transplant and Mechanical Circulatory Support Programs at Columbia University Urban Medical Center.

58:09
I think you're on mute still.

58:13
Sorry about that.

58:13
Good afternoon, everybody, and thank you for having me here.

58:16
And thank you, Nicole, for speaking again.

58:18
We continue with New York a little bit.

58:20
So as you said my name is Neil, I'm running the heart failure program transplant in MCS at New York Presbyterian.

58:26
It's actually 2 transplant program, 11 is the Columbia transplant program and the other is while Cornell transplant program.

58:33
We are currently the biggest heart transplant program in the country which runs for more than 3000 patient year to date and the program is following 1000 patient close to 1000 patient.

58:45
When you follow so many patient actually the efficiency of the follow up and identification of problem problem is something that became in a key when you do 1021 hundred 200 transplant.

58:58
There is one way to address those.

59:01
However, when you start moving to a big program that is following a lot remote patient monitoring together with biological marker that you will include cell free DNA and gene expression and I will talk about the utilization of both of them in our program is becoming a key to the safety and efficacy of how to follow those patient.

59:23
One thing that we learned in the last, I think 4 years specifically after COVID is that it's a instrumental and actually foundation now to treat patient as much as we can outside of the hospital walls, specifically transplantation.

59:41
As you mentioned COVID started at 2020 but it didn't left it completely and we always dealing with a small wave of more viral infection coming on.

59:50
So to keep the patient outside of the hospital but still having the eyes on him and knowing what's going to happen to him on her is a key elements.

1:00:00

Another thing that is very unique in our program is that we have a lot of patient to transplant 2030 and something even 40 years ago.

1:00:08
We have patient that we follow up to actually that when transplant in the during the late 80s.

1:00:15
Again, there is still thing to follow up.

1:00:18
Transplant acute rejection may happen originally in the beginning of the transplant.

1:00:24
Career, but many years after we can still see chronic rejection that's happening and other element that will be a little bit more of a subtile and we need to be more sensitive to those changes as a result of it.

1:00:38
Our transfer protocol that include only four biopsy in the first year however continue to follow those patient on a long period of time for years with biological marker biomarker that includes self reading.

1:00:53
In that regard it is important for us to understand whether the patient is developing any kind of chronic Mr.

1:01:03
or Cav.

1:01:04
That something can also be a earlier sign with biological biomarker that will give us a clue that we need to continue and follow those patient.

1:01:14
As a result of it, we build our self protocol that will routinely follow those protocol on a regular basis with a cell free DNA in order to make sure that we are not missing it.

1:01:28
You know it's actually by coincidence only a couple of hours ago had to speak with one for our patient that was seven-year post transplant, 7 year post transplant and we start seeing a elevation in her cell free DNA.

1:01:42
We knew that she have a little bit of DSA but biopsy did not detect anything.

1:01:47
When we continue to follow those cells for DNA and we saw that they continue to rise.

1:01:52

We do gene actually evaluation of the biopsy with the molecular microscope and a chronic AMR was noticed and actually we are treating this patient right now spent to her.

1:02:05
The implication of it, despite having the traditional immunos to chemistry biopsy that is not positive, meaning that we are in a new era.

1:02:15
What is what was once to be the gold standard is not the gold standard anymore.

1:02:20
And it's not only with us, it's all over the country and we understand that a lot of the patient that we had the graft dysfunction from unknown cause, actually there was a cause.

1:02:29
We just did not have the eyes to see what it is.

1:02:34
Biomarker actually opened our eyes to this and together with the modern ability to understand gene expression with biomarker that's the MMDX in combined with cells with DNA we can identify patient that actually we would not have treated otherwise and maybe prevents them early deterioration of the graft.

1:02:57
So this is not ending in one year, not in two years rather than much later and identification of a chronic Mr.

1:03:06
or Cav is crucial and self free DNA can help us utilization that.

1:03:13
It's also very important to emphasize that whenever we see patient we need to understand that sometimes the utilization of the self free DNA is 1 tool.

1:03:25
We still take into account in some occasion the gene expression and the other map for example.

1:03:34
What I mean in that is when the other map score is very low like 26, we may feel that we are over immune suppress the patient something that other biomarker will not give us this understanding.

1:03:47
So this is not only to monitor for rejection, sometimes the tools give us an understanding about how to immunosuppress our patient and make sure that we're not over immune suppress our patient as we know that there's a key key problem in the deterioration of patient.

1:04:08

So if I want to emphasize those two points, first of all biological biomarker are key elements in the longevity of patient post transplant.

1:04:17
That's not only in the early period of the transplant rather than years to follow.

1:04:22
And it's give us an understanding not about only the monitoring to detect rejection rather than explanation about how immuno suppression, what immuno suppression we need to give.

1:04:33
Furthermore, I want to emphasize actually the utilization of both tests in a conjunction with the with the traditional biopsy.

1:04:43
I have to say that this is a a specific error of focus for me myself on personal level because someone to do transplant for so many years and seen I think 1000 patient post heart transplantation.

1:04:56
It's always was frustrated to me that I didn't understand what was going on all the time and why.

1:05:02
The biopsy that was always negative did not reveal what happened to this patient heart in the last few years.

1:05:10
I'm starting to learn and it's very similar to me other physician across the country that there is a reason that actually we need to have much more hands on the patient and not only follow the regular biopsy as the gold standard as I mentioned before and the imaging technique, the echo and the MRI that will be a little bit too late rather than follow other marker that will give us explanation earlier and actually going to redefine the way we we actually practice our transplantation.

1:05:45
Our protocol in the Europe Presbyterian changed dramatically in the last actually in the last 200 cases that we did per cause biopsy due to elevation of cell free DNA and those per cause biopsy actually was associated with MMDX 52% of the patient.

1:06:08
We changed the protocol and we treated them.

1:06:11
Those patient in the past would not been treated and this is suddenly take us to a new era something that we did lately is really analyzing what happened to those cases.

1:06:24
Cell free DNA is elevated by the biopsy is negative and we learn again from our cohort and we have a

big court of close to a 700 patient in the cell free DNA that we following right now and we've close to 4000 cell free DNA samples.

1:06:44
We identified that those patient have worse outcome if they are selfredinate positive biopsy negative what in the past would probably just been something that we will ignore.

1:06:56
So I do think we're in a new era few years from now probably we'll stop biopsying all those patient.

1:07:03
We need also to remember the risk associated with biopsy as someone that every Tuesday performing probably 6 to 8 biopsy still because we have so many patient that sometimes we need percos biopsy or we have fresh patient that we just transplanted.

1:07:20
I have to say that it's maybe became a routine to me but I also remember and every time it's will this is very humbling professional.

1:07:30
So you know why that there is a patient that it can take a risk because there is a patient that actually sometimes there is a lot of scar tissue specifically the patient that are many years out and there is going to be also the patient that eventually traumatized by those event.

1:07:47
The new era of medicine is going to take us to a new direction, a direction that will be much less invasive, a direction that will be much more personalized medicine with actually protocol that will identify the early signed in adjustment of immunosuppression based on those early signs.

1:08:03
Reduction in immunosuppression in one group of patient that we don't see a risk that the gene expression tell us you can go down one.

1:08:11
On the other hand it will tell us which patient we need to do some more deep diving and change in immune suppression even if the regular will be negative.

1:08:23
Again I will emphasize you know to be in a in a time of change is sometimes scary.

1:08:29
We did heart biopsy since the first time we biopsy heart runs been started in 1967 at Columbia.

1:08:37
We started doing biopsy in 1977, only 10 years later and as I said more than 3000 patient in our transplant program and it's part of our routine.

1:08:46
But thing change and we see it across everything in life right now and this is one of the change that the tar transplant patient actually should embrace and this is given them a better quality of life and a better chance for longer longevity that actually probably will help us both reduce the damage from rejection and reduce the damage from immunosuppression over immunosuppression that we give.

1:09:16
I would be happy to answer any question that you have.

1:09:21
Thank you Doctor Ariel.

1:09:23
Our next speaker is Paul Conway, who is the Chair of Policy and Global Affairs at the American Association of Kidney Patients.

1:09:41
Good afternoon.

1:09:42
Good afternoon.

1:09:54
Thank you very much.

1:09:54
Set to go.

1:09:58
Yes, go ahead.

1:09:59
OK, Thank you very much.

1:10:01
On behalf of the American Association of Kidney Patients, it's a pleasure to be here today and I'd like to provide you with comments and candid feedback on the dust up regarding the actions of your organization and CMSI appear before you as the Chair of Policy and Global Affairs for the American Association of Kidney Patients and a former President.

1:10:23
We are the largest kidney patient organization in the United States and we've been proudly independent since 1969.

1:10:30

I also appear before you as a kidney patient of 46 years, 26 years out on a kidney transplant after three years of dialysis.

1:10:38
Since my kidney transplant, I've taken over 160,000 pills for immunosuppression.

1:10:44
And so I know this issue rather well and the challenges that come to my medical professional teams when it comes to monitoring my health and those of my patient colleagues around the United States.

1:10:54
Over the past several months, we've been highly involved in this issue, raising it to the attention of appointed leaders and elected leaders and the media in the US.

1:11:04
And the reason why we have done that is because the actions that were taken stand in such stark contrast to American consensus bipartisan policy regarding transplantation and better kidney health.

1:11:20
And the reason why I put this out to you, quite frankly, is because I've had the honor to serve under 4U S presidents and four governors here in the state of Virginia.

1:11:28
I understand what it means to manage healthcare costs from a government perspective and some of the blunt instruments that can be brought to bear to do cost control.

1:11:37
So some of those are just simply not patient centered and they're not intuitive.

1:11:41
And on this particular measure, it is such a miss for where we are in the United States right now.

1:11:48
On kidney health.

1:11:49
I want you just to consider a few points of the past decade.

1:11:53
In 2013, we were able to achieve policy in the United States Congress that allowed the first HIV to HIV positive transplants.

1:12:02
long-awaited goal and aspiration for the HIV community and all patient advocates.

1:12:08

In 2016, the White House held the first summit on Oregon Transplantation and a AKP was a proud partner in that effort.

1:12:17
With the administration and with all the related kidney organizations in the space in 2018, we work closely with the US Department of Labor to create greater, better protections for living donors to encourage more living organ donation in the United States.

1:12:33
And we're happy to see that came through.

1:12:36
In 2019, we worked very closely with the Department of Health and Human Services to advance the American Kidney Health Executive Order, and that was a bipartisan executive order that stands to this day that prioritizes kidney transplantation as the best therapy for those who have kidney failure.

1:12:54
In 2020, we worked with the US Congress and the White House to make certain that immunosuppressive drugs, which had been covered for only the 1st 36 months, were extended to lifetime coverage for patients in the event that they had interruptions to their insurance.

1:13:10
And this year, as we have for the past several years, we are fighting right now on Capitol Hill to extend greater protections for living organ donations.

1:13:18
And our organization has loan has sent thousands of letters to Capitol Hill, Republicans, Democrats, Senate House, encouraging greater protections for living organ donors.

1:13:29
Why?

1:13:29
Because it is the policy of the United States government to increase organ transplantation in the United States at a couple of levels.

1:13:39
One, you have better outcomes when you have an organ transplant, especially a kidney transplant, then living life on dialysis.

1:13:46
Right now the mortality rate on dialysis is 50% at five years.

1:13:50
Think about that.

1:13:51
The cost of dialysis is over $30 billion a year.

1:13:56
Think about that.

1:13:57
What's not included in that figure is the disability payments that the US taxpayer pays for.

1:14:03
Because when you're on incenter dialysis, for the most part you're disabled.

1:14:08
And so across that spectrum of time in the past ten years, the other things that patient advocates and medical professionals, including transplant surgeons have fought for are greater innovations in making certain that those who have their transplants and patients who act responsibly can keep them longer.

1:14:25
This is very important because right now the clinical endpoints for determining the efficacy of transplant medicines are 20 and 40 years old.

1:14:34
The FDA has failed to approve a new coprimary clinical endpoint for transplant drugs that checks and sees and tries to determine longterm efficacy and the reduction of side effects, including those side effects of transplant drugs, which are nephrotoxicity.

1:14:51
So when you put this Stew together and you look at it as a patient and trying to advocate for patientcentered medicine, all the horses are going in the right direction for transplant policy in the United States.

1:15:02
And then up pop something like this from your organization, which to be honest with you is you should call it what it is.

1:15:09
It's not a clarification for coverage.

1:15:11
This is a blunt instrument of cost control.

1:15:14
It's what our organization calls government determinants of health.

1:15:18

Now while that sound might might sound kind of harsh, it does point to the factor that the government is making decisions here through a contractor that directly impact patient outcomes.

1:15:30
If you cannot celebrate the innovation that has come from molecular diagnostic testing and understand what that means to patients in terms of avoidance of biopsy and the many complications that can come from that, you simply do not understand this issue.

1:15:45
It is simply not an issue of cost and utilization.

1:15:48
You're talking about outcomes of people who have been lucky enough and fortunate enough to get a transplant.

1:15:55
And you're ultimately talking about how you value those who have offered an organ to save a life.

1:16:02
If you're not willing to stand up and say that the flexibility needed to surveil those patients to make sure they stay healthy and to make certain that those who have organ transplants can continue to work for those who have returned to work and provide for their families and understand the central role that diagnostics play in that and how that is a tool that we trust our surgeons and doctors to use wisely, then you just simply don't understand this issue and you really do not understand the progress that has been made in American Kidney Health.

1:16:35
I'd like to one add one other quick point here, which is this.

1:16:39
We understand you're in a difficult position because you're a contractor to CMS.

1:16:45
Ultimately, CMS bears responsibility for this, but to be perfectly clear to everyone who's listening, you have heard that there's not enough evidence.

1:16:53
You have heard this is contrary to medical expertise in this field.

1:16:59
But this is the most important thing.

1:17:01
The onus should not rest on patients and patient advocates and transplant recipients to move to reverse this policy.

1:17:08

The onus rest with CMS and those seated in the room who made this decision to do the right thing, be patient centered and wise up.

1:17:17
Thank you very much.

1:17:21
Thank you.

1:17:22
Mr.

1:17:22
Conway, our next speaker is let's see it's is Dr.

1:17:28
Narav, why Rival of heart failure transplant cardiology.

1:17:33
Dr.

1:17:33
Rival, thank you.

1:17:36
I think everyone can see and hear me.

1:17:38
Is that correct?

1:17:38
Yes.

1:17:41
I'm in Orlando, FL.

1:17:42
I'm a heart failure heart transplant cardiologist and I want to just expand on on even what Doctor Ariel said earlier.

1:17:52
And so somewhat I'll limit my comments because I think you've heard some of these comments already from him.

1:17:58

But you know a biopsy use in general has been declining with the use of gene expression profiling and donor Dr.

1:18:06
cell free DNA.

1:18:06
And that's a good thing because the number one complaint of patients post heart transplant is, is the end of my cardio biopsy.

1:18:14
It's invasive et cetera.

1:18:15
But in in, in the past as near pointed out, that's all we had in an imperfect tool.

1:18:23
We've seen the advent of problems and he alluded to this already with TREC husperd valve problems where you actually damage the heart that you work so hard to put into the patient because of these biopsies as well.

1:18:34
And sometimes they even require, you know, repeat surgeries to to fix the valve, et cetera.

1:18:41
End of my cardio biopsy is really practical if you are living close to a center.

1:18:46
But you know some of the centers including hours in Orlando, FL, we have patients coming from right here in town 0 hours to six hours away and that you know, we have to factor in travel time, fuel costs, lodging, wages lost, etc.

1:19:02
It's an imperfect gold standard, as I said, but we have to have something to really help us to understand what's happening from a rejection perspective that has high sensitivity and specificity.

1:19:14
So biopsy schedules in different centers are highly variable, certainly zero to two years, but even beyond two years, there's really not much standardized in that way at all.

1:19:25
So if you try to push towards a standardization towards a biopsy schedule, I think that's that's relatively difficult to do.

1:19:34
You really can't biopsy these patients forever for reasons that I mentioned.

1:19:38
It's certainly not a patient satisfier and also damage to the the heart as well as other untoward events that might happen during during biopsies.

1:19:46
But it is important to surveil these patients especially late, greater than two years I'd say.

1:19:53
And and really we're looking for things like late rejection that might be because of non adherence.

1:19:57
There's a certain complacency sometimes that comes into play with these patients and they kind of fall off taking their medications.

1:20:04
Correct way and if you catch these things early this is helpful to prevent graft damage that becomes really problematic later.

1:20:12
Certainly what I'll give you an example, we've seen antibody mediated rejection, a formal rejection and really the only way to to detect this is beyond two years that we we've done in our in our center is really look at gene expression profiling and and also self rate DNA and biopsy as well.

1:20:34
So using these two complementary is is helpful because really the only way to make that diagnosis is to see what's happening by histopathology in in in that's typical doctor Ariel mentioned molecular microscope another another sort of biomarker tape test that is that is being used as well.

1:20:58
But the point is, is that we really need biopsy and molecular diagnostic here in this situation.

1:21:05
This is the only way to really formulate the plan to treat that patient.

1:21:10
Otherwise you may treat improperly, treat the patient, maybe treat for cellular rejection which would potentially cause the patient to be over immunosuppression over immunosuppression on one hand, but also not address the underlying cause of the the antibody immediate rejection.

1:21:25
Now if somebody does have antibody immediate rejection as I've given this example, if we have an idea of what the suffery DNA is as an example or what the, what the diagnostics results are.

1:21:38
As the patient recovers, we may be less, less likely to do a follow up biopsy.

1:21:46
Because as you see those levels come back down towards towards normal or a baseline or you know certainly down from where they were and they were in in an acute projection circumstance.

1:21:57
We may not want to you know biopsy the patient for all the reasons they mentioned at the beginning of this one area that we've been using in our center is really for the older than 65 population.

1:22:10
And you know that gets a little bit strange because I think you know as I start to get a little older that old you know area becomes grayer.

1:22:18
But you know certainly we've had patients above the age of 70 in our program transplanted well selected, well selected patients in that population service 65 or 70 or older, they can do well and well selected situation.

1:22:34
Well we know this population is uniquely susceptible to the side effects of immuno suppression.

1:22:39
The former speaker was talking about metro toxicity that's toxicity of these medications to the kidneys and and that's really a a real thing.

1:22:46
And so a lot of times we need to, we need to really personalize the situation for these for this special population and by using molecular diagnostics we've been able to reduce immunosuppression you know sparing kidney function and and other end organ function of these patients.

1:23:04
And we find that to be very helpful in our, in our situation.

1:23:08
Another kind of interesting thing where you use the two different molecular diagnostics together, the gene expression profiling and the and the cell free DNA donor.

1:23:19
Dr.

1:23:19
cell free DNA we have circumstances in which we have a high gene expression profiling or sorry yeah high effects rate gain special profiling but actually a low cell free DNA and that sometimes indicates to us that maybe this is not necessarily rejection that we should be looking for other causes for this and CMV disease or CMD reactivation, it's a virus that patients that are immunosuppression can can can reactivate or obtain and we actually treat that, we look for that rather than rather than than biopsying the patient and that helps us and it helps save the patient from a invasive procedure as well.

1:24:03
So you know certainly if you look at the gene expression profiling and the donor Drysol free DNA tests together as a as a unit they perform Better Together than they do individually.

1:24:19
So it it it's, it's ideal to use it together and you know we have nice peer reviewed literature that that supports this now and clinically centers are are using it in this fashion and we're finding good utility as I point out in closing I I really want to you know disagree with the limits on concomitant testing.

1:24:39
I've given some good examples of using biopsy and the the molecular diagnostics together and then also where we might use two different molecular diagnostics together themselves.

1:24:51
And I think that that you know these are good examples.

1:24:55
We really don't get paid more to to do molecular diagnostics and we're really taught to only use testing if it's going to change our management.

1:25:05
Dr.

1:25:06
Uriel mentioned this also previously.

1:25:08
The extra data, if it's extra data, this is not something that I necessarily want If I'm gonna, if I'm gonna get data, I need to do something with that data and it does change protocols.

1:25:17
So how we're gonna treat the patient or treating regimens as as Dr.

1:25:21
Uriel mentioned as well.

1:25:24
So you know, I think you know we are asked to a lot, a lot of data coming in about individual patients.

1:25:29
And frankly if I don't need that data, I don't want it because my coordinators are are you know, already kind of you know, running a tight ship in terms of getting data and these patients taken care of.

1:25:40

Certainly you know things coming to my attention, I don't need more noise, I need signal and and I believe that this is really signal.

1:25:48
You know we also tend to look at direct costs in all our programs that we don't want to be the most expensive place to do.

1:25:55
You know heart transplants, you know no matter the payer whether it's Medicare or or a private payer, you know we also want to look at quality.

1:26:04
We obviously have quality metrics that we must meet through OPTN and you knows as well and you know this quality over cost evaluation that we do.

1:26:15
You know quality over cost equals value.

1:26:17
And this is something that that is kind of really brought into what we do on a day by day basis.

1:26:23
I mean keeping this in mind, we really should be our decision to use two molecular diagnostic tests together or molecular diagnostic testing in tandem with end of myocardial biopsy.

1:26:35
I think to do anything else is probably somewhat disingenuous and I think there has to be some understanding that in our, in our field that we would deploy these logically and and the patients you know will be see the benefit of overall less endobiocardial biopsies.

1:26:58
Dr.

1:26:59
Riel mentioned earlier, maybe it'll go away completely, you know, not potentially now, but maybe that will be.

1:27:04
But the point is, is that we are moving in that direction and we want to be cost conscious as well.

1:27:10
But I think artificially limiting this becomes problematic from you know, the individual patient perspective.

1:27:18
Thank you.

1:27:18
And if anyone has any questions, I'd love to entertain them and I'm looking forward to providing some written commentary as well to further embellish this.

1:27:29
Thank you, Dr.

1:27:30
Rabal.

1:27:31
Our next speaker is doctor because Darnadarka, who is the Vice Chair for Clinical Investigation and the Department of Pediatrics, as well as professor in Chief of the Division of Pediatric Nephrology, Hypertension and Ephrasis at the Washington University School of Medicine and Saint Louis Children's Hospital.

1:27:51
Can you hear me OK?

1:27:52
Yes, we can.

1:27:53
I am at a meeting in Baltimore for another study, so I apologize if there's some background in these.

1:28:00
I am also the Medical Director of Pediatric Kidney Transplantation at Saint Paul's Children's Hospital.

1:28:06
And so I thank you for the opportunity to speak on behalf of children.

1:28:11
While this population for children is a small proportion of the overall transplant recipients, the needed longevity of these transplants means the impact of good biomarkers of early injuries even higher for us.

1:28:23
You already heard from one of the earlier speakers about her through kidney transplant.

1:28:28
This is a reality for most of the children that we have subjected to a kidney transplant.

1:28:38
They know that they're they're sick in their in their life treatment.

1:28:44

Our pediatric kidney transplant has two decades for his experience from in subsequent other studies looking at molecules such as indolone dioxides, 2 feed abstinence and CD14 cell Atpscs, and then more modern donor drug selfie DNA and blood and urinary gene expression kinds.

1:29:05
What I'd like to point out is that in children, the serum creatinine is even less sensitive than in adults.

1:29:12
We transplant adult kidneys into our children to reduce the vascular thrombosis risk from small kidneys and small blood vessels of being attached to small recipients with also small blood vessels.

1:29:23
The larger room was very that use children therefore in their adult kidney means that the serum preactin may remain very low and will not budge even with significant injury within the kidney transplant tissue.

1:29:35
Plus as children grow, these serum creatinine rises and we do not know if this is normal Physiology.

1:29:41
Whereas this guaranteer of the kidney transplant, we could not judge that by and measured iothalamic clearance.

1:29:51
GFR studies or biopsies are both invasive and time consuming.

1:30:02
Most of the leading pediatric kidney transplant centers, including the ones for children, anesthesia another night statement.

1:30:10
Some of these kidneys are intraparatementally placed and those are harder to biopsy.

1:30:15
So overall there is some greater risk and considerable extra cost.

1:30:19
With fewer pediatric organ transplant centers than are available for adults, families have to travel long distances for biopsies.

1:30:27
We published last year in the clinical Journal of the American Society of Nephrology of CJSON IN2022A comprehensive Longitudinal Assessment of donor Dr.

1:30:35
self feeding children.

1:30:37
The Area Under the curve or UC for a food projection was 0.82, the most identical to that seen in adults.

1:30:44
In the same publication we also saw like others that we don't drive self Ed and everything is up with BK virus replication.

1:30:52
In fact that even at an early stage of urinary BK virus replication when most other studies are suggesting that later blood replication is the point at which tissue damage occurs behind the kidney trace, we also saw that the DNA dry selfie DNA level drops as the antivirus replication.

1:31:09
In the 33 results at the 2023 American Transplant Congress which was earlier this summer, we reported our single center results with a combination of blood donor dry cell free DNA and a blood gene expression panel.

1:31:23
The combined area under the curve using principle performer analysis was incredibly high at 0.96.

1:31:29
This was in part due to the performance of the blood gene expression panel to associate to acute cellular rejection as also shown by others and which you heard about earlier today.

1:31:39
Within the first year most of our rejection episodes tend to be cellular and tight.

1:31:43
And after the first year antibody meter rejection, we also saw a high area into the target that is sending the other gene expression panel that the C top in the first study that previously validated in the fashion.

1:31:56
The negative predictive value of these tests is very our prospective 3 center appeal for trial of donor Dr.

1:32:05
selfie DNA in the gene expression panel to look for allograft injury in surveillance biopsy will finish its last follow up visit this month and our data analysis will be in this October.

1:32:17
In addition, in collaboration with Doctor David Bursko at Harvard, we have a four center paper and review that was presented by Doctor Michael Seyfert in the $2020.00.

1:32:26

And I can transplant Congress as a planner that's to in this study looked at a urinary combination panel of chemo fine receptor receptor markers that also had a very high and negative predictive value to rule out allograft injury.

1:32:41
So to sum up, we believe that a combination panel of different molecular tests that can associate to a high negative predictive value can avoid surveillance biopsies in children, which would be a desirable for us.

1:32:55
And we're getting reduced cost to the BSA overall healthcare system.

1:32:59
Thank you.

1:33:01
Thank you.

1:33:01
Dr.

1:33:02
Donna Darka.

1:33:03
Our next speaker is Alexandra Harrison Flaxman.

1:33:09
Good afternoon and thank you for allowing me the time to speak today.

1:33:14
My name is Alexandra Harrison Flaxman and I am here not just to share my own voice, but on behalf of the entire transplant patient community and particularly the voices of those patients who do not have the opportunity to be here today.

1:33:27
As a two time kidney transplant recipient and patient advocate for over 2 decades, I believe that the patient voice is powerful and should be present and heard in every room where decisions are being made that could impact patient outcomes and access to care.

1:33:41
I was diagnosed with water syndrome before birth, went through many years of reconstruction surgery including having one of my native kidneys removed, went on dialysis for the first time at only 8 years old, and received my first kidney transplant at barely 11.

1:33:55

Unfortunately, at 18 I lost my first transplant and went back on in center hemodialysis for almost nine years.

1:34:02
In May of 2013, at 27 years old, I finally received my second gift of life, and it is because of access to noninvasive testing that I am in good enough health to be here sharing with you today.

1:34:15
As many of you already know, the path to transplant is no easy journey, and for some patients, it's a journey that they won't even have the opportunity to start.

1:34:22
With over 100,000 people currently waiting on the wait list for an organ transplant in the US today, almost 90 thousand of those are specifically waiting for a kidney.

1:34:32
Sadly, 17 people die each day still waiting for their gift of life and a new person is added to the wait list every 10 minutes.

1:34:39
With the national organ shortage crisis at an all time high, now more than ever for those of us lucky enough to have a transplant, we want to have access to innovations that would allow us to keep our new kidney, heart or lungs healthy for as long as possible.

1:34:55
An innovation that not only can detect if there is a possible issue, but can detect it sooner than standard post transplant testing, allowing for earlier intervention and treatment and potentially better outcomes.

1:35:07
Also providing A noninvasive option to alternative invasive biopsy.

1:35:13
I have been fortunate enough to receive the gift of life not once but twice.

1:35:18
Receiving a transplant is precious and we as patients want to do everything within our power to ensure that that gift is cherished and well taken care of.

1:35:27
In February of 2020, right before the start of the COVID-19 pandemic, I had my first experience with a noninvasive blood test.

1:35:34
I just moved back to my home transplant center and was reestablishing care, and while the rest of my standard labs like like serum creatinine were within normal range for me, due to not having been under their care for some time, they wanted to perform a biopsy.

1:35:48
This terrified me because of my previous issues with biopsies.

1:35:53
When I had a biopsy done when I was younger, they accidentally nicked an artery, causing me to bleed uncontrollably for almost 3 days.

1:36:00
My parents were told I was losing too much blood and it needed a transfusion while hospital staff rotated, holding bricks wrapped in towels on my abdomen trying to stop the bleeding.

1:36:11
Since then, the thought of biopsies gives me anxiety and PTSD to the point that I must be fully sedated in order to have one.

1:36:18
At that time that my team wanted to do another biopsy, I was aware of the fact that there was a noninvasive option that we could try.

1:36:25
I advocated for this and my team ordered an aloe shirt to get a full picture of the health of my kidney.

1:36:31
A few days later, I would get a call from my coordinator letting me know that my Alasher score had come back at 2.7, signaling that I was in fact experiencing some sort of injury.

1:36:41
More testing would later confirm antibody mediate rejection.

1:36:45
Mind you, the rest of my labs were still within range for me.

1:36:49
My team quickly went into action, putting together a treatment plan, starting me on multiple infusion therapies to help stabilize the A/B Mr.

1:36:57
Three months later Ala sure was performed again, showing it had come down to 2.32 months later my creatinine would finally start to reflect that something was wrong.

1:37:06
Now this might not seem like a significant amount of time to you, but as a two time kidney transplant recipient who lost her first kidney at 7 years and 10 months, this was my greatest fear to lose my kidney around the same timeline and I was months from celebrating my seven-year anniversary with this current transplant.

1:37:24
After nine months of infusion therapy and immunosuppressant changes, my ulcer would come down to .6.

1:37:30
While the damage had already been done and I had entered into rejection because of my team having the opportunity to act quickly, they were able to stabilize me the last three years, keeping me off dialysis and working towards a preemptive living donor transplant.

1:37:45
I like to use the analogy of a house on fire, aloshur being the smoke alarm saying hey something is wrong but it's not too late to try and fix it, and even though the damage could not be reversed because of the aloshur, I only lost a room, not the whole house because of aloshur.

1:38:00
I celebrated 10 years on May 18th of this year.

1:38:03
While I am now on the road to my third transplant, I could be in much worse shape than I am now.

1:38:09
Only last week I found out that my husband has been approved and is moving forward as my nondirect living donor, and I want to be sure that his donation, which will lead to me getting my new kidney, is not done in vain.

1:38:20
I'm already fearful of what the future may bring.

1:38:23
Whether I have access to noninvasive testing shouldn't have to be a part of that.

1:38:28
I share my story with you today to demonstrate how much we as recipients go through to protect our gift of life, the gift that was given so selflessly and deserves to be honored.

1:38:37
Transplant patients need and deserve access to innovation in a space that has seen so little over the last several decades.

1:38:45
It is important that transplant patients and their care teams be able to make informed decisions about their care without the worry of coverage.

1:38:52
What is best for a patient and their transplant is a decision that should be made between the patient and their care team.

1:38:59
Every transplant patient is unique and deserves individualized care and treatment.

1:39:03
Restricting access to noninvasive testing will be detrimental to the transplant community, not only impacting patients and their transplants, but also the living donors and donors, families who have given the gift of life.

1:39:15
This could also stifle future advancements that could be coming down the pipeline, limiting future innovation for our community.

1:39:22
I hope that you will take all the remarks you've heard today into consideration.

1:39:27
Thank you for your time.

1:39:29
Thank you, Miss Harrison Fussman, for sharing your story.

1:39:32
Our next speaker is Samuel Curtain.

1:39:48
And if Samuel Curtain is not ready and we can move on to Edward Garcia.

1:39:54
I'm ready.

1:39:55
Oh, we can.

1:39:55
OK, there you are.

1:39:57
And my name is Samuel Curtain.

1:39:59
I live at Lake Anna near Mineral, VA.

1:40:05
I was diagnosed with idiopathic pulmonary fibrosis on January 31st, 2017.

1:40:12
IPFA chronic progressive lung disease for which there is no cure there.

1:40:18
At the time and even today, there were two approved therapies which potentially slow the progression of the disease.

1:40:25
Otherwise there are two possible outcomes.

1:40:28
First, that is to be eligible for and receive a lung transplant.

1:40:33
The 2nd outcome, death is less desirable.

1:40:37
On July 10th of 2021, I received a bilateral lung transplant.

1:40:42
A lung transplant is not a cure, it is a commitment to a lifetime of medical surveillance.

1:40:50
Shortly following my transplant, my care team began the required surveillance to look for signs of rejection using a non invasive blood test.

1:40:59
In my case, it specifically was Care Dx's Allosure Lung product.

1:41:04
I was among the first lung transplant patients to be monitored using Allosure Lung for the first year following my transplant.

1:41:12
These tests were monthly and beginning in the second year those blood labs were drawn on a quarterly basis.

1:41:19
The introduction of molecular diagnostics for post transplant surveillance provides my care team and me as the patient a noninvasive method to monitor the health of my transplant.

1:41:32
A biopsy of my lung is an invasive assault on the very lungs, which provide me the opportunity to extend my life during the last two years.

1:41:44

A noninvasive blood test provides my care team with the opportunity to see any early signs of rejection of my donor lungs.

1:41:55
Each post transplant patient experience is unique and mine is not without exacerbations.

1:42:02
For ME3 separate exacerbations have benefited from this noninvasive blood test.

1:42:09
In the fall of 22, I had pneumonia followed by COVID in April of 23.

1:42:15
Between these two exacerbations, my care team discovered my left bronchial stem was closing up or narrowing during several balloon dilations.

1:42:24
The decision was made to add a stent to my left bronchial stem when it narrowed to 3 millimeters.

1:42:30
Following each of these exacerbations, my care team could determine quickly by a simple blood test whether I was at an increased risk rejection.

1:42:39
Following the exacerbation, my bilateral lung transplant was fully covered by Medicare and Tricare for Life, both federal government insurance programs.

1:42:49
It is absolutely confounding to me why Medicare would risk the health of my transplant by using an invasive biopsy when any risk of rejection can be detected and dealt with earlier using a noninvasive blood test.

1:43:03
Is there a medical procedure where an invasive procedure or test is performed over as preferred over a noninvasive test?

1:43:12
Additionally, limiting the use of noninvasive predictive blood test until signed or projections appear has the potential to further burden the Medicare and the healthcare system when more advanced rejection requires hospitalization for treatment.

1:43:28
The use of medical molecular diagnostics is a medical decision based on a doctor's knowledge of their patient.

1:43:35
The transplant community is more susceptible to the potential risk of invasive testing.

1:43:41
What other predictive surveillance is at risk by this type of decision?

1:43:44
Mammograms?

1:43:46
Colon cancer screening.

1:43:47
The testing is vital to the transplant community.

1:43:50
Thank you for your time and the opportunity to share these comments.

1:43:57
Thank you, Mr.

1:43:58
Kirton, for sharing your story.

1:44:00
Our next speaker is Edward Garcia.

1:44:02
And then you're on mute.

1:44:11
There we go.

1:44:12
There we go.

1:44:13
Good afternoon.

1:44:13
My name is Eddie Garcia.

1:44:16
Thank you for allowing me to share my thoughts on the March 2023 billing article regarding molecular testing for solid organ allograph rejection.

1:44:25
I received the heart transplant on April 16th, 2020.

1:44:29
During the summer of 2021.

1:44:31
The non invasive post transplant test most likely saved my life.

1:44:35
At a minimum it saved me from pain, suffering and additional financial stress.

1:44:41
My heart journey started on June 7th, 2010.

1:44:45
That day, a 100% occlusion in my left anterior descending artery, otherwise known as the Widow Maker, caused a massive heart attack.

1:44:54
I was 46 years old, my wife and I had two young daughters, and my career was on the rise.

1:45:08
10 days later, cardiac arrest caused my heart to stop beating and a rare form of lung failure required me to be on life support in the ICU.

1:45:17
My medical record on June 28th, 2010 simply stated that I was, quote, intubated, sedated, and paralyzed.

1:45:26
I remained in that state for six weeks as doctors worked on my lungs.

1:45:29
When I emerged from the medically induced coma and survived the lung failure, I still had a badly damaged heart.

1:45:37
For the next 10 years, I managed congestive heart failure with a strict diet, exercise, and medicine regimen.

1:45:44
My heart transplant in 2020 gave me a new lease on life.

1:45:48
A critical part of my post transplant management plan included the non invasive post transplant tests for surveillance purposes as opposed to invasive, expensive and as we as we have heard, traumatizing biopsies.

1:46:03
The test was simple.

1:46:05
The Bottoms came to my home to do a standard blood draw.

1:46:08
Within three days of each test, I had the results for the first four quarters.

1:46:12
Post transplant, my doctor called to confirm that there were no signs of rejection.

1:46:17
So far so good.

1:46:19
In late June 20, 2115 months post transplant, the non invasive test detected that my body was rejecting my heart.

1:46:27
I had just completed a three mile walk when my doctor called.

1:46:31
I had no symptoms of rejection and I was feeling really good.

1:46:35
Nonetheless, her direction was urgent and to the point.

1:46:39
I checked into the hospital that day to undergo 11 days of treatments to address the rejection.

1:46:46
In the hospitals, doctors administered plasmapheresis treatments.

1:46:50
It's a process that removes blood plasma from the body, separates it into plasma and cells, and transfuses the cells back into the bloodstream to remove antibodies that cause organ injection.

1:47:03
After the 11 day treatment and six monthly outpatient treatments, my body was free of the antibodies that were attacking my heart with minimal allograft damage.

1:47:13
The short story is that noninvasive post transplant tests work.

1:47:18
It's the proverbial Canary in ACOMA.

1:47:21
The noninvasive test is effective, efficient, and it saves lives and money without reservation.

1:47:28
I urge Medicare to continue covering noninvasive post transplant testing, as was done pre March 2023.

1:47:36
Additionally, proposed coverage for these tests, as stated in Malbex's March 2023 billing article, is too restrictive.

1:47:46
Limiting patient access to these tools for surveillance purposes and requiring patients to exhibit symptoms of rejection before being able to use these tests is both costly, it's emotionally draining, and it usually is usually too late to save lives.

1:48:03
Under the 20 the March 2023 order, I would not have had access to the test that detected rejection for me in 2021.

1:48:11
There's a good chance I wouldn't be here testifying before you today if that were the case.

1:48:17
As other patients have described, transplant surgery is a significant emotional and financial investment for patients, families, insurance providers and doctors.

1:48:28
Regular non invasive post transplant test for surveillance purposes effectively and efficiently preserves the investment for all involved.

1:48:38
The March 2023 billion article just doesn't make sense.

1:48:43
My heartfelt hope that Moldex and it's a new heart by the way.

1:48:47
So my new heartfelt hope is that Moldex and Medicare reconsider the decision regarding the March 2023 Billion article.

1:48:55
Once again.

1:48:56
Thank you for the opportunity to share my thoughts.

1:49:01
Thank you Mr.

1:49:01
Garcia, for sharing your story.

1:49:03
Our next speaker is John Deluna.

1:49:08
We can come back to Mr.

1:49:18
Deluna if Doctor Eugene De Pasquale is available.

1:49:28
Okay, great.

1:49:29
So Doctor Eugene De Pasquale is the Medical Director of the Heart Failure, Heart Transplantation and Mechanical Circulatory Support Program at the University of Southern California.

1:49:40
Thank you for the opportunity for me to speak with all of you today on this important topic.

1:49:44
I have got the comments of those who have spoken before me.

1:49:47
As as mentioned, I'm a transplant cardiologist at USC.

1:49:50
Additionally, I also served as a guideline author and a part of the steering committee for the IAC, HLT, International Society for Heart and Lung Transplantation guidelines for the care of the heart transplant recipients.

1:50:02
I am very supportive of the noninvasive tests for rejecting surveillance gene expression profiling and self free DNA in particular particular concomitant use.

1:50:13
I've also been the π or on the steering committee of some of the studies that have been published regarding this, these efforts such as or D or and the shore registries.

1:50:25
These innovations have had a great impact on our patients.

1:50:28
At USC in particular we've reduced the number of endomyocardial biopsies during the first post transplant year to less than two or in other words only one surveillance biopsy at week one.

1:50:41
And all biopsies beyond that point are driven for cause by Al Shore and Al MAP, the non AVISA tests for gene expression profiling and self free DNA.

1:50:51
So the loss of this concomitant approach will dramatically adversely affect our patients.

1:50:56
And with this approach the outcomes and patients quality of life have been excellent while reducing and a greatly limiting biopsy related complications which you've heard about earlier today and are not insignificant and can harm the new organ.

1:51:12
This target approach enhances the yield of endomyocortal biopsies as the histopathologic interpretation of the so-called gold standard of the biopsy really leaves much to be desired with pathologists agreeing one in significant rejection less than 2/3 of the time.

1:51:29
The nontarget approach can result in these variations interpretation that can really affect clinical decision making.

1:51:36
So if you did, if the, yeah, if the biopsy alone and the pathologists are concerned for rejection because they're worried about the patient but not necessarily or or worried about the patient, then you could be treating rejection unnecessarily which also increases risk for that patient.

1:51:52
So really having this, this molecular marker data is really critical to make an informed decision on what to do with the patient.

1:52:02
This has also been a useful tool for our center to extend our ability to care for our patients so far as we also transplant patients from Nevada and Hawaii, which lack transplant centers and are not down the road from my center.

1:52:14
These tests will also enable personalization of care of the transplant recipient to optimize the transplant medications which may help prevent the long term consequences of the immune depression therapies.

1:52:24
And you know, this was probably most dramatically presented by Amy Silverstein in our New York Times editorial.

1:52:30
Again, the use of these noninvasive tests concomitantly enhances the care of heart transplant recipients.

1:52:35
These tests are supported by the heart transplant guidelines.

1:52:39
Additionally, these tests give a better assessment to the patients, reduce potentially unnecessary invasive testing and complications and the loss of this will dramatically and adversely affect patient care.

1:52:51
I urge for Medicare to continue coverage of these tests.

1:52:54
Thank you for your attention.

1:52:55
I'm happy to answer any questions.

1:52:59
Thank you, Dr.

1:52:59
Dipasquale.

1:53:01
And I wanted to circle back to our last presenter, Mr.

1:53:04
John Deluna, are you here?

1:53:10
I don't see him on the presenter list.

1:53:17
If he is not available, I would like to thank all of our presenters and this concludes our open meetings.

1:53:27
Please remember to submit your written comments through the formal comment process and we wish everyone a good afternoon.

1:53:35
Thank you.

1:54:33
The.