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HIF081140

EVALUATING APPROACHES TO DIAGNOSTIC TEST REGULATION AND THE IMPACT OF THE FDA'S PROPOSED RULE

THURSDAY, MARCH 21, 2024

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The Subcommittee met, pursuant to call, at 10:01 a.m., in Room 2123 Rayburn House Office Building, Hon. Brett Guthrie [Chairman of the Subcommittee] presiding.

Present: Representatives Guthrie, Burgess, Latta, Griffith, Bilirakis, Bucshon, Carter, Dunn, Pence, Crenshaw, Joyce, Harshbarger, Miller-Meeks, Obernolte, Rodgers (ex officio); Eshoo, Sarbanes, Cardenas, Ruiz, Dingell, Kelly,

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Craig, Schrier, and Pallone (ex officio).

Also present: Representative DeGette.

Staff present: Jolie Brochin, Junior Professional Staff; Abigail Carroll, FDA Detailee; Grace Graham, Chief Counsel; Sydney Greene, Director of Operations; Nate Hodson, Staff Director; Calvin Huggins, Staff Assistant; Tara Hupman, Chief Counsel; Alex Khlopin, Staff Assistant; Peter Kielty, General Counsel; Chris Krepich, Press Secretary; Karli Plucker, Director of Operations (shared staff); Carla Rafael, Senior Staff Assistant; Emma Schultheis, Clerk; Lydia Abma, Minority Policy Analyst; Jennifer Black, Minority FDA Detailee; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Una Lee, Minority Chief Health Counsel; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and Jessica Zhao, Minority Intern.

*Mr. Guthrie. All right, the subcommittee will come to order. I am glad everyone is enjoying fellowship, so that is good, but now we will come to order, and the chair recognizes -- I recognize myself for five minutes for an opening statement.

Thanks to our witnesses for joining us today. We are here to examine the history of diagnostic test regulation, previous legislative proposals to update this regulatory framework, and the Biden administration's current proposal to regulate laboratory developed tests, or LDTs, as medical devices. The current oversight structure for a diagnostic test, including laboratory developed tests, is split between U.S. Food and Drug Administration and the Centers for Medicare and Medicaid Services

In 1976 Congress gave the FDA the explicit authority to regulate the medical device industry. At the time of enactment, the FDA adopted an enforcement discretion policy as a matter of practice over LDTs. Over time it became clear to policy makers, industry stakeholders, and patient groups that a separate regulatory approach was needed for LDTs to protect the health and wellbeing of patients as well as create more standardization across the healthcare system

which led to the passage of the 1988 Clinical Laboratory Improvement Amendments. In establishing the CLIA -- or CLIA. In establishing the CLIA Program, Congress intended to ensure the accuracy and reliability of all laboratory testing in the wake of reports of inaccurate clinical tests.

LDTs are viewed as an important -- as important tools for medical uses from helping to treat cancer to common public health purposes like helping law enforcement and healthcare professionals determine which drugs are being trafficked and sold in their communities. Lab developed tests also must go through certification requirements under CLIA in addition to state public health regulators and independent accrediting agencies such as Dr. Karcher's organization, the College of American Pathologists, or CAP.

Despite many known benefits of lab developed tests, the FDA has repeatedly attempted for almost two decades to completely reform how these tests are regulated in order to give the agency sole discretion and policing power over all diagnostic tests regardless of whether they are developed and run by the same laboratory or developed to be -- and to be sold and used elsewhere. Under proposed FDA rule announced in September 2023, the vast majority of the LDTs

will be regulated as medical devices. This means they would need to go through FDA's existing medical device framework such as the 510(k) clearance process or premarket approval. Labs will not be able to make simple modifications to existing diagnostic tests or even novel tests, undermining the flexibility provided through the LDTs.

Even more problematic, the proposed rule doesn't include a grandfathering clause that would allow for the continued use of CLIA certified LDTs without disruption. Commissioner Califf cited concerns relating to the performance of current LDTs that could potentially lead to unnecessary care or delaying necessary care as a primary reason why the FDA needs this additional policing power. He further states that over 70 percent of medical conditions rely on LDTs and other senior FDA officials have stated the current approach to disincentives innovation -- the current approach disincentivize innovation as convention kit manufacturers do it here to the medical device framework.

To be clear, I agree with Commissioner Califf that our regulatory approach always needs to ensure we are protecting patients while facilitating innovation. However, I remain concerned whether FDA's proposal will protect patients in

the most effective way, achieve lower costs or foster greater innovation. However, we cannot overlook the unintended consequences this proposed rule could cause. Namely, it could lead to greater consolidation among testing providers, reducing access to high quality care for patients living with life-threatening diseases, especially in the cell and gene therapy space, set our healthcare system back on our mission to move closer toward personalized medicine and have harmful effects on disadvantaged and rural populations.

I also question whether the update is going to execute the authorities that it seeks given its experience with an influx of COVID applications. To put all of this into greater context, the American Hospital Association's comment letter, one of nearly 7,000 the FDA received on this proposed rule, mentions one of its systems has 1600 lab developed tests. Assuming they were pursuing a 510(k) clearance, the 2023 user fee rates paid by manufacturers to the FDA for a 510(k), this could mean the system ends up paying upwards of more than 31 million to comply with the FDA's rule.

As diagnostic testing becomes more complex, I believe

it is essential that Congress work with the public health community physician and patient groups to address any current challenges with providing patients with the highest quality diagnostics without stifling innovation. I cannot support the FDA's proposed rule and it -- hope it is withdrawn but do look forward to continue the discussion on possible legislative proposals to address outstanding challenges with LDTs.

[The prepared statement of Mr. Guthrie follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you, and I yield back.

The chair now recognizes the ranking member, Ms. Eshoo, for five minutes for her opening statement.

*Ms. Eshoo. Thank you, Mr. Chairman, and good morning, colleagues. Good morning to the witnesses, thank you for being here.

Today we are going to discuss, excuse me, how diagnostic tests are regulated by the FDA and hear how Congress can improve processes in place to ensure that tests that patients rely on are safe and effective. Congress passed the medical device amendments to the Food, Drug, and Cosmetics Act in 1976 to give the FDA additional authority over medical devices. The FDA has generally not required diagnostic tests to complete premarketing approval and instead allows tests to be used in medical settings if they can meet certain requirements.

Today, I think we are in a golden era of medical innovation. Diagnostic tests available are increasingly complex and identify an array of medical conditions for large patient populations. Diagnostic tests are firmly enmeshed in our healthcare system and their results influence more than 70 percent of all medical decisions.

Tests we may think of as simple can be a big deal and there should be better processes in place to validate whether tests patients rely on are reliable and effective for detecting COVID, cancer, or other medical conditions.

Certainty is sorely needed. FDA's Center for Devices and Radiological Health reviewed 125 requests to grant COVID tests emergency use authorization, the EUA, and found two-thirds of tests had major issues such as inadequate or missing data. 41 percent of tests with major issues were ultimately denied, or declined EUA status, or withdrawn from consideration. Another study completed in 2022 of sophisticated technology for analyzing cancer-causing genes produced substantially different results despite assessing samples of the same DNA.

We should ensure test results are accurate and do not contribute to worsening health outcomes or higher cost for patients. Simply put, Americans rely on -- and they should be safe and effective, and I think that is something we all agree on, which is why I support the FDA's intent to bring certainty to diagnostic tests by requiring lab developed tests, the LDTs, to go through more rigorous review processes. However, I don't believe the FDA's proposed rule

is the only way to achieve our shared goal, and the device 510(k) review process is not perfectly tailored for LDTs.

Our subcommittee previously considered the VALID Act introduced by Representatives Bucshon and DeGette which established a specific framework for regulating diagnostic tests similar to how drugs are approved and monitored for safety or quality issues. The legislation also directs a report on the unique challenges academic medical centers and hospital based labs face. I believe the FDA's proposed rule should reinvigorate discussions on the legislation and call all stakeholders back to the table to earnestly negotiate the framework.

So I look forward -- genuinely look forward to the testimony today on this rather complex issue.

[The prepared statement of Ms. Eshoo follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. And thank you, Mr. Chairman, and I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back. I now recognize the chair of the full committee, Chair Rodgers, for five minutes for an opening statement.

*The Chair. Good morning, everyone. Today this committee will continue our work to ensure America remains the world leader in biomedical innovation. We have previously heard testimony on many examples of regulatory and reimbursement challenges that are stifling innovation and delaying patient access to care.

Unfortunately, the FDA is doubling down on this troubling pattern by failing to account for the important role laboratory testing plays in this country. Patients, doctors, and caregivers rely on diagnostic tests to detect, guide treatment decisions, and monitor a host of medical conditions and diseases. Some of these tests are made in the form of kits by conventional manufacturers for the use by other entities such as laboratories, healthcare practitioners, or even patients. Other tests known as laboratory developed tests, or LDTs, are designed, manufactured, and used within a single laboratory.

While conventional manufacturers certainly serve an important role, LDTs fill in the gap for indicators that have a smaller patient population such as rare diseases, particularly cancers, and certain pediatric conditions where large scale commercial manufacturing and distribution do not make sense. Instead of capitalizing on advancements in precision medicine and exciting genetic technologies to help patients, the FDA has proposed dramatically increasing the regulatory burden on a subset of diagnostic tests, specifically LDTs.

These regulations extend far beyond any of the legislative proposals that Congress has considered. Under the proposed rule, laboratories will incur significant costs to come into compliance. New administrative and clerical burdens along with oppressive submission fees will be a substantial drain on a lab's limited resources.

Take for example a lab that offers a thousand laboratory developed tests. By FDA's estimate, 50 percent of existing LDTs will require premarket submissions. That alone translates to hundreds of millions of dollars, not even accounting for ongoing changes and maintenance. Moreover, for a phase-out period over four years, this lab

will need to submit 250 tests a year or one per working day, something that is likely impossible for the lab to do and for FDA to review in a timely manner.

According to a recent survey of over 500 clinical laboratory respondents, only three percent of the labs believe that they will have the financial resources to pay user fees. For the overwhelming number of labs without the financial resources, they will have to stop performing tests, severely limiting access for some of our most vulnerable patient populations. And as preliminary regulatory impact analysis, the FDA estimates that there is 80,000 LDTs currently on the market and nearly 8,000 new LDTs per year that would be affected by the rule. By comparison, the agency approved a little over 3,000 premarket submissions in 2022. As currently written, the rule would take FDA years to simply review the tests that already exists on the market.

But what does this all really mean? Given that the FDA is already struggling to keep up with innovation and what it currently regulates, this undertaking would mean fewer diagnoses, higher costs, and delays in care for patients who can't afford to wait for the FDA to approve a test they need

to finally figure out what is wrong and the path to getting well. Their lives depend on it.

I know members of this committee hold a variety of positions on the need for regulating LDTs and the manner in which Congress should do so. I would hope that we would all agree that this rule is on the wrong path. I look forward to hearing more from our witnesses about legislative alternatives to this stifling administrative action.

[The prepared statement of The Chair follows:]

**********COMMITTEE INSERT**********

*The Chair. Thank you, and I yield back.

*Mr. Guthrie. Thank you. The chair yields back. I now recognize the ranking member of the full committee, Mr. Pallone, for five minutes for an opening statement.

*Mr. Pallone. Thank you, Mr. Chairman. New technologies can improve the lives of patients, and the products we are discussing today, laboratory developed tests, or LDTs, are no exception, but for them to make a difference for patients, they must be accurate and reliable. Congress gave the FDA authority over lab developed tests under the Medical Device Amendments in 1976. In 2015 we held a hearing in this subcommittee on regulation of diagnostic tests and laboratory operations.

Even then almost a decade ago we saw the use of the scientific advances also have potential to pose serious risk to patients if they are not accurate. For example, they can lead patients to undergo unnecessary treatment or delay or forego proper treatment resulting in harm. In the past, FDA generally applied an enforcement discretion approach for LDTs because most were manufactured in small volumes by local laboratories to meet the needs of local patient populations or were similar to other well understood

standard tests. However, many LDTs are now used more widely with large laboratories accepting specimens from across the country and in larger volumes.

LDTs have also gotten more complex and they increasingly rely on more advanced technology and software. With advancements in artificial intelligence, it is likely that this trend will continue. The FDA has expressed increasing concern that some LDTs may not produce accurate results or perform as well as tests that are reviewed by the agency or otherwise comply with FDA standards. Concerns include issues with COVID-19 diagnostic tests, genetic non-invasive prenatal screening tests, and the blood tests manufactured by the infamous biotech company, Theranos. And yet there is no required post-marketing reporting for LDTs, so we don't know the full extent of harm inaccurate tests can lead to.

The Centers for Disease Control and Prevention estimates that 70 percent of medical decisions are made based on laboratory test results. With many of these results coming from LDTs, it is scary to think that these tests do not currently have oversight and are not validated by FDA. New York State's Department of Health has conducted

premarket review for thousands of LDTs. The Department said that over half of the LDTs they have received for review could not be approved based on their initial submission due to problems that called into question the reliability of the tests.

And we have also seen that some manufacturers buy research grade components that are not intended for clinical purposes because these parts are cheaper. It simply does not make sense that tests are treated differently based on where they are made. Now I continue to believe that we have a responsibility to provide patients with greater certainty over the tools that are used to guide their medical decisions.

That is why FDA's action in proposing a rule to regulate LDTs and end their enforcement discretion approach is an important step. It is my hope that this will help eliminate patients harmed from unnecessary treatment or undertreatment from inaccurate LDTs, not to mention the cost to the overall healthcare system.

So I would like to submit a letter from Dr. Dan Hayes, an expert with more than 40 years of experience as a laboratory clinical investigator and a medical oncologist in

academic breast cancer programs. He noted, and now I am quoting, "Clinicians and patients depend on the FDA to carefully review the data and render difficult but reliable decisions about whether a drug is safe and effective.'' He went on to write that FDA should take the same approach towards diagnostics. He continued that, "A bad tumor biomarker test is as bad as a bad drug.'' And I completely agree.

The information that LDTs provide clinicians and patients is of grave consequence, and that is why many major cancer advocacy groups and those in the lab community welcome greater FDA oversight. Physicians have years of training and the best interest of their patients in mind, but by not providing oversight of LDTs, we are failing them by not ensuring they can trust the tools that they have to guide their patient counseling and develop effective interventions.

So the proposed rule is in my opinion an important step to help ensure that healthcare decisions are made based on test results that providers and patients can reliably trust. I look forward to hearing from our witnesses today to understand how we can level the playing field so patients

and the healthcare providers know that they can trust the FDA process while keeping up with medical progress.

[The prepared statement of Mr. Pallone follows:]

**********COMMITTEE INSERT**********

*Mr. Pallone. And with that, Mr. Chairman, I yield back. Thank you.

*Mr. Guthrie. Thank you. The gentleman yields back, and that concludes opening statements for members. And so I will introduce all of our witnesses and then I will call on you one at a time for five minutes for your opening statement.

Those of you who haven't testified before, there is a green -- you will have a green light in front of you for four minutes, and then it will turn yellow, that means you have a minute; when it turns red, it is time to wrap up. So we appreciate you being here, and I will introduce our witnesses.

First we have Ms. Susan Van Meter. She is the President of the American Clinical Laboratory Association. We have Mr. Zach Rothstein, Executive Director of AdvaMedDx. Is that the way you say it correctly?

*Mr. Rothstein. AdvaMedDx, thank you.

*Mr. Guthrie. AdvaMedDx, okay. All right. And then we have Donald -- Dr. Donald Karcher is the President of the College of American Pathologists. We have Dr. Jeff Allen, who is the President and CEO of Cancer -- Friends of Cancer

Research. And Dr. Dara Aisner, who is the Director of Colorado Molecular Correlates Laboratory.

So we now will begin -- your opening statements and, Ms. Van Meter, you are recognized for five minutes for your opening statement.

STATEMENT OF SUSAN VAN METER, PRESIDENT, AMERICAN CLINICAL LABORATORY ASSOCIATION (ACLA); ZACH ROTHSTEIN, JD, EXECUTIVE DIRECTOR, ADVAMEDDX; DONALD S. KARCHER, MD, FCAP, PRESIDENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS (CAP); JEFF ALLEN, PHD, PRESIDENT AND CEO, FRIENDS OF CANCER RESEARCH; AND DARA L. AISNER, MD, PHD, MEDICAL DIRECTOR, COLORADO MOLECULAR CORRELATES LABORATORY, PROFESSOR OF PATHOLOGY, UNIVERSITY OF COLORADO, REPRESENTATIVE OF THE ACADEMIC COALITION FOR EFFECTIVE LABORATORY DEVELOPED TESTS

STATEMENT OF SUSAN VAN METER

*Ms. Van Meter. Chair Rodgers, Ranking Member Pallone, Subcommittee Chairman Guthrie, Vice Chair Bucshon, Ranking Member Eshoo, and members of the committee, thank you for the opportunity to testify today.

I am Susan Ven Meter. I am the President of the American Clinical Laboratory Association, or ACLA. ACLA is the trade association representing leading laboratories that develop and offer essential diagnostic testing services to patients and providers. ACLA advocates for the expanded access, improve patient outcomes, and advancing the next

generation of patient -- of personalized care.

Laboratories offering testing services have delivered groundbreaking innovations for decades. One example, the first test to detect BRCA gene mutation, which revolutionized breast cancer care, was offered by an ACLA member laboratory. Laboratories also frequent -- are frequently the first to respond to emergent public health threats, play pivotal roles in the development of new drugs and biologics, and address unmet patient needs.

We are proud of the extraordinary contributions laboratories have made to advance the public health of this country, but today the FDA is poised to reshape the industry by bypassing Congress and unilaterally imposing medical device regulation. But device regulation is inappropriate when applied to laboratories and raises profound concerns. My written testimony provides a more complete description of our concerns, but let me briefly address three areas: patient access, innovation, and legal concerns.

First, device regulation would result in reduced patient access to critical diagnostic testing services. Laboratory developed testing services would be removed from testing menus, not because they don't yield reliable and

accurate results, but because seeking FDA approval can be prohibitively expensive. We are acutely concerned about -- that patients will lose access to essential testing services, especially those that serve pediatric patients, small patient populations, and patients with rare diseases, cases where revenue is modest.

Access would also be harmed because FDA would become a bottleneck. Because the proposed rule lacks a grandfathering provision, FDA would receive an avalanche measured in the tens of thousands of applications of existing tests. FDA lacks the resources to deal effectively with that surge in workload.

Let me give you an example. Last year an ACLA member obtained the first FDA authorization of a groundbreaking genetic test that helps identify patients who are at risk of developing cancer, but it took the laboratory over one year and seven figures to prepare the submission. It had took the FDA two-and-a-half years to review and authorize it. During that time, the laboratory performed the test for over 230,000 patients, of which more than 22,000 tested positive for an actionable result.

Had FDA's rule been in place, those 22,000 patients and

their families would not have learned about their risk of cancer or had their cancer informed by their genetics. And an exemption for academic medical centers is not the answer to these problems. That type of exemption would exacerbate health disparities by favoring patients who can be treated at an academic medical center leaving everyone else without access to the care they need.

Second, if the FDA's rule is finalized, innovation and diagnostic testing would suffer. Instead of developing the next generation of diagnostics, labs would be forced to justify tests that physicians have been using for decades. Given the timelines proposed by FDA, laboratories would need to begin this work immediately and, in fact, our members have begun work towards implementation.

Innovation would also be harmed because the device framework is wrong for laboratories. Device regulation is rigid and cannot account for the rapid evolution that occurs in diagnostics. The device approval standard and numerous other aspects of device law do not work when applied to professional services.

Third, regulating laboratory developed test services is beyond the agency's jurisdiction. Congress has always been

clear. FDA regulates medical products but not healthcare services. Laboratory developed testing services are not products but professional services that leverage a variety of tools to derive a test result for a patient.

Let me end with a commitment. Over the past several years, ACLA worked collaboratively with this committee as well as with the FDA and other stakeholders, many here today, on legislation that could have established a role for the FDA in an appropriate regulatory system designed specifically for diagnostics. ACLA steadfastly maintains that legislation is the right and only approach for regulation of laboratory developed testing services. We would be pleased to work with the members of this committee on an appropriate legislative framework.

I thank you for this opportunity to testify and I look forward to your questions.

[The prepared statement of Ms. Van Meter follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Yeah, thank you for your testimony. And also I needed to recognize the ranking members asked for a letter to be put in the record. We are going to put it to the documents list and we will act on it at the end of the hearing.

So, Mr. Rothstein, you are now recognized for five minutes for your opening statement.

STATEMENT OF ZACH ROTHSTEIN, JD

*Mr. Rothstein. Good morning. Thank you, Chairman Guthrie, Ranking Member Eshoo, Chair McMorris Rodgers, Ranking Member Pallone, and members of the committee for the opportunity to testify.

My name is Zach Rothstein. I am the executive director of AdvaMedDx, a division of AdvaMed, which is the med tech association. AdvaMedDx members are among the world's most innovative companies. They have brought to market nationwide and accessible to patients of all backgrounds exceptionally sophisticated, groundbreaking, and technology advanced diagnostic products. These companies have developed many of the diagnostic tests that are a cornerstone of the modern healthcare system.

Many diagnostic tests that are performed by clinical laboratories are what are referred to as test kits. They are subject to FDA's medical device regulations which generally include premarket review and post-market requirements which can be used in more than one laboratory. Other diagnostic tests are developed by a clinical laboratory as laboratory developed tests, or LDTs, and are

used solely in that laboratory. These clinical laboratories often utilize instruments and other materials made by our members. In most cases, LDTs are used for the same diagnostic purposes as other tests that are FDA regulated.

There are currently two federal frameworks applicable to diagnostic tests and to laboratory testing. IVDs, which are subject to FDA regulations promulgated under the Food, Drug, and Cosmetic Act, or the FDCA, are often reviewed in the premarket context for both their clinical and analytical validity to provide for a reasonable assurance of the test's safety and effectiveness.

The FDCA also provides for comprehensive post-market oversight of IVDs, including the reporting of adverse events, malfunctions, and recalls. In contrast, the Clinical Laboratory Improvement Amendments of 1988, or CLIA, ensures that laboratories operate and perform tests appropriately. Unlike the FDCA, CLIA does not require premarket evaluation of a test's accuracy or its clinical validity, nor does it provide for a comprehensive post-market oversight mechanism for tests themselves, including LDTs.

Indeed, CMS has stated that the CLIA Program is

separate in scope and purpose from FDA oversight, and that simply updating CLIA is insufficient to ensure the analytical and clinical validity of LDTs being used to inform patient care. While most LDTs have not been subject to FDA regulation as medical devices, there have been notable exceptions as several dozens of LDTs have applied for and received FDA clearance or approval as devices.

The FDA has long played a critical role in ensuring the safety and effectiveness of IVDs under the existing law, but we strongly support comprehensive legislative reform to modernize the device framework so that it is tailored to provide an appropriate risk-based oversight program for all IVDs, including test kits, LDTs, and the instruments upon which they run. The current regulatory framework was established decades ago, and while there have been important targeted improvements, it has remained fundamentally unchanged, despite dramatic advancements in the field.

An updated and modernized framework reflecting the unique nature of diagnostics is essential to foster continued innovation and ensure patients and providers have confidence and transparency in the tests they use and rely upon. In particular, we appreciate the interest of members

of Congress from both sides of the aisle on this issue and the leadership of Representatives Bucshon and DeGette in developing the VALID Act. The approach envisioned in the legislation would serve patients and providers now and well into the future.

Today the testing community is at a crossroads. After more than a decade of efforts to bring clarity to LDT regulation through other means, FDA initiated rulemaking last October to clarify that an IVD that meets the statutory definition of a device is a device regardless of who makes the test. The rulemaking comes as the gap in diagnostics oversight continues and as they grow and the tests become more varied and complex.

In med tech, everything we do comes down to how best to serve patients because all of us have been or will be patients at some point. The vast majority of us do not know where the test that might diagnose a life threatening disease or infection is made, but we should have the confidence that whatever test we use and wherever it is made, that it has met the same standard and is subject to the same oversight as any other test. For high stakes tests such as for cancer diagnosis or to guide important treatment

decisions, we believe that those standards should involve a premarket review of analytical and clinical validity, and for all tests there should be appropriate controls and post-market monitoring.

Comprehensive reform of the regulatory system would benefit all test developers, and most importantly patients, by supporting access to trusted, reliable, and cutting edge diagnostics. I would also like to point out that regulatory certainty is a critical element to encourage a favorable innovation environment for diagnostic tests. A unified oversight program would clarify regulatory expectations and reduce the ambiguity that currently hampers investment decisions.

Thank you for the opportunity to participate in today's hearing and we look forward to the continued engagement on this issue.

[The prepared statement of Mr. Rothstein follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you for your testimony.

Dr. Karcher, you are now recognized for five minutes.

STATEMENT OF DONALD S. KARCHER, MD, FCAP

*Dr. Karcher. Thank you. Chair McMorris Rodgers, Chair Guthrie, Ranking Member Pallone, and Ranking Member Eshoo, thank you for the opportunity to testify today. The College of American Pathologists appreciates the subcommittee's interest in this important topic.

I am Dr. Donald Karcher, President of the CAP. I am also Professor and Immediate Past Chair of Pathology at George Washington University. I have been a practicing pathologist for more than 40 years, including eight years in the Army, two years in private practice, and most of my career as an academic pathologist.

The CAP is the world's largest organization of board certified pathologists and the leading provider of laboratory accreditation and proficiency testing programs supporting the highest standards of laboratory quality in the U.S. and around the world. The CAP has been constructively engaged for over a decade with Congress and the FDA on developing a framework to oversee laboratory developed tests, LDTs. Our position has always been to put patients and quality first. All LDT should be safe and

effective.

LDTs are developed and used in a single clinical lab to meet a specific clinical need. These tests are developed almost always because there is no FDA approved or cleared test that meets the specific need in question. Most LDTs are developed and used for patients being cared for in the hospital or healthcare network where the lab is located.

Although many LDTs represent innovations and patient care, most utilize well-established laboratory methods that medium and large size labs already have experience using. The clinical validity of the majority of LDTs is already well-documented in the medical literature before the test is developed.

The CAP strongly believes that any LDT regulation must allow innovation to continue and must not introduce overly burdensome or costly requirements for the lab. Stifling innovation and burdening labs would lead to many labs having to stop developing LDTs, depriving their patients of these life-saving tests. This is why we have significant concerns with the proposed rule released by the FDA in October. We believe the proposal as written would reduce the number of highly accurate LDTs available to patients and delay medical

innovation and timely patient care.

Instead, the FDA should be focused mostly on tests that pose the highest risks to patients. Such a test was developed more than 10 years ago by an academic medical center to detect a form of cancer and resulted in many women receiving false positive results that led to unnecessary removal of their ovaries and other surgeries. The right balance would have the FDA exercising full regulation of only the highest risk LDTs with sufficient flexibility in their oversight of these and all lower risk LDTs. This would allow clinical labs to continue to develop and run these vitally important tests. This is the LDT framework that Congress should adopt.

To that end, the VALID Act, dealing with LDT regulation, has enjoyed bipartisan and bicameral support. It would establish a reasonable and balanced regulatory framework that would ensure quality testing for patients and minimize the regulatory burden on labs. It focuses FDA's resources mostly on the highest risk LDTs and provides flexibility with lower risk LDTs to preserve quality and patient safety. Further, it places guardrails around LDT regulation to prevent duplication of existing CLIA

requirements and infringement on the practice of medicine.

Finally, there has been some discussion in Congress to legislatively change CLIA to address LDT oversight. The CAP strongly opposes this effort. CLIA, which provides the basis of all clinical lab operations in the U.S., has stood the test of time. We recognize that it periodically needs minor updates to reflect changes in practice and technology. This is currently being done through the regulatory process.

Opening CLIA legislatively to address this issue risks creating a parallel structure with the FDA and severely disrupting the framework under which clinical labs have provided high quality testing for decades.

Thank you again for holding this hearing. The CAP stands ready to work with you to ensure that patients have continued access to accurate, innovative, and timely laboratory tests. I look forward to answering your questions.

[The prepared statement of Dr. Karcher follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you for your testimony.

The chair now recognizes Dr. Allen for five minutes for your opening statement.

STATEMENT OF JEFF ALLEN, PHD

*Dr. Allen. Good morning, Chairman Guthrie, Ranking Member Eshoo, and members of the committee.

I am Jeff Allen, President and CEO of Friends of Cancer Research, an advocacy organization dedicated to accelerating science and technology from bench to bedside. It is an honor to testify here today and provide the perspective of my organization and on behalf of patients at this -- as this committee examines how diagnostic tests can support the future of medicine and patient care.

The treatment that patients with cancer have access to today are in many cases far more effective but also more complex than their predecessors. It is not unusual for a variety of diagnostic tests to be used by healthcare providers to identify elevated risk, diagnose certain conditions, inform treatment options, or even measure if a treatment is working. Above all, it is imperative that these test's performance and accuracy be well characterized before their results are used for important treatment decisions. Inaccurate or unreliable tests can have significant implications on healthcare costs, system burden,

and patient outcomes.

A report from the National Academies concluded that diagnostic errors, including from some molecular tests, account for 17 percent of adverse events in hospitals and play a role in 10 percent of patient deaths. Given the critical role of diagnostic tests in patient care, the approach to regulating these tests needs to be realigned. Tests manufactured and sold as diagnostic kits, as well as those marketed as companion diagnostics, are subject to premarket review by the FDA.

This review process ensures that their tests meet stringent standards for safety, efficacy, and accuracy before they are made available to the public. Conversely, laboratories that establish and run lab developed tests, or LDTs, are subject to CMS oversight under CLIA. While CLIA provides important regulation, it focuses more on the standards for laboratory operations rather than the clinical validity of individual tests. CMS themselves has acknowledged that the agency does not have the expertise to assure the tests work.

For patients, consumers, and healthcare providers, it is the information provided by the test that is important,

not the place it is manufactured. This distinction in oversight creates a regulatory landscape where the rigor of test validation and review can vary significantly, potentially impacting the consistency and reliability of results across different testing platforms. This is not uncommon.

Our research indicates that there are many tests used every day for which performance and accuracy have not been independently verified. Specifically, we conducted an audit on hundreds of medical records from across the country and found that nearly 30 percent of lung cancer patients were evaluated for key biomarkers with versions of LDTs that had not gone through premarket review, despite the availability of an FDA approved test.

While it is a positive that there has been increased testing for recommended biomarkers, tests that have not been independently reviewed for accuracy are being used to inform treatment decisions. Without centralized FDA oversight, it is not known how many tests are even being offered, let alone how they may perform. This is not the reliable path to precision medicine.

The reality is some patients may be making major

medical decisions based on potentially discrepant test results. To begin to resolve this, we partnered with 17 leading diagnostic test developers in clinical laboratories to determine and define differences and how each of their test measure emerging biomarkers using a common set of samples. These pilot projects demonstrated that there is variability across different tests and multiple factors contribute to differences in test results.

So as future policies are considered, improved transparency of test performance would help identify and manage potential variability and ensure consistency in the information being utilized by patients and healthcare providers.

Over the last several years, the need for modernizing the regulatory requirements for diagnostic tests has been acknowledged. Most recently, the VALID Act was introduced with bipartisan support. This proposed legislation would provide the framework for the future by establishing a quality assurance floor for the performance of all tests while ensuring an open ceiling to foster future innovations in diagnostic testing.

In the absence of congressional action, FDA has moved

forward with the public process of rulemaking to clarify uniform policies for diagnostic tests. It should be noted that nothing precludes Congress from continuing to work on a legislative approach as FDA continues working on its proposed rule. No matter the path forward, action to ensure high quality test performance is needed and progress to that end can no longer be stalled. The future of precision medicine and the health and lives of patients depends on the accuracy of these tests.

[The prepared statement of Dr. Allen follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you for your testimony.

The chair now recognizes Dr. Aisner for five minutes for your opening statement.

STATEMENT OF DARA L. AISNER, MD, PHD

*Dr. Aisner. Good morning, Chairs Rodgers and Guthrie, Ranking Members Pallone and Eshoo, and members of the subcommittee. Thank you for the opportunity to testify today. I am also honored that my representative, Ms. DeGette, is in attendance today, and I thank you for everything you have done for medical research.

My name is Dr. Dara Aisner. I am representing the Academic Coalition for Effective Laboratory Developed Tests. My testimony does not reflect the view of my employer. The Coalition represents 325 pathologists and professionals from a hundred academic and hospital-based laboratories across the U.S. We oppose the FDA's rule.

I am a triple board certified pathologist and the Medical Director of the Colorado Molecular Correlates Laboratory at the University of Colorado where we perform testing for patients in oncology, genetics, and infectious disease. I am also a cancer patient. As a physician with expertise in laboratory testing, I have trusted my own care to LDTs, even when FDA approved choices are available for the same clinical question.

Professionally, I find the FDA's proposal to be misguided and I worry for the future of American medicine. Personally, I fear the consequences for me and my family.

LDTs are not devices, they are processes performed with expertise. Knowledge of all the steps, combined with an understanding of the scientific and clinical data, allows for nuanced care that simply cannot come from an assay kit. The use of FDA's device infrastructure is quite simply forcing a square peg into a round hole. There is no substantive evidence of systematic harm arising from LDTs, just anecdotes. The FDA has vastly underestimated the number of LTDs.

The rule would create delays to implementation of essential care and a contraction of the laboratory market would be inevitable. This will magnify inequities with disproportionate impact on marginalized, underserved, rural, pediatric, and rare disease populations. Innovation will be directly hampered owing to cost and unpredictability.

These are not hypothetical concerns. The oldest targeted therapy in lung cancer, one of the most effective forms of precision medicine, is based on a mutation that was first reported in 2004. Labs started offering LDTs for that

mutation that very same year. The first FDA-approved test kit for the mutation came out nine -- almost nine years later. In that interval, roughly two million Americans were diagnosed with lung cancer, which would mean 100,000 patients with the mutation.

Cutting edge therapies mean little if patients cannot access the testing that renders them eligible for it. The steady decline for -- of mortality for many cancers can be directly attributed to precision medicine. In 2010 we used PCR-based tests to look at one gene in lung cancer. Today we use next generation sequencing, NGS, and examine dozens or hundreds of genes at a time. For 20 years the vast majority of sequencing tests for all cancers have been LDTs.

Under the FDA proposal, NGS, a transformative technology, would likely still not be in place, to the detriment of hundreds of thousands of cancer patients. The Coalition's members are not manufacturers. We have years of training, board certifications, and experience to provide specialized care for our patients.

A regulatory system needs to recognize that the testing environment impacts risk mitigation. A regulatory system should hold everyone to the same standard, but that means

working to ensure outcomes are similarly safe and effective not that regulations are similarly burdensome. There are other approaches for an outcomes-based paradigm instead of a one size fits all approach.

I would like to circle back to where I started today. I am a cancer patient. That is a hard truth to hear for anyone, especially someone who has spent her career on cancer diagnostics. In facing it, I never questioned the use of LDTs in my care. Not once, not even a little. I know that if the FDA rule moves forward, patients will suffer.

Ultimately we all want the same thing, to provide the best possible care for all Americans. As a physician, I want to deliver the most up-to-date testing for my patients. As a patient, I want to know that the next decision in my cancer case is based on science and access to testing is not hampered by counterproductive regulation. For the sake of patients like me, I urge the FDA to withdraw the rule. Congress should endeavor to explore all outcomes and modernize oversight that fosters innovations and leads to the best patient outcomes.

We look forward to partnering with you to advance a

sensible path forward. Thank you again for the opportunity to testify and I look forward to your questions.

[The prepared statement of Dr. Aisner follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you for your testimony. That concludes all of our witness testimony, and we will now begin the questioning period of the hearing, and I will recognize myself for five minutes for the hearing.

And, Dr. Aisner, you kind of summed up the issue we are trying to deal with is that you have a LDT that was developed within the same year and put out, and then nine years for the FDA to approve. And we are always dealing with that. We had a witness the other day talk about what is a few months in FDA approval, and sometimes it is not a few months, but it depends on what your diagnosis is how much a few months matter. You know, it is a lot of times regulators, and I think this was a professor at Harvard Law.

It was just -- every -- it is not theoretical, it is real and it affects real lives, but we want to make sure they are accurate as well. We want to make sure they are moving forward. And so -- and we do things in Congress like right to try, accelerated approvals to try to get around this -- try to not get around the -- try to get around how long it takes, try to make -- to speed the process up to make -- but we want to make sure they are safe and effective as well.

And, Dr. Karcher, I know the College of American Pathologists offers proficiency testing for LDTs, and do you have any data to suggest that LDTs perform any better or worse in that proficiency testing?

*Dr. Karcher. So proficiency testing is a very important part of maintaining the quality of all laboratory testing. We do occasionally have problems with a number of tests that are recognized by proficiency testing. We are oftentimes analyzing data from hundreds, maybe thousands of laboratories that are doing the same methodologies. So like any other test, yes, LDTs do occasionally have -- there are inaccurate results that are submitted by laboratories.

That said, we still feel that it is one of the best ways to independently verify the accuracy of results, regardless of whether or not it is an FDA approved or cleared test or an LDT.

*Mr. Guthrie. Okay, thank you for that.

And, Ms. Van Meter, do you believe that -- so it gets back to the process here. Do you believe that the LDT rule effectively eliminates bottom-up innovation in diagnostics, and do you believe this could lead to consolidation within the diagnostic space and cause price increases and limit to

access to care?

*Ms. Van Meter. I feel strongly that implementation of the rule will have a downward impact on innovation, it will reduce the number of innovative tests that are available to patients, and it will extend the amount of time it takes for an innovative test to reach patients. We think about the example I offered of a test that had been approved by New York State assessed for analytical and clinical validity and was offered to patients over a period of time during which they took that test through the FDA, a seven-figure cost, all told three-and-a-half years to get through the agency. In the meantime, 22,000 patients received an actionable result. Those 22,000 patients, under an FDA regime such as the proposed rule puts forward, would not have had the benefit of that information.

Certainly there could be consolidation under this regulation within the market. I think that is a possibility. I think at the end of the day the medical device authorities, the application to laboratory developed testing services is inappropriate and we will see a constraint in access and in innovation. It is really not the right approach and we encourage the committee to look at

comprehensive legislation.

*Mr. Guthrie. Okay, thank you.

And I will ask this for a couple of witnesses that haven't gone forward yet. So, Mr. Rothstein and also Dr. Allen and Dr. Aisner, if -- we have a minute and a half, so I will get my question out. What in the current CLIA framework most needs modernizing and do you believe the FDA's proposed rule will help address any challenges posed by the current framework?

*Mr. Rothstein. Thank you for the question. I would defer to my colleagues who are more familiar with the CLIA construct in terms of what needs modernization. However, I would say there are two elements that is missing in CLIA compared to what is in the FDA statute, which is premarket review for both clinical and analytical validity, as well as comprehensive post-market oversight.

*Mr. Guthrie. Okay, thank you.

Dr. Allen?

*Dr. Allen. I think the concern with even mixing the two is that CLIA was designed to provide oversight for laboratory operations not individual performance of tests, so I -- CMS also has noted that they in house do not have

the expertise to evaluate these tests properly. So instead of trying to reconstruct that agency's approach, I think it would be more effective to allow it to continue to be able to provide its vital services for laboratory operation oversight, but then give the FDA the tools that its need -- that are needed to be able to identify potentially underperforming tests in advance before they are even used.

*Mr. Guthrie. Okay, thanks.

Dr. Aisner?

*Dr. Aisner. I think it is important to recognize that CLIA is nearly 36 years old. It was put into place before computers were part of our modern day-to-day life. So no matter where the ultimate solution to this lies, CLIA needs to be updated no matter how you look at it. I think for us to say that we are -- we know what that looks like now and how that would impact a future framework that deals with LDTs, we got to tackle one thing at a time. Let's tackle a 36 year old statute that needs updating and then go from there.

*Mr. Guthrie. Thanks. My time is expired, so I appreciate your answers and I will yield to the -- I will yield back and then recognize the ranking member for five

minutes for her questions.

*Ms. Eshoo. Thank you, Mr. Chairman, and thank you to each one of the witnesses for your testimony.

There are a couple of things that I know going into this and that is that this is the sixth year for Congress to be grappling the VALID Act, so we have not acted validly, all right, so we have to accept that. I do know that Dr. Shuren has expressed to me many times that -- you know, that generally speaking he supports the VALID Act, and I know that the authors of the legislation have been working with stakeholders I think rather consistently over this period of time.

I think that the issue of place is not the issue, and I don't know -- I am not so drawn to, you know, revamping CLIA, I think it complicates this issue. I don't think that that should be a part of it.

But having said all of that, I want to ask each witness so that we have this for the record. Do you prefer the FDA rule or the passage of the VALID Act? Why don't we start with you. I think you have already expressed it, but let's say it again.

*Ms. Van Meter. We think that the VALID Act has a

number --

*Ms. Eshoo. Just yes -- which one, what do you support?

*Ms. Van Meter. We would prefer comprehensive legislation to unilateral FDA action.

*Ms. Eshoo. And you support the VALID Act?

*Ms. Van Meter. We think there are a number of extremely positive attributes to the VALID Act and am committed to working with the committee on it.

*Ms. Eshoo. So you are no on one and lukewarm on the other, is that right?

*Ms. Van Meter. We think legislation is --

*Ms. Eshoo. I mean, but yes or no. Do you support the VALID Act? If you don't, you don't. If you do --

*Ms. Van Meter. We have worked earnestly on it and we will commit to continuing to do so. We think it is the right approach moving forward.

*Ms. Eshoo. Okay.

*Mr. Rothstein. We strongly support the VALID Act.

*Ms. Eshoo. Good.

*Dr. Karcher. The CAP also strongly supports the VALID Act and we have real problems with the FDA's proposed rule

as it is currently written.

*Ms. Eshoo. Mm-hmm.

*Dr. Allen. We also support the VALID Act and feel that inaction would be the worst outcome.

*Dr. Aisner. I cannot speak for all academic medical centers, but those I have spoken with --

*Ms. Eshoo. But you are here testifying. Do you --

*Dr. Aisner. Those that I represent do not support the VALID Act. We believe there is room to find middle ground. We do not support the FDA proposed rule.

*Ms. Eshoo. What is the middle ground?

*Dr. Aisner. The middle ground is to ask the question what are all of the options. Why do we need to go all the way to a hundred out of the gate? What are the other options? There are other options here, there are options for an outcomes driven approach.

*Ms. Eshoo. But I am asking you to state the outcomes. You -- other pathways.

*Dr. Aisner. One pathway is to center on proficiency testing. Dr. Karcher mentioned the importance of proficiency testing. A pathway that asks laboratories to undergo proficiency testing prior to launch achieves the end

point without the burden. There are other options.

*Ms. Eshoo. You know what terrifies me? Having a test relative to cancer and it comes up positive but it is not accurate, and I think that that is most troubling to me, that frightens me, and I think that it is a chilling case for anyone.

I do think that there is a good support, solid support for the VALID Act, and I -- most frankly, I think that Congress needs to be pursuing that. The lack of action by Congress really forced FDA's hand to come up with their proposal, and I think that is a fact of life here, so I think it is fashionable, at least in some quarters, to just bash the FDA coming and going, but it is up to Congress to act, and I do think that the answers with some refinements in the VALID Act would be an appropriate way to go.

So I can ask many questions. I mean, there are only two states in the country, New York State and Washington State, they are the only two states to pass laws to regulate LDTs. The New York experience is a really rather broad one. And, of course, states approve the labs but there are only two states that do that, so we can't look to a majority of states and their experiences. But it is worth mentioning

that two states do -- have passed laws to regulate the LDTs.

I think I will yield back, Mr. Chairman.

*Mr. Guthrie. Thank you. The gentlelady yields back, and the chair recognizes the chair, Chair Rodgers, for five minutes for questions.

*The Chair. Dr. Karcher, a laboratory in my district develops drug tests to detect substances and aid in substance use disorder treatment. This committee has heard how xylazine has been mixed into fentanyl and made that crisis even worse as xylazine does not react to overdose reversal medications. Are there any drug tests approved or cleared by FDA that would detect xylazine? The laboratory in my district has one already available for healthcare providers, and it seems like if this rule had been in place, Spokane may not have access to that valuable resource.

*Dr. Karcher. There is no FDA approved or cleared test that I am aware of for that substance, and therefore, you are exactly right. If the proposed rule as published by the FDA in October were to go into effect as written, that lab in Spokane and frankly anywhere would have a difficult time developing a very important LDT to care for people that are suffering from potential contamination with this substance.

*The Chair. Thank you.

*Dr. Karcher. So we agree with you.

*The Chair. Thank you. Dr. Aisner, in your role as a pathologist, how is the expertise you bring to your patients distinguishable from the results of routine commercial test kits?

*Dr. Aisner. Okay, sorry about that. I will apologize for stumbling because it is a broad question and it is something I feel very passionate about. You know, I think an example I can provide for you is that a sample that comes in and has a lot of pre-analytic factors that have rendered it highly fragmented is something that I analyze differently than a sample that came in and is very pristine. And it is because I have the knowledge of the sample, it is because the data tells me something about the sample, it is because I can look at the patient's situation and say, if I look at the data through the lens of a highly fragmented sample and I see this versus I assume it is a clean sample and I see this, how does it all come together.

It is really about bringing it all together in a way that you can make everything make sense. I tell my pathology trainees that being a pathologist is about being

an integratition. We really work to bring all of the pieces of data together.

*The Chair. Thank you. As a follow-up, in what circumstances do you rely on your specialized medicine training to best support your patient's clinical care?

*Dr. Aisner. I would argue that there is no situation where I don't. It is every day, every specimen, every piece of data.

*The Chair. Thank you.

Ms. Van Meter, as referenced in your testimony, your organization provided an economic assessment to rebut the preliminary regulatory impact analysis that accompanied the FDA's proposed rule. Could you please summarize your findings and conclusions and how those might have differed from FDA's estimates of cost and benefit?

*Ms. Van Meter. Yeah. Thank you for the question. We did analyze the FDA's economic impact analysis of the rule, and in short, we believe that the FDA has dramatically underestimated the cost while also significantly overestimating the benefit. If I may, I will give you just a couple of facts and figures here where I think we can show that there are just fundamental flaws in the logic and that

work could have been done to more accurately assess what the impact would be.

I am going to just utilize FDA's own assumptions. Let's presume for a moment that they are correct on the number of total LDTs. We believe it is too low, but let's assume it is correct, that there are 80,000 laboratory developed testing services that exist. It presumes, the FDA does, that LDT revenue is about 28.6 billion. That was a 2023 figure. That would roughly mean for each LDT service on average generates $350,000 in annual revenue.

For tests that would have to go through the PMA or premarket review application, FDA estimates the cost of submission would be 4.3 million. The math simply doesn't work. So given the agency's projections of the number of LDT services that would go through premarket review, De Novo, 510(k) pathways, it projects a cost of all submissions of 32 billion dollars. Recall the same analysis of total FDA services revenue is at 28.6 billion dollars. It is not possible to bring all of those tests through the agency. Simply the math doesn't work.

*The Chair. Thank you. Thank you for those insights and appreciate everyone being here today as we sort through

this issue.

With that, I yield back. Thank you, Mr. Chairman.

*Mr. Guthrie. Thank you. The chair yields back, and the chair recognizes the ranking member of the full committee, Mr. Pallone, for five minutes for questions.

*Mr. Pallone. Thank you, Chairman. I wanted to start by expressing my appreciation to all our witnesses for coming here today to talk about this important issue. And I have heard arguments that the FDA's proposed rule will have a negative impact on the LDT market, but I would say that anyone who is concerned about the cost of the FDA's proposed rule on LDTs should also be concerned about the potential cost every day in our healthcare system from unproven tests.

The FDA's analysis showed the benefits of the regulation significantly outweigh the cost. So we know the downstream cost for unproven treatments can be staggering, and I think about cancer and other conditions where the cost of having the wrong treatment or waiting too long to be treated are enormous, never mind the pain and suffering for patients and their families.

So I basically have two questions. First is of Mr. Rothstein. Do you agree there is potential for significant

cost to our healthcare system if we do not ensure that tests work, regardless of where they are made?

*Mr. Rothstein. We do, yes.

*Mr. Pallone. All right. And then let me go to Dr. Allen. What are the consequences for cancer patients who receive the wrong treatment or fail to be treated early on -- when they need it?

*Dr. Allen. In some cases it probably depends on the different scenarios, but there is data that is emerging that if a patient receives the wrong treatment, they may not respond to subsequent treatments, and this is due to the changing modality of treatments and where there has been detrimental effect shown for patients that, you know, for example, receive a targeted therapy, the immunotherapy that they may also be available for, you know, it isn't -- it is shone to be not quite as effective. Let alone potentially just excluding them from something that would work, and I think that is the biggest concern of having tests that are not properly identifying the treatments that have been shown to benefit patients.

*Mr. Pallone. All right. Well, you both answered my questions briefly, so let me go back to -- since I still

have two-and-a-half minutes, let me go back to Mr. Rothstein about the potential for significant costs you want to -- if we don't ensure the tests work. Do you want to talk a little bit more about those costs and what they might mean?

*Mr. Rothstein. Yes, thank you, Congressman. So there are really two areas that we think about in terms of how costs of tests that are either inaccurate or inconsistent among different classes could potentially lead to more costs within the healthcare system. The first, of course, is to the patients themselves and the actual costs associated with those patients needing to go back for retreatment, undergoing treatments that are otherwise unnecessary, and other similar costs that are actually economic costs incurred by the healthcare system.

The other cost is just in the sense of how those types of inaccurate tests or variable tests ultimately lead to less confidence in the testing community, and that is something that we are acutely concerned about in the sense that it is important that patients, providers all have confidence in the tests that they receive, that they have all undergone similar review, similar regulatory oversight, and that there is a public repository especially for them to

have their information known so that patients and providers can understand the context in which they are using these tests.

*Mr. Pallone. Okay. Look, I will just say we can discuss what the exact solution should look like, but at this point, I just think we can all agree that the status quo is not tenable and there is a problem that needs to be solved, and I think we have a responsibility to make sure that FDA has the tools it needs to allow patients and health providers to trust the results of these tests. And I understand that these tests are used in many cases as screening, but the fact is that the results of these tests are being used for treatment decisions, regardless of whether they are accurate, and that is the problem that I see. So thank you all.

And with that, I yield back, Mr. Chairman.

*Mr. Bucshon. [Presiding.] The gentleman yields back. I now recognize Dr. Burgess, five minutes.

*Mr. Burgess. Thank you, Chairman.

Ms. Van Meter, I have got some questions for you, but before I do that, I would like to insert into the record a list of quotes from 40 pathologists across the country

citing the impact of the rule on innovation and patient access to tests as well as a Wall Street Journal article citing the potential outcome of the FDA regulating LDTs, and I will ask for those to be considered for the record.

And let me just ask you, Ms. Van Meter, and maybe I might ask you, Dr. Aisner, would you care to respond to the question that was just posed by Ranking Member Pallone? I mean, he said what is the cost of a test that is in error, but there is also a cost if a test is not done, is that correct?

*Ms. Van Meter. There is no question about that. The cost to patients if access is diminished should test that we use for day-to-day care, it -- for times when, you know, we are looking at precision medicine, laboratory developed services are driving precision medicine. Without those tests, think about the 22,000 patients in the example I offered not that long ago. They and their families would not have had the information they need to make a decision about their cancer or their potential for cancer. So I think that is an enormous factor, Dr. Burgess.

*Mr. Burgess. Thank you.

And, Dr. Aisner, would you care to respond to that?

*Dr. Aisner. I agree completely that the cost analysis is a one-sided analysis that only looks at presumed errors in tests and does not evaluate the benefit that is gained by having LDTs in the market with nimbleness and adaptability, patients would be on diagnostic odysseys cobbling together a piecemeal of FDA-approved tests as opposed to tests that are put together specifically for indications that are not covered by FDA tests.

*Mr. Burgess. Spoken like an integratition, if I may say so. I have got way more questions that I will have time for, so I am going to submit a number for the record, and I do ask that you pay attention to those because they are important. But let me just say this, we have had this hearing a lot of times since the reauthorization in 2007. I was here for that, for the FDA reauth of the user fee agreements. There have been numerous times where I have asked Dr. Shuren what is the problem that you are trying told, and frequently he will be unable to tell me the problem that he is trying to solve.

Now look, all of us want access to tests timely, we want the tests to be accurate. The -- but obviously, Dr. Aisner, if you did a test for a biomarker for someone for

lung cancer, just taking that single result, would you recommend the patient have a thoracotomy?

*Dr. Aisner. Absolutely not. Everything is taken in a context, it is taken in a totality, and part of what a practitioner like me who is integrated into the medical system can bring to the system is exactly what I referred to earlier, this integratition. This does everything, makes sense question.

*Mr. Burgess. Yes. And that is so important. We forget that there -- you know, most physicians do not practice via protocol, we practice using our clinical judgment, our -- based on our years of training and experience, we will always say. So that is what has been particularly irritating to me when we have this discussion and people say, well, someone could get an errant test and then undergo the procedure to remove a body part, and the test was inaccurate and they didn't need it.

Well, wait a minute, no doctor does that. You get an abnormal test, the next thing you do is you call up your friendly radiologist and get imaging or you do subsequent testing. This is not a -- it is not a conditioned response if you get an abnormal test result and you hit the operating

room.

Now I am going to run out of time, but I just have to tell you something, and this is what we forget sometimes when we deal with laws, and we do pass a lot of legislation, I have passed legislation this committee. One of the things you find is after the law is passed, after you go to the signing ceremony and everybody pats themselves on the back, it goes to the agency. And just as we are talking about, we are worried about the FDA promulgating a rule when they violated the Administrative Procedures Act.

If we pass the VALID Act, I don't have the current text in front of me, but I guarantee you there is going to be language that says, and the Secretary shall or the Commissioner shall. And what happens next? An episode of rulemaking. So how can we construct the legislation so we get the desired result and we don't leave ourselves open to an invalid interpretation by the agency when the rules are written.

Again, I have got several more questions, I think they are all important. I encourage you to look at those and provide answers. Look, again, we have had multiple hearings on this in the last 20 years. I will bet this is not the

last one.

So thank you very much, and I will yield back.

*Mr. Bucshon. The gentleman yields back. I recognize Mr. Sarbanes, five minutes.

*Mr. Sarbanes. Thanks very much, Mr. Chairman. Thank you all for being here today. We are going to be hitting the same themes, as you can imagine.

We certainly know that over the last decade FDA has made known its need and its intent to modernize regulation of lab developed tests, which is the subject of this hearing. It is a good thing that biomedical research and innovation has also dramatically increased over the last decade, it is yielding more and increasingly complex diagnostic tests that have the potential -- dramatic potential to improve care and save lives.

At the same time, this increase in the existence and use of LDTs has also, as we know, presented increased regulatory challenges and increased urgency to ensure that the regulatory approach is keeping pace with this innovation to keep patients safe. And by the way, in my former life I actually did work with a lot of these labs as an attorney, so I certainly understand the varying perspectives here.

Dr. Allen, the CDC estimates that LDTs are being used to inform approximately 70 percent of medical decisions these days. That is incredible. Could you just give me a sense, kind of walk through the spectrum of the kinds of decisions, like categories of decisions that are being made now based on results from diagnostic tests in current medicine, just give a sense of what is at stake here?

*Dr. Allen. Sure. I will focus my comments on oncology.

*Mr. Sarbanes. Mm-hmm.

*Dr. Allen. Although there are countless other therapeutic areas that diagnostic testing plays an equally important role, but in cancer alone, it ranges from the initial diagnosis, which may require a test in order to detect the presence of cancer, it would continue into characterizing that type of cancer, does it harbor certain molecular alterations that render different treatment options, be the best course of action for that potential patient. It could continue to even monitoring if the treatment is working. Best case scenario it is and that cancer may be alleviated and diagnostic testing may play an important role in order to monitor the potential or presence

of recurrence. So it is really through the gamut of diagnosis to treatment.

*Mr. Sarbanes. It is high stakes. It is very high stakes.

*Dr. Allen. It is very high stakes.

*Mr. Sarbanes. Millions of patients each year are making critical decisions about their health, potential treatment plans, as you just said, and more based on these tests, and yet we know FDA has very little ability to fully understand exactly what tests are out there, how they are being used or marketed, and their accuracy. So there is a lot of potential risk here or existing risk, frankly, and it is something that is worrisome as one wrong test could truly mean the difference between receiving preventative care, appropriate treatment, or diagnosis for patients.

Dr. Allen, what are the real world implications of inaccurate diagnostic tests and how important is it that FDA be able to ensure the accuracy of all tests being used in the practice of medicine? Maybe just take the second half of that. FDA, given what its mission is, right, and what we invest in it as the public in terms of our expectations of its overview of the landscape, why is it so important to

make sure that the accuracy of these tests is sound?

*Dr. Allen. I think just given the magnitude of decisions that are made based on the results of these tests and the risks associated if an inaccurate result is provided. And this environment continues to get increasingly complicated. What we have seen from our research itself is that there are multiple different tests that are out there that have a similar intended use. It doesn't mean they necessarily all perform the exact same.

It doesn't mean they are all wrong, it just means that there needs to be a more transparent system to be able to understand how different tests relate to one another to ensure that when the patients are given the results, no matter which test they receive, they are able to be correctly interpreted and the right action taken.

*Mr. Sarbanes. Right. I have long advocated for increasing FDA's oversight of LDTs to ensure the patient safety, to give providers the tools they need to best serve their patients. Of course, you know, the finalization of the rule doesn't preclude Congress from continuing to work together to further promote patient and provider confidence in or the safety and efficacy of the diagnostic tests, but

we know patients deserve to be able to trust the diagnostic results they receive from any test, regardless of where it is made.

I mean, just we all know from our own lives like how much you hang on to this result that is coming, the expectations that are there, and how it can affect you. And so I hope to continue to engage with my colleagues on this critical issue.

And, Mr. Chairman, I yield back the time. Thanks.

*Mr. Bucshon. The gentleman yields back. I now recognize myself for five minutes.

Certainly I agree with Dr. Burgess. Congressional intent is commonly misconstrued, and that is why we need to be very prescriptive and that is why we are going through this process. Today for me is an exciting day. I have been working on this issue for many years, over seven years. I know it is a complicated topic, so I want to express appreciation to all my congressional colleagues who are participating here today so that we can learn more about this critical issue.

I would like to associate myself with the comments of many of my colleagues who have expressed displeasure at the

thought of the FDA regulating LDTs as medical devices for a lot of reasons, ones that we have already heard will -- and continue to hear. These unique tools should not be evaluated in the same way that the FDA reviews machines, implants, and other kinds of devices. But it is not just L -- that LDTs are ill-suited to be evaluated as medical devices, the entire category of in vitro diagnostic tests should be differentiated from devices and provided their own less burdensome pathway for review and approval. Congress needs to act.

That is the idea behind the VALID Act, which Congresswoman DeGette and I have been working on, again as I mentioned, for over seven years. While the VALID Act, like the LDT rule, assumes that diagnostic regulation is in need of change, takes a much different approach. First of all, there is a grandfathering clause in VALID, which is really important. VALID creates a new pathway for the FDA approval of in vitro diagnostics including LDTs. Under a framework, tests would be categorized as low, medium, or high risk and treated in a manner that is appropriate for each level of risk.

For example, low risk tests could bypass the FDA's

premarket approval process all together, and even most medium risk tests could obtain a technology certification that would allow them to immediately enter the market. Under VALID, high risk tests, while generally subject to FDA approval, would be exempted if developed for specific individuals or small groups of people. This would allow, for example, a hospital to offer a highly sensitive toxicology test to a toddler presenting with seizures and altered mental state to accurately identify potential substances consumed.

The VALID Act is complex so I will spare everyone further details at this time, but just know that it is a carefully developed, well-vetted piece of legislation that needs further work, and that many experts and stakeholders have weighed in on this. In fact, many of our witnesses and their organizations work constructively -- in fact, all of our witness's organizations work constructively with Congress to provide feedback on VALID, and I am grateful to them.

So I think some of you have already answered this, but would all of you be willing to continue to work with Congress and this committee to find a good place to be on

regulation of these tests?

*Ms. Van Meter. Yes, sir. Thank you.

*Mr. Rothstein. Yes. Thank you.

*Dr. Karcher. Yes, definitely. Excuse me. Yes, definitely.

*Dr. Allen. Absolutely. Thank you.

*Dr. Aisner. Absolutely. Thank you.

*Mr. Bucshon. And that is great and thank you for all of that.

To my colleagues, please don't let the FDA's overreaching, overburdensome rule dissuade you from taking action related to diagnostic testing. This is -- there is a lot of work here that needs to be done. The future will include more complex testing, including genetic testing, as has been talked about today. This requires a regulatory climate that ensures accuracy and clinical relevance. Patient safety is paramount. As a physician, I can't overstate that.

Mr. Rothstein, do you believe that the VALID Act actually encourages innovation as compared with the status quo, or how so, and particularly if the rule is implemented?

*Mr. Rothstein. Sure. Thank you for the question. So

in terms of the current economic environment that the laboratory testing and in vitro diagnostic testing community engages in, it is really riddled with regulatory uncertainty. So at an initial level, the VALID Act would bring in regulatory confidence in the sense that investors, laboratories, manufacturers would all understand where this issue would finally lie.

In addition, we think that the VALID Act has a number of provisions in it that are really helpful to bring innovative products to market. These include modernized frameworks like the technology certification program. That allows for a company to go to FDA one time with a technology platform and be able to iterate on top of it in the market without going back to FDA for future tests that utilize that same platform. It also offers better provisions around how device modifications are made in the post-market context. So again, not like [indiscernible], but something similar. It would allow for test makers to develop new parameters of their tests that allow them to iterate in the market also without potentially going back to the agency.

In addition, I would just add one more, and that is the fact that the VALID Act includes mitigation measures that

FDA can deem certain types of individuals who make the test as a mitigation measure to bring that test down to a lower risk classification which would also help spur innovation and bring more tests to the market.

*Mr. Bucshon. Thank you for those answers, and thank you all for your commitment to continue to work with the committee in this really what I see as a critical area that needs to be addressed.

With that I yield back, and I recognize Mr. Cardenas for five minutes.

*Mr. Cardenas. Thank you, Mr. Chairman, and I would also like to thank the ranking member and the chair of the committee for holding this important hearing, and I would like to thank the witnesses for being here and providing your expertise and your opinions in full view of the public.

As many colleagues have discussed, laboratory developed tests, or LDTs, are being used to guide important medical decisions for many Americans. Not only is there a clear public health impact, but LDTs often influence medical decisions and help determine the best course of treatment. Ensuring these tests are adequately regulated and held to the proper standard is vital to functioning -- a functioning

health system.

More importantly, patients deserve peace of mind when it comes to their health information and test results that are communicated to them. As diagnostic technology advances, it is our responsibility to make sure we are taking the appropriate steps to maintain quality and accessibility while allowing innovation to continue. Finding the balance between the elements is precisely why I am looking forward to hearing from our witnesses today.

We cannot proceed without first understanding what kind of resources are available to the FDA to appropriately mitigate public health risks and guarantee safety and efficiency in diagnostic testing. I am encouraged by the collaborative efforts from my colleagues on both sides of the aisle in recognizing the importance of addressing the regulatory environments of LDTs

Seeing as we agree on the need for access to trusted and reliable diagnostic testing, I would like to direct my first questions to Mr. Rothstein. Mr. Rothstein, in your testimony you mentioned the importance of providing necessary appropriated resources to support the implementation of regulatory frameworks. What are some of

the resource constraints you expect the FDA to have, if any, and how can Congress ensure implementation is resourced appropriately?

*Mr. Rothstein. Thank you for the question. In terms of -- I guess there is two ways we could think about this. One is in terms of the proposed rule itself and how FDA will implement it. The other is in terms of VALID and what VALID would require. And I think when we look at things like the VALID Act, we would expect for Congress to help FDA increase its ability for review capacity of additional products.

It would also set up a user fee program, and that user fee program is essentially to bringing both the industry and the FDA together to ensure that both the product makers and the regulator have kind of clear rules of the road in terms of what that review timeline would look like and that FDA would be able to meet those timelines. Of course, Congress would also have a say in this after those user fee negotiations are complete.

*Mr. Cardenas. Thank you. I also want to discuss how to best ensure patients are getting trusted results. Can you clarify your concerns with leaving the FDA framework as it exists currently?

*Mr. Rothstein. So currently laboratory developed tests that are not subject to FDA regulations don't include a public repository of the data associated with how they operate. CMS has actually testified to this issue before before this committee in the sense that not only could different LDTs have variability in their results but also that there is no public mechanism to understand what that variability looks like. And so we think it is important that any comprehensive regulatory reform in this space include that public repository so that both patients and providers have access to that information and are able to understand the decisions they are making with these tests.

*Mr. Cardenas. Thank you. As we look to regulate effectively, access to innovation should be an important focus. How would you respond to concerns that oversight could prevent or unnecessarily delay the development of LDTs?

*Mr. Rothstein. Well, I think as an initial matter I would say as a nation we would all be better off in a system that really puts test makers in a place where they are competing based on quality and innovation not gaming out a bifurcated regulatory program. The VALID Act has a lot of

provisions in it to really encourage not just the regulatory certainty that the community needs but also to encourage the development of cutting edge novel diagnostics that patients would be able to access through programs such as the technology certification and through also a clarified mechanism for all tests to follow.

*Mr. Cardenas. Thank you.

Mr. Allen, can you elaborate on the dangers of not taking a uniform regulatory approach in diagnostic testing for cancer patients in particular?

*Dr. Allen. I think it begins with uncertainty. You know, we have heard a number of times today both from those of us at the table and from members in their statements that everyone is citing estimates of the number of tests that out there. Under the current paradigm, there is no way of knowing the number of tests that are being offered, let alone how they are performing, and I think that that is issue number one that would be achieved by additional oversight here, by bringing all tests into a common construct, a level playing field, and understand what is being done in the environment, and giving FDA the ability to act if warning signs are seen so that they can work with the

developer, mitigate those challenges, and make sure that they are resolved.

*Mr. Cardenas. Thank you, Mr. Chairman, I yield back.

*Mr. Bucshon. The gentleman yields. I now recognize Mr. Latta, five minutes.

*Mr. Latta. Well, thank you, Mr. Chairman, and thanks for our witnesses for being with us today.

Clinical tests play a major role in nearly 70 percent of all clinical decisions through screening, diagnosing, and managing diseases and medical conditions. As innovation advances, we are better able to intervene and assist with our health infrastructure. Accessibility and accuracy of tests save lives.

I am very concerned about what the Food and Drug Administration's proposed regulation for laboratory developed tests will do. It is an outrageous overreach of the agency's statutory authority. The rule will limit our healthcare professionals' ability to tailor and modify LDTs to patients' needs.

Ms. Van Meter, diagnostic tools used in pediatric health are sometimes vastly different than for adults. LDTs allow pediatric-focused institutions to serve pediatric

patients through the use of age-appropriate and needed technical modifications. How will this rule impact pediatrics? And just by coincidence, this week I was at a pediatric facility and this came up. And will we, in fact, be discriminating against our children because of this rule?

*Ms. Van Meter. Thank you for the question. We are tremendously concerned about pediatric patients, small patient populations, patients with rare disease. LDTs are the principal source of diagnostic tools that serve these patient populations. I fear that with a one size fits all application of the Medical Device Authority's tremendously inflexible authorities, we are going to see patients lose access to those necessary services.

I will give you an example of a tremendous test I am sure that you heard about in your visit recently. There is a laboratory developed test service that is used on patients in the neonatal intensive unit, our smallest patients, rapid hold genomic sequencing. This tremendous test allows for there to be determinations of what is ailing the patient, in 40 to 50 percent of cases avoiding a diagnostic odyssey for patients and families. That is a laboratory developed test service. I worry that patients will lose access to those

types of services if, in fact, this rule is implemented.

*Mr. Latta. Let me follow up. Given the -- that the proposed rule does not contain any exemptions for low volume, or custom, or even humanitarian tests, how do you anticipate your members will adapt when providing care for rare diseases?

*Ms. Van Meter. I think that the laboratory community across the country, and certainly ACLA members, are already doing the work to determine how to implement this rule. That means calling through test menus to make determinations about for which test submissions can be developed and submitted. And keep in mind, it is within three-and-a-half years that all high risk test submissions must be submitted to the agency. It is an impossibility that that could happen.

So in short, I think we will see some tests come off of test menus, and I worry most about those who serve the small patient populations for which revenue is modest.

*Mr. Latta. Thank you.

Dr. Aisner, what are the impacts to diseases with a genetic basis that require more specialized and sophisticated tests such as gene and cell therapy?

*Dr. Aisner. In order to effectuate gene and cell therapy, a number of tests have to be developed on a per patient basis, and oftentimes an individual patient needs to have a test developed just for them. It is unclear how a laboratory could establish a paradigm in which they have the ability to move forward with this. If these tests are determined to be high risk, I believe that the technology certification no longer applies.

I think that there is a real danger that we will cut off the ability to bring about the most cutting edge, the most innovative testing. An example I can give you is a laboratory at the University of Colorado is working on cell therapy and they have sought out our approach -- our assistance in molecular diagnostics to make sure that their product doesn't have any contamination from any of the non-patient cells that are needed to generate the product. These are things that we can adapt to on the fly because we know what we are doing.

*Mr. Latta. Thank you.

In my last 37 seconds, Mr. Rothstein, how would you anticipate your member companies allocating their investments into research and development differently if the

final rule is published?

*Mr. Rothstein. In terms of the current regulatory uncertainty that exists within the environment that we deal with today, the final rule would bring about at least some level of certainty, potentially long term; however, litigation is likely to ensue. We would prefer regulatory certainty through VALID because that would really allow for investments, decisions both from the investment community and from members who make our -- who have R&D dollars to spend to really understand what the future of diagnostics regulation will look like.

*Mr. Latta. And I know, Mr. Chairman, my time is expired, but I guess I am going to assume then when you are looking at pediatric diagnostic tests and other small [indiscernible] I assume you would say that those would be hard hit then?

*Mr. Rothstein. No patient should lose access to these critical tests. At the end of the day, you know, if there are concerns in the docket, we would expect FDA to address them in terms of how it implements the final rule. We don't think, though, that, you know, any patient, particularly those in a vulnerable population, should have a test that

has not gone through the same standards of review as any other patient's.

And that is why, again, we think VALID has a number of provisions in it to really bring those types of tests to vulnerable populations, those with unmet needs, rare diseases, and pediatrics in a much more equitable fashion. It has that technology certification platform that allows for tests to be made more rapidly without going through the FDA review. There is a low volume exception in it as well, plus it includes grandfathering, which means all the tests that are on today and potentially those for the next four or five years after the act would be implemented, could also remain on the market without going through FDA review.

*Mr. Latta. Thank you.

I appreciate the indulgence of the chair. Thank you very much.

*Mr. Bucshon. The gentleman yields back. I recognize Dr. Ruiz, five minutes.

*Mr. Ruiz. Thank you. Thank you, Mr. Chairman. We must continue to work towards developing new diagnostics and treatments and we need to ensure adequate protections for patients along the way. Patients must be able to have

access to accurate information about their health and providers need to be able to trust that the tests they are prescribing for their patients work and are safe.

Many of these tests have the potential to change the way we approach cancer detection, such as multi cancer screening tests. These tests have lifesaving potential, and that is why I am an original cosponsor of the bipartisan Nancy Garner Sewell Medicare Multi Cancer Early Detection Screening Coverage Act. So this bill would require such tests to receive FDA approval before being able to even engage Medicare in the national coverage determinations process.

So, Ms. Van Meter, how can we evolve our testing capabilities as we learn more about biomarkers and cancer DNAs and ensure patients feel safe and assured of tests performance?

*Ms. Van Meter. Thank you for the question. I would like to take the opportunity to explain that there is significant regulation and oversight in place right now for laboratory developed testing services that not only includes CLIA and all ACLA members are accredited at the highest level to develop high complexity tests. Every ACLA member

is also accredited by CAP, the College of American Pathologists. The vast majority go through the risk base assessment program that New York State offers, looking at analytical and clinical validity, and the majority of molecular laboratories in this country are within the 28 states that Medicare's MolDX Program assesses for analytical and clinical validity.

In short, I would say that patients and providers should have confidence now in the accuracy of tests. We can see a potential role for the FDA not through unilateral rulemaking to take the medical device authorities and apply them to laboratory developed test services. They are not medical devices, they are professional services. This is an opportunity I think to do this right and would encourage the committee to look at comprehensive legislation.

*Mr. Ruiz. Thank you. The FDA's proposed rule lays out several examples of lab developed tests that produce inaccurate results that lead to harmful outcomes for patients. COVID made clear the importance of FDA oversight of these tests. If these tests don't work, we undermine the public health response to such public health emergencies.

FDA published an analysis of the first 125 emergency

use authorizations requests for COVID-19 LDTs where 82 showed problems. In one case, the approach to test validation was so poor that when redone correctly, there was a 400 fold difference in performance. Multiple laboratories that offered their test did not provide any analytical or clinical validation data in the EUA request that they submitted after the tests were in use.

Mr. Rothstein, what are the consequences for patients and the public health response if FDA is not reviewing tests for public health emergencies?

*Mr. Rothstein. Well, thank you, Congressman, for the question. Look, at the end of the day, if there are not -- if we do not have the regulator with expertise to review these products, looking at them ahead of time, we lead to a situation where patients and providers will lose trust in the market. It also again creates regulatory uncertainty in the investment community, which is not good as we want to try to develop tests rapidly and iterate.

I would like to point out that during the COVID pandemic the diagnostics industry really had a tremendous response here, ramping up our production domestically, increasing our ability to bring novel tests for COVID-19 to

market. In addition, not just for laboratories but also at the point of care, those are at clinics and other types of --

*Mr. Ruiz. Thanks.

*Mr. Rothstein. -- providers outside the hospital setting.

*Mr. Ruiz. Thank you. Thank you. I have one minute left.

Dr. Karcher, in your testimony you discussed a tiered risk-based approach. How would creating a tiered risk-based approach to FDA approval of LDAs (sic) protect patients?

*Dr. Karcher. Thank you for the question. Thank you very much for the question. So we do advocate a tier-based approach, we have for 10 years -- actually longer than 10 years. We believe that there is a group of high risk tests, it is a small subset of laboratory developed tests, that are really in need of high level oversight and we believe the FDA is the appropriate agency to do that. That would protect patients that are receiving those tests.

Likewise, we also strongly believe that there should be significant flexibility in the oversight of the less -- lower risk tests so that it would allow those tests to

continue to be developed without any restraint, and that patients would continue to have access to all of those tests, including now high risk tests with a higher level of confidence.

*Mr. Ruiz. Thank you.

*Mr. Bucshon. The gentleman yields back. I now recognize Mr. Bilirakis for five minutes.

*Mr. Bilirakis. Thank you. Thank you, Mr. Chairman, I appreciate it.

As co-chair of the Rare Disease Congressional Caucus, it has been our priority to improve the development and access to diagnostic testing for the more than 30 million Americans with rare diseases. There has been an incredible amount of innovation in this space, particularly in the field of molecular diagnostics for rare cancers as we move forward towards personalized position -- precision medical.

For example, Moffitt Cancer Center in my home state of Florida currently serves over 20,000 patients per year with innovative biomarker testing with fast, safe, and accurate results to improve patient outcomes. Needless to say, I am highly concerned that the FDA's proposed rule to regulate lab developed tests would reduce patient access to these

types of innovations, and I appreciate the panel's testimony this morning.

Ms. Van Meter, there are many challenges in treating rare diseases, including the small patient populations, lack of natural history studies, and lengthy diagnostic journeys for most rare patients. Will the FDA's LDT rule add further challenges to conducting clinical trials for potential treatments and cures for rare patients and how should Congress think about the economic and patient impact tradeoffs of offering LDT services for rare disease under the FDA's proposed framework?

*Ms. Van Meter. Thank you for the question. We do indeed think that there will be a downward impact on patient access to testing generally. We are acutely concerned about patient populations, small patient populations, rare diseases in particular. Laboratory developed testing services is really the backbone of diagnostics for those patient populations, so we are very concerned with the unilateral approach that FDA is taking in this proposed rule to apply the medical device authorities, which are dramatically inflexible and ill suited for diagnostics period, to laboratory developed testing services.

*Mr. Bilirakis. Thank you.

My next question for Mr. Rothstein. Can you share your perspective on the FDA rule's impact on rare disease patients? Is there a way Congress could tailor diagnostics regulations to avoid or mitigate these concerns and do you believe FDA's recent announcement of its intent to down classify most high risk IVDs will provide a less burdensome pathway for most LDTs? Again, for Mr. Rothstein.

*Mr. Rothstein. Thank you for the question. In terms of the proposed rule, again, our position is that no patient should lose access to these important tests and FDA needs to respond to any comments that are in the docket on this point. We do continue to believe though that all patients deserve tests that undergo the same regulatory review, and that is why the VALID Act really provides a much more suitable mechanism here, particularly for those with rare diseases and unmet needs.

The VALID Act includes a technology certification program which allows for tests to be rapidly iterated and brought to market without going to FDA. It provides for modifications to be made once the product is in the market, too. There is also a low volume exemption which is included

in the VALID Act at this time that would allow for tests up to 10,000 to be brought into the market without going to the FDA under the VALID Act.

In terms of the down classification proposal that FDA has issued, that is something that I would have to look into a bit more to provide a more succinct answer for you.

*Mr. Bilirakis. I appreciate that. If you can get back to us, we would appreciate that.

Third question. Dr. Karcher, given your organization's perspective accrediting CLIA labs, do you believe the proposed timeline for ending enforcement discretion is realistic for labs to meet in order to prevent gaps in care? Again, for Dr. Karcher.

*Dr. Karcher. Thank you for that question. So we do not believe that laboratories would be able to function and provide the services that are vitally important to patients if enforcement is ended prematurely. We think that it would take laboratories a much longer period of time to be able to adjust to the changes that are in the rule as written, and therefore, many laboratories would simply give up and stop developing LDTs, so we think it would really impact access.

*Mr. Bilirakis. Well, thank you so much. Very

valuable information, great feedback, and we appreciate it so much. Thank you.

I yield back, Mr. Chairman.

*Mr. Bucshon. The gentleman yields back. I now recognize the gentlelady from Michigan, Mrs. Dingell, five minutes.

*Mrs. Dingell. Thank you, Mr. Chairman. As we have heard today, the FDA plays a very important role in regulating and ensuring the highest levels of safety to laboratory developed tests, or LDTs, as we have been talking about. The new proposed rule aims to provide greater oversight of LDTs to improve their safety and effectiveness. In addition to diagnosing, monitoring, and treating diseases, this new rule has implications for the testing and screening of serious diseases, such as tuberculosis, that can be transmitted to patients in donor materials used for medical procedures.

A lack of oversight and accountability for tissue donation services can lead to devastating consequences for patients and their families. In fact, I am co-leading the bipartisan Shandra Eisenga Human Cell and Tissue Product Safety Act to strengthen awareness and accountability of

tissue product providers. This legislation comes as a response to the passing of Shandra Eisenga, a woman from Michigan who actually -- her sister works for my colleague, John Moolenarr, due to the complications of tuberculosis infection. She fatally contracted TB after receiving a bone graph that was used from an effective (sic) donor.

Mr. Rothstein, my understanding is there is not currently an FDA approved test to detect tuberculosis in donor materials. What impact might the new proposed rule on LDTs have on the testing and screening of tuberculosis in donor materials to prevent infection?

*Mr. Rothstein. Thank you for the question. And as I have said, no patient should lose access to critical tests as a result of the FDA rule. What I would like to point out, though, is that the current market dynamics are likely what leads to the lack of an FDA approved test to be on the market today as opposed to innovation within the manufacturing community of IVDs.

With a two-prong system in terms of how we bring tests to market right now, there are cases even documented in FDA's proposed rule that show once a IVD manufacturer brings a product through the FDA program into the market, LDTs are

then developed and compete with them. And so right now under the current system, the manufacturers of IVDs have to consider that potential for whether or not they bring a test to market through the agency.

That is why comprehensive diagnostics reform would be so important. It would put everybody into the same program, into the same system, and patients would continue to receive these products, and we would be able to understand how to best allocate our investment resources, our R&D dollars to meet the patient needs that exist.

*Mrs. Dingell. So, Mr. Rothstein, from a public health standpoint, why is it equally important for FDA to have oversight over all diagnostic tests including conventionally manufactured tests, test kits, those developed and used in laboratories and tests used in academic settings?

*Mr. Rothstein. Sure. Thank you for the question. At this time, LDTs and IVDs continue to become more and more complex. They also continue to be made by various and very different types of entities, more than just those that are represented at this table right now.

The current framework is very old, to say the least, but VALID -- well, VALID is a much more appropriate approach

here to bring these tests to the market because what it would do is offer again a more tailored mechanism for them to come into the fray. However, under the current system, all LDTs right now do not go through premarket review. They also do not have consistent post-market review, or analysis, or a comprehensive program to capture any adverse events, malfunctions, or recalls that occur.

*Mrs. Dingell. Thank you.

This question is going to be for Dr. Allen. Some have also raised concerns that prenatal testing has led to false positives that wrongly indicate a fetus has a genetic condition. Also, women who have been tested for breast or ovarian cancer have received false positives, which could impact their decision to receive a mastectomy or hysterectomy, a huge medical decision that relies on -- can rely on inaccurate information.

Dr. Allen, can you speak about the inaccurate results from LDTs? How would oversight from the FDA be helpful in lowering such errors?

*Dr. Allen. I think what you have noted here is just the magnitude of the issue that is at hand, and so that is really the insurance that FDA oversight would provide, and

do so before these tests are being utilized in the market. That is an important distinction. What -- premarket review would ensure the performance of the task before they are being applied and the -- those results are available to patients.

So in these particularly high risk scenarios, the true accuracy of the tests is what is very important, not where it is developed, and that is what a level policy at FDA would provide.

*Mrs. Dingell. Thank you.

Mr. Chairman, I am out of time, so I yield back, and will be submitting questions for the record.

*Mr. Bucshon. The gentlelady yields back. I recognize Dr. Dunn, five minutes.

*Mr. Dunn. Thank you very much, Mr. Chairman, for holding this hearing today. The testimony that has been presented is very compelling and I hope that the administration and the FDA are listening.

I will be clear, I strongly oppose the proposed FDA rule. I appreciate hearing the perspectives from industry leaders, practitioners, and patients. Sweeping decisions about the regulation of lab developed tests that are

utilized by hundreds of thousands of patients and providers should not be left to FDA bureaucrats, many of whom have never worked in a lab in their lives.

We know the FDA is slow, they move at a glacial pace to approve innovative medicines and devices, and we know that CLIA provides robust oversight of laboratory operations, as outlined in the testimony of Mr. Rothstein. I agree with our witnesses today. The FDA rule crush innovation, put unsustainable upward pressure on the costs to labs, and set America back on genetic testing, toxicology testing, and screening. Why in the world would we subject our innovators to review by an agency that is already bogged down with inefficiencies that deter innovation?

The landscape of lab development tests is robust, it is very successful today. We have a plethora of tests that exist to diagnose and screen for rare and common diseases. Ensuring the patients and physicians, not bureaucrats, are in the driver's seat when it comes to delivering care should be our goal. This is particularly important in rural areas like my district with access challenges. smaller labs that develop tests that allow rural patients to access complex diagnostics in a timely manner close to home.

Imagine if a custom diagnostic test had to pass through the web of the FDA device approval regulations to be available. That diagnostic test would likely be obsolete, a true fossil by the time it actually saw the light of day. That is not to mention that the rural facilities my constituents have access to would be crushed under the increased regulations that this would require. And let's not forget the impact that this rule would have on high performing cancer centers as well, such as the NCI designated Moffitt and University of Miami in Florida, UF -- all in Florida.

These centers provide top of the line laboratory developed tests and quality control processes to deliver high quality tailored care to their patient populations and their teams of world renown experts and faculty members who interpret many thousands of tests every year would be hampered. Dr. Theresa Boyle of Moffitt has said that this proposal to change the FDA policy of enforcement for the LDTs will shut down our routine and our innovative molecular testing at Moffitt, such as the philanthropically funded prescreening test for clinical trial matching. In an era of highly personalized medicine and strides in rare disease

research, inhibiting clinical trial matching is an unacceptable consequence of this rule.

Dr. Aisner, thank you so much for sharing your expertise today, both from the physician perspective and also from the patient perspective. Can you speak to the incentives that would drive workforce decisions? You know, you do wonderful work at your lab in Colorado, the molecular correlates laboratory, but if facilities such as cancer centers and academic medical centers can't innovate in the lab, I suspect we will see a stagnation in innovation and a consolidation of -- in the pipeline, we will see fewer people applying. What do you think?

*Dr. Aisner. I agree completely. I think that if I need to stop innovating new lab tests and bringing new lab tests into the lab in order to retroactively focus on the things we have already done, I will have to completely restructure who we hire, why we hire them. We will have more regulatory staff than we will have technical and R&D staff, and I think that that will bring the pace of the lab to a grinding halt.

*Mr. Dunn. Thank you very much for that.

Ms. Van Meter, can you elaborate on some of the issues

that medical device style regulation might have on toxicology testing for developers and hospitals and in the emergency room?

*Ms. Van Meter. Yes. Thank you for the question. When patients are being treated for substance use disorder, toxicology testing is really essential to drive the right care and also for public policy to ensure that we understand what substances are impacting our communities. So laboratory developed test services are the core testing available for these circumstances. As was pointed out earlier during the hearing, for example, xylazine with fentanyl, which is plaguing communities around the country, the only test for those substances is an LDT.

And so we think the downward impact on the accessibility of a needed testing for toxicology would suffer tremendously under the FDA rule.

*Mr. Dunn. Thank you very much. And I thank the chair for this meeting again. Thank you to the panel.

*Mr. Bucshon. The gentleman yields back. I now recognize Ms. Kelly for five minutes.

*Ms. Kelly. Thank you, Mr. Chair, and thank Chair Guthrie and Ranking Member Eshoo for holding today's

important hearing.

The FDA and CMS have issued a joint statement reiterating that modernizing the Clinical Laboratory Improvement Amendment is not the answer to addressing concerns about the accuracy of laboratory diagnostic testing or LDTs. In fact, CMS has repeatedly said and testified before this committee that it does not have the expertise to ensure the tests work. This expertise lies with the FDA.

The joint FDA and CMS statement reiterates that CMS's CLIA program is separate in scope and purpose from FDA's oversight. In the statement which CMS posted on its website, CMS specifically said that they support FDA's proposed rule on LDTs. CMS also clearly says that expanding CLIA to oversee LDTs would be duplicative of what FDA is already doing and would create more government bureaucracy and inconsistencies.

Dr. Allen, what are the deficiencies in CMS's current regulatory structure and how would FDA regulations address those?

*Dr. Allen. As you mentioned, they were just set up to be very different, and so to expect a agency that has been directed for decades to oversee laboratory operations, to

shift their focus and start focusing on the performance of individual tests and the analytical and clinical validity of them is not in their wheel house, and so I think it would be a misguided approach to what we are hoping to see achieved through additional oversight.

As you said, the expertise and the experience, frankly, lies at the FDA. They have been reviewing similar diagnostic tests for many years and I have the faith that they have the expertise to continue to do so.

*Ms. Kelly. Thank you for your response.

Mr. Rothstein, it is evident that even among FDA approved diagnostics, women and individuals from marginalized communities are underrepresented in the trials necessary for approval, resulting in these tools being less effective across all populations. The FDA is working to improve this by encouraging diversity in clinical trials, but my concern is that for LDTs, the issue is in lack of representation, could even be worse than for commercial tests given the lack of oversight.

How can we ensure that laboratory developed tests and use are equally effective in screening for conditions across diverse populations?

*Mr. Rothstein. Thank you for this question, it is a very important issue. And in terms of the current status of representation in the population used to validate LTDs, we simply don't know, and that partly comes to the fact that LDTs do not have currently a public repository. We still believe that the VALID Act or other types of comprehensive regulatory reform would be most appropriate to bring all tests under a single framework. By doing so, we would ensure that all the tests that are currently LDTs are also going through the same process at FDA that IVDs do, that ensure that the clinical trials represent diverse populations.

*Ms. Kelly. Thank you so much for your response.

And I yield back.

*Mr. Bucshon. The gentlelady yields back. I now recognize Mr. Carter, five minutes.

*Mr. Carter. Thank you, Mr. Chairman. Thank all of you for being here. We appreciate this is extremely important. And I know that my colleagues have pointed this out, that diagnostic tests, including laboratory developed tests, play such a critical role in our healthcare system. As a healthcare professional, as a pharmacist, I understand

that, and I appreciate that, and I appreciate what you all do.

It has been estimated that 70 percent of all healthcare decisions are influenced by lab tests. I know I was a consultant pharmacist in nursing homes and we depended on lab tests quite often to help us in our decision making on drug therapy, and that was extremely important. The rules that the FDA is proposing could stifle innovation, as we all know, and that is our fear and our concern, and it could hinder patients' access to tests.

Ms. Van Meter, I wanted to ask you, and I don't mean to be redundant, and I suspect you have answered this already, but could you elaborate again on the importance of laboratory developed tests and for innovation and diagnostics in medicine?

*Ms. Van Meter. Yes. Thank you for the question. So laboratory developed tests really are the cutting edge when it comes to leading the foundational work for personalized medicine. Laboratory developed tests are among the first tests that are developed when we are facing a new pathogen of concern. Among the first EUAs, for example, for a COVID test were laboratory developed tests and laboratories across

the country were able to dramatically augment the Nation's testing capacity.

So if it is for infectious disease, is it for precision medicine, laboratory developed tests are really leading the way on innovation. So we are significantly concerned that a medical device authority application broadly in this unilateral fashion without any exceptions is not the right approach. We think a comprehensive legislative approach would be the right direction.

*Mr. Carter. Okay. I want to ask each of you a yes or no question. You pretty much just answered it, Ms. Van Meter. But yes or no, do you think the current medical device framework is best suited to address regulation of all diagnostic tests, including laboratory developed tests?

*Ms. Van Meter. I do not.

*Mr. Rothstein. No, we believe something similar to the VALID Act would be much preferred.

*Dr. Karcher. We do not and we also believe the VALID Act would provide the flexibility that we would need for this kind of oversight.

*Mr. Carter. Good.

*Dr. Allen. It is better than the absence of oversight

but would favor the VALID Act.

*Mr. Carter. Right.

*Dr. Aisner. We do not believe the device approach is appropriate.

*Mr. Carter. Okay. Dr. Karcher, let me ask you, do you think that the LDT rule places independent pathologists in large corporations on an equal playing field? And I will preface that question or I will add to that question by saying that I was an independent retail pharmacist, so I am very concerned about independent pathologists as well and I have quite a few in my district as well.

*Dr. Karcher. Thank you very much for that question, and it is a very pertinent observation. So, no, it does not create a level playing field. Local laboratories are very -- would be very disadvantaged if this rule were to go forward as written.

We think it is very important that laboratories that are performing LDTs develop and perform those LDTs for patients in the hospital or the network where that laboratory is located. We are familiar -- as a pathologist, I can say we are familiar with those patients, we are in constant communication with their physicians, and that

allows us to safely offer those tests. So we would be at a disadvantage and patients would equally be disadvantaged.

*Mr. Carter. Right. Good. Well, thank you for that answer.

Dr. Aisner, let me ask you, do you share the same worry that I do and that is that raising the barrier to accessing new cancer diagnostics will be another arrow aimed at cancer patients?

*Dr. Aisner. I absolutely do, and I can speak from personal experience as a patient who accessed LDTs for my own personal patient care. The environment that allowed those tests to exist in the first place is the reason I was able to avoid chemotherapy. That is a really big deal to me, and I think that if we lose the ability for people to bring new and innovative technology, that we are going to be treating everybody in a very broad fashion rather than tailoring the care that we need to tailor.

*Mr. Carter. Thank you for that.

Mr. Rothstein, let me ask you one last question. As we consider possible legislative approaches to address this issue that has been raised here today, what would be the most important component of any alternative legislative

proposal and what should we avoid?

*Mr. Rothstein. Sure. Well, thank you for the question. In terms of what the proposal should look like, we think the VALID Act takes it pretty much all of the way there in terms of a single framework that addresses patient needs, provides a single regulator with innovative premarket and importantly post-market concepts included.

In terms of avoidance, I would defer to my colleagues on the CLIA side there in terms of what issues they experience would be most problematic.

*Mr. Carter. Great. Okay, I will leave it at that. But thank you all.

And I will yield back, Mr. Chairman.

*Mr. Bucshon. The gentleman yields. Now I will recognize Dr. Schrier, five minutes.

*Ms. Schrier. Thank you, Dr. Chairman, and thank you to all the witnesses for coming here to discuss the FDA's proposal to regulate lab developed tests. I know all of us here have varying views on how the Federal Government should regulate LDTs, which tests require regulation, how the urgency and the severity of illness should factor into these decisions, also how the absence of a good alternative should

factor in.

To me the heart of this issue is ensuring a balance. A balance is struck between ensuring that the tests are trustworthy and accurate but also maintaining that access to testing. We don't want to allow inaccurate testing to mislead and harm clinicians or patients. We also want to ensure that people have adequate access. And we just heard about a case where having access to a lab developed test guided treatment.

Dr. Allen, my first question is for you. Can you just point to maybe a couple examples of, you know, this testing can save lives but the opposite is true as well? It could have misguided the way that cancer was treated in this case. Could you share some of the potential harms, some of the potential benefits?

*Dr. Allen. Sure. You know, I think that, you know, the role that diagnostic testing is playing in oncology care, diagnosis, decision making is increasingly complicated. The analytes that are being evaluated in order to determine treatment continue to evolve and that has -- you know, to the benefit of patients that are receiving these tests, and I think their availability is hand in hand

with the -- their accuracy, and we need to make sure that both are accounted for.

And I think it is important to look at it perhaps at a local level. It had been mentioned earlier that a number of these tests are regulated by New York State. Laboratories big and small have been able to comply with those regulations and I don't believe that patients in New York State, whether they be in urban or rural areas, are precluded access to these innovative tests. Given their importance, I think that is something to consider --

*Ms. Schrier. Thank you.

*Dr. Allen. -- as we look toward federal --

*Ms. Schrier. We also have a state regulation in the State of Washington. I just want to quickly mention, there is lots of tests that have different sensitivities and specificities like the flu test that we use, the strep test we use, even the COVID test, we all had to understand that if you got a negative the first time, you check two days later. I just would like to mention that like with these lab developed tests you can also have that discussion with a patient about how accurate you think this is and how much we can depend on it and kind of the risk involved.

I wanted to turn to pediatrics, my specialty, and I want to commend the FDA for taking action to move this effort forward, but I have some concerns about the lack of consideration of pediatrics, rare diseases, and kids require specialized care, and LDTs play a critical role because they also may need very urgent care. We just heard from Ms. Van Meter about rapid genetic testing in a sick newborn.

I often emphasize the importance of early detection. Even with newborn screens, we get a confirmation the day later to make -- to see what type of a disease they have and how urgently it needs to be treated. So many labs need to do these tests in house. Children's hospitals use LDTs when there is no FDA-approved alternative or when they have a test that is just better and faster.

Dr. Karcher, there doesn't seem to be any specific mention of pediatrics, children's hospitals in this proposed rule. I was wondering how FDA might make some exceptions?

*Dr. Karcher. Thank you so much for that question because we very much worry about pediatric patients really being on the losing end if this proposed rule goes forward as written. There -- we clearly need to be able to allow pediatric hospitals who develop a large percentage of LDTs,

as you know well in your own practice, we need to find a way to have a flexible system that ensures accuracy and validity of the test but also allows enough flexibility that they don't -- they are not prevented from continuing to develop those lifesaving tests.

*Ms. Schrier. I appreciate that. In five seconds I will just say that I agree that we need this flexibility and that when we talked with researchers at the University of Washington and Seattle Children's, they described lack of flexibility in this rule as potentially devastating.

Thank you. I yield back.

*Mr. Bucshon. The gentlelady yields back. I now recognize Dr. Joyce, five minutes.

*Mr. Joyce. Thank you. Thanks to the panel for being here today, for testifying on an issue that could have dramatic impact on patient care, specifically with diagnostic testing. The FDA's decision to clarify laboratory developed tests as medical devices has rightfully raised concerns among pathologists, hospitals, including children's hospitals and others across the industry.

I would like to thank both Dr. Bucshon and Representative DeGette for their work in putting together a

comprehensive bill that negates the need for the FDA's regulatory overreach here and settle many of the problems that this new regulation would allow to come to the table.

My first question is for you, Mr. Rothstein. Can you elaborate a little bit more on what would happen in this space if we do not statutorily exempt tests for rare diseases? And let's clarify rare diseases because I think we all recognize that rare diseases have impacts, each described as a rare disease if there are more than 200,000 cases in America. Rare diseases like cystic fibrosis, rare diseases like sickle cell disease. Diseases that many of us don't consider to be so rare.

*Mr. Rothstein. Thank you for the question, and it is a really critical issue that we address here, and we think that the VALID Act really provide thoughtful mechanisms to ensure that these tests can come to market quickly and efficiently.

The VALID Act provides for a couple of platforms that allow for this to occur. One is the technology certification program where a company would be able to iterate on top of a platform that has already gone through FDA once but does not require further FDA review. There are

also low-volume exemptions provided in the VALID Act which we think are really important in this context. And lastly, the VALID Act includes grandfathering, meaning all the tests that are on the market today and tests that will come onto the market in a certain of period after enactment, I think it is currently at five years, would also be exempt from going through FDA.

*Mr. Joyce. Dr. Aisner, as a physician also, I have witnessed the evolution of innovation in cancer detecting tests from relatively simple antigen markers for cancers being diagnosed by next generation sequencing. Do you feel that significant innovation would be stifled if we do not address this appropriately with legislation?

*Dr. Aisner. I am confident that innovation will be stifled and I do not believe that a uniform approach, i.e. a so-called level playing field, is the thing that we should be focusing on here. A level playing field assumes we are all playing the same sport when, in fact, we have got different leagues. And the reality is is that the resources of a hospital-based lab are not the same as the resources of a test manufacturer. A hospital-based lab does not box their kit up and distribute it to other labs, thereby

needing additional stringent controls. A hospital-based lab and an academic lab monitors the assay right in front of them.

So I think this idea that everybody needs to go through the same process doesn't account for the nuance of the reality of our medical care.

*Mr. Joyce. And I think that nuance has been so clear as we have seen innovation continue and allow more diagnoses to occur earlier allowing more lives to be saved.

Dr. Karcher, the FDA says that they lack the evidence to quantify the number of LDTs currently on the market as there is no publicly available source of this data. Would such a central site be of value?

*Dr. Karcher. Excellent question. Thank you for that question. Absolutely. It would be very helpful for us to know the scope of what we are dealing with. I know that the estimate of 80,000 we believe is an underestimate of the actual number of LDTs that are out -- offered currently today for patients.

*Mr. Joyce. Would your --

*Dr. Karcher. So, yes, it would be helpful.

*Mr. Joyce. Would your organization or even the CLIA

program be able to collate such information on all available tests?

*Dr. Karcher. Under the current structure in CLIA, that would be difficult to do. I mean, our organization has deemed status from CMS to do laboratory accreditation and ensure CLIA standards are being met, but that is not one of the mandates that is part of our deemed status, so we don't really have a mechanism. We could certainly investigate that and we would be happy to work with you to see if we could find a way to make that calculation.

*Mr. Joyce. Ms. Van Meter, you talked briefly about xylazine testing with fentanyl, and as we have seen the opioid crisis continue to rapidly approach so many borders, so many individuals, so many families in the United States. Can you talk about the ability for laboratory developed tests to address the presence of xylazine and in that overlap between xylazine and fentanyl as so many overdose and substance use patients have to be able to be aware, as do those who address that with them as they present?

*Ms. Van Meter. Yes. Thank you for the question. It is essential to have laboratory developed testing services in order to discern what are these new and damaging

substances that are coming into the country every day. Xylazine, like fentanyl, has been one that has ravaged communities across the country and it is only through a laboratory developed test can clinicians and public health officials discern that it is actually in their community. So really laboratory developed tests are essential to toxicology testing.

*Mr. Joyce. I thank all of the panel for being present here today for your widespread and wide approach to how we address this from a congressional basis.

Mr. Chairman, I yield back.

*Mr. Bucshon. The gentleman yields back. I now recognize Mrs. Harshbarger, five minutes.

*Mrs. Harshbarger. Thank you, Mr. Chairman. Thank you to the witnesses here today.

I will start with Dr. Karcher. CMS recognizes your organization's laboratory accreditation program to help ensure CLIA compliance. What is the importance of CAP accreditation and what has generally been CAP's experience inspecting CLIA labs?

*Dr. Karcher. Yes. So thank you for recognizing that role that the --

*Mrs. Harshbarger. Mm-hmm.

*Dr. Karcher. -- CAP has. And we do -- we have this -- we do this work through our deemed status from CMS. We believe that laboratory accreditation obviously ensures at a minimum that laboratories are upholding CLIA standards.

*Mrs. Harshbarger. Mm-hmm.

*Dr. Karcher. We would like to believe that actually our accreditation goes above CLIA standards so that CAP accredited laboratories we believe are the best in the world.

*Mrs. Harshbarger. Okay, very good. And I will follow up with you again. The FDA proposed rule references third party review programs. And how might CAP's checklist be updated and leveraged to reflect the validation that the FDA is looking for in lieu of duplicative oversight, sir?

*Dr. Karcher. Yes, thanks for that question. So, you know, we are -- in a way, we are an example of a third party reviewer --

*Mrs. Harshbarger. Mm-hmm.

*Dr. Karcher. -- because of our accreditation program for CLIA. We have learned a lot of lessons in applying that. Our expert member -- pathologist members and other

laboratorians manage -- you know, administer our program, inspect the labs, update our standards as needed for new technology and practice. So I think an external review --

*Mrs. Harshbarger. Mm-hmm.

*Dr. Karcher. -- accreditation or review process, some of the same benefits could very likely be brought to this process as well.

*Mrs. Harshbarger. Okay. Your organization endorsed the VALID Act, but a lot of your pathologists have diverse views about the Act, and how did you come to the decision that you would do that?

*Dr. Karcher. Yeah. So thanks very much for that question. It was a very tough decision for us, and we do support the VALID Act, we did endorse it, but we endorsed it really at the very end of the process in 2022 because it needed work.

*Mrs. Harshbarger. Yeah.

*Dr. Karcher. And we worked very hard with Congress and the FDA to get it to the point where we could endorse it. You are right, not everyone of our members is -- feels exactly as we do --

*Mrs. Harshbarger. Yeah.

*Dr. Karcher. -- about the VALID Act. All of our members do, however, care about patients and want the best --

*Mrs. Harshbarger. Of course.

*Dr. Karcher. -- thing ultimately for patients. How we get there, obviously there is a difference of opinion.

*Mrs. Harshbarger. Yeah.

*Dr. Karcher. So you are absolutely right, not a hundred percent of our members --

*Mrs. Harshbarger. Well --

*Dr. Karcher. -- support that, but it was --

*Mrs. Harshbarger. -- who wants to give the FDA more authority? I don't as a pharmacist.

*Dr. Karcher. It does, but we believe the VALID Act --

*Mrs. Harshbarger. Mm-hmm.

*Dr. Karcher. -- makes that authority very flexible and allows laboratories to continue to develop these lifesaving tests.

*Mrs. Harshbarger. Gotcha. Okay. Thank you, sir.

Ms. Van Meter, if the FDA proposed rule as written were to go into effect, what type of testing might move out of hospital laboratories into large reference labs and can you

describe any potential challenges with such a development?

*Ms. Van Meter. Thank you for the question. So ACLA member laboratories are clinical laboratories throughout the country. Many of our member laboratories work hand in glove with hospital laboratories --

*Mrs. Harshbarger. Yeah.

*Ms. Van Meter. -- on a day-to-day basis. I think across the board for laboratories, if this rule does, in fact, go into effect, and to be fair, right, we anticipate that it will, and our members are already working to understand how to implement it.

*Mrs. Harshbarger. Yeah.

*Ms. Van Meter. I think across the board, clinical laboratories will be taking a hard look at their testing menus.

*Mrs. Harshbarger. Mm-hmm.

*Ms. Van Meter. And those menus will shrink as a result of implementation.

*Mrs. Harshbarger. Yeah. Well, I look at it as national consolidation. How do you feel about that, would that hasten that toward national consolidation?

*Ms. Van Meter. I think there is the potential for

some consolidation.

*Mrs. Harshbarger. Yeah.

*Ms. Van Meter. And I just come back to thinking about the patient access issue --

*Mrs. Harshbarger. Yeah.

*Ms. Van Meter. -- and if we have curtailed menus of testing from laboratories across the country, that is not serving patients well.

*Mrs. Harshbarger. Exactly. Thank you, ma'am.

Dr. Aisner, you know I have heard worries that FDA's proposal could make it more difficult to treat antibiotic resistance infections and address antimicrobial resistance. And currently FDA has no pathway for off-label antibiotic tests, and at Vanderbilt University Medical Center ICUs, roughly 60 percent of antibiotics prescribed are for off-label organisms or off-label indications, and use of off-label antibiotics are made possible by LDT testing for antibiotic susceptibility. How would the loss of such tests affect the management of patients, including those with compromised immune systems or facing extremely rare infections?

*Dr. Aisner. Thank you for the question. I think that

it is quite evident that the FDA rule as proposed would clamp down on LDTs in a way that would bring testing, such as antimicrobial resistance testing, to a halt. That could leave hospitalized patients without a pathway --

*Mrs. Harshbarger. Yeah.

*Dr. Aisner. -- to exiting their infectious status. It could lead to overtreatment with multiple antibiotics in an attempt to eradicate which can lead to kidney failure --

*Mrs. Harshbarger. Yeah.

*Dr. Aisner. -- liver failure, et cetera. I think that it is a huge challenge to understand the global impact of LDTS because it is not just about oncology genetics, it is about infectious disease, it is about rare disease --

*Mrs. Harshbarger. Yeah.

*Dr. Aisner. -- it is about anatomic pathology, it is -- there isn't a field of medicine where LDTs aren't part of the picture. And I think it is understandable that we are talking a lot about oncology today. I, for one, appreciate that perspective, but I think when you look at the larger landscape of laboratory testing, LDTs play such a pivotal role --

*Mrs. Harshbarger. Yeah.

*Dr. Aisner. -- across every specialty.

*Mrs. Harshbarger. Oh, it does. And I know I am over time, but thank you all for being here, and antibiotic resistance is a huge issue, and it is something that we need to look at.

Thank you, sir, and I yield back.

*Mr. Bucshon. The gentlelady yields back. I will recognize Ms. DeGette from Colorado, five minutes.

*Ms. DeGette. Thank you so much, Mr. Chairman, and thanks for your partnership in all these years in working on the VALID Act. I am here batting cleanup, so I will do my best.

Mrs. Harshbarger asked about some of your members, Dr. Karcher, who don't really like the VALID Act, but I would wager to say they like the VALID Act a lot better than the proposed FDA rule, would that be correct?

*Dr. Karcher. I cannot read their minds. However, I believe you are right. I believe what we are dealing with, what we are looking at today, I think many people would look back into the past and say the VALID Act would have certainly been much more workable than what we are facing today.

*Ms. DeGette. Thank you. Now also, Dr. Karcher, you work in an academic setting, is that right?

*Dr. Karcher. Yes, ma'am.

*Ms. DeGette. Now do you think the VALID Act or something similar to the VALID Act would bring your lab to a grinding halt? Yes or no will work.

*Dr. Karcher. I am sorry, would you --

*Ms. DeGette. Would bring your lab to a grinding halt, the VALID Act?

*Dr. Karcher. No, ma'am, I don't.

*Ms. DeGette. Thank you. Now I want to talk for a minute about the VALID Act because it is not a one size fits all system, it is a fit for purpose, risk-based system to oversee lab diagnostics, including LDTs. And so it focuses on the high risk tasks, which is what we really need to do.

So, Dr. Allen, I want to ask you very briefly, in your view, what constitutes a high risk task and what are the consequences to patients of a high risk task if it does not return an accurate result?

*Dr. Allen. I think those high risks tests include things that are directly utilized in order to inform a treatment decision, that that result is the definitive

factor. And because of that, the potential harm that could come with an erroneous test lends to its risk level, and as you say, it requires proper oversight.

*Ms. DeGette. So some people have said there is really no evidence of inaccurate test results and so therefore we don't need to regulate these LDTs. Is -- do you know of examples of how there have been problems with -- in some of these high risk situations?

*Dr. Allen. Yeah. Well, thank you for that question. I think, you know, what we have seen from our own work is that there is variability between different tests, including those that would fall into the high risk categories because they are a diagnostic directly informing the utilization of a drug. One of the challenges of pinpointing whether there is harm that has come from those tests is the lack of oversight that is currently there.

The tests that go through FDA, hopefully those challenges of underperformance are mitigated in advance and they never make it to the market. That may not be the same with LDTs. And I don't say that because LDTs are inherently bad. There is just not the same level of oversight before they get used.

*Ms. DeGette. Right, so we just don't know.

*Dr. Allen. Correct.

*Ms. DeGette. Now I want to ask you, Dr. Karcher, can you describe instances where premarket review might be appropriate?

*Dr. Karcher. Yes, thanks for that question. So we believe that there are very high risk tests that would benefit from premarket approval and premarket review by the FDA. We, however, believe that the numbers of those very high risk tasks are small and that the VALID Act, as you well know, introduces, you know, several mitigating measures that might down risk some of those tests because of the use of well established laboratory methodologies, the ability to do proficiency testing, medical literature that supports the validity of let's say the variant that that otherwise high risk task would introduce.

*Ms. DeGette. Is there currently any premarket review federally for LDTs?

*Dr. Karcher. There is none.

*Ms. DeGette. Thanks. Now I haven't frankly heard anybody say they support using medical device regulations for LDTs today, and so I would like to know from I think Ms.

Van Meter, is medical device regulation appropriate for in vitro diagnostics in general, could we improve on it, and is a comprehensive system needed?

*Ms. Van Meter. Thank you for the question. I really think that is the heart of the matter here.

*Ms. DeGette. Yeah.

*Ms. Van Meter. I think that the medical device authorities are wholly inappropriate for diagnostics and certainly for laboratory developed test services. I think the VALID Act that you have authored with Mr. Bucshon is precisely the right type of legislative effort that would create diagnostic specific framework that suits the characteristics of diagnostics, understands the roles of clinical laboratories.

So there was really a tremendous opportunity here not to go with the unilateral approach and superimpose medical device authorities, it is not the right direction for patients and for innovation. But instead to look at a comprehensive approach through legislation that is diagnostic specific, and I commend you for that work.

*Ms. DeGette. Thank you.

I just have one more question, Mr. Chairman, if I can,

and that is to you, Mr. Rothstein. Does CLIA ensure clinical validation?

*Mr. Rothstein. There is no premarket review by a CLIA inspector for clinical or analytical validity.

*Ms. DeGette. Thank you.

Mr. Chairman, I am sure we will have many more questions and we will submit them to the panel. But I just want to thank all of you, in particular my constituent for coming today to testify. I appreciate it.

I yield back.

*Mr. Bucshon. The gentlelady yields. I am going to take a short period of personal privilege as being in the chair and thank Congresswoman DeGette for working closely with me for many years on trying to address the issues that I think have been well outlined today in this hearing.

I now recognize Mr. Crenshaw for five minutes.

*Mr. Crenshaw. Thank you, Mr. Chair. Thank you for holding this hearing. It is on an important subject that could impact our economy to the tune of billions of dollars.

And I just want to start, as every policymaker should, with trying to identify the problem, you know, before we take a hammer to our regulatory regime and to our

industries. What problem are we trying to solve? So I hear conflicting testimony on that.

So maybe we will start with you, Dr. Allen. What is the problem we are trying to solve or do we just -- do we really have these laboratory testing facilities just running amok hurting patients constantly, it is so bad that we have to make such a drastic change?

*Dr. Allen. Yeah, I hope we are not in that scenario. I don't think running amok would be the proper characterization of that, but the definitive fact is in most instances we don't know. So the number one issue that I think we are trying to solve is awareness. The number two issue that we are trying to solve is the ability to act. If a problem is identified, is there an expert entity that has reviewed those challenges and help mitigate them and fix them. And number three I think is trying to avoid errors before they happen.

*Mr. Crenshaw. Yeah. I agree with that, but I didn't hear a glaring problem in any of that. You know, I think there is room for a scalpel approach to some of these.

Dr. Aisner, you have had a somewhat different opinion on this. Can you --

*Dr. Aisner. I do indeed have a different opinion on this and I will cite for you this paper from JAMA Oncology which showed that LDTs and FDA approved assays had equivalent performance for tests that dictate cancer therapy for melanoma, colorectal cancer, and lung cancer. I think we have vastly lost sight of the fact that the magnitude of the problem is a very narrow constrained concern.

And frankly as somebody who focuses on biology, I can say that when I see that there are areas that laboratories struggle to find the same answer, it is because we are not yet fully studied up, we don't understand the biology of what is happening. It is not because the test is wrong, it is because the biology is so complex we haven't gotten there yet.

I think there is ample data from decades of proficiency testing data provided by my colleague's organization at the CAP that demonstrates that laboratories perform at an exceptionally high level. This idea that there is no post-market review I think does not account for the fact that there is proficiency testing and laboratorians are incredibly committed to monitoring their assays longitudinally.

*Mr. Crenshaw. Yeah, and look, not having dealt with this problem in depth before like some of my colleagues have and walking into this, it does not appear to me that there is a major problem that requires a very extreme solution. And if there was a major problem, it should be deliberated by a body like this one where we do hearings, and we have debates, and then it has to go through the Senate. God knows what happens in the Senate. And then actually signed into law by the President.

We have a process for this. We -- when we make national law, we have a very arduous process to do so because it affects so many people, and that is a good thing. What is not a good thing is when unaccountable bureaucrats just decide things and try to do it through regulation. This is happening way too often, and in this case, the FDA now believes that lab developed tests should just go under the same pathway as medical devices. Why? I am not sure what the explanation is for that, but it is obviously overreach, and it is overreach with pretty severe consequences. Those consequences have been laid out by our witnesses multiple times. I think it is worth noting just some of them.

The FDA shows that they would have to approve between 40,000 and 160,000 diagnostic tests currently on the market, between nearly 4,000 and 15,000 new lab diagnostic tests per year. That is an enormous increase. And just having, you know, personal experience watching pretty simple medical devices try to go through that pathway and it taking years because they don't even have the right personnel and the right expertise to even assess those medical devices, I can't imagine how they are going to assess complex lab tests which involve, I mean, a number of people, a number of processes, a number of different chemical reactions.

I mean, I can't imagine how they are going to do it, so I can't imagine how this stuff is going to actually get approved. And then we are left with nothing, we are left with no tests. I mean, we can question the validity of a test, but we can be sure that if you have no tests, you are not going to get any result, good or bad, and that is a real problem, and we have to be careful about that just as legislators, as regulators. We can't have safety at any cost. You know, we have to have -- we have to understand that there are tradeoffs in these things.

It is worth mentioning the third party review program

because that is part of the FDA's claim is that, you know, they are going to ease the burden of this excessive amount of new applications through the third party review program, but that only reviews 3,000 applications or submissions a year. So just do the math. It is just never going to work.

Mr. Rothstein, given the current program, is it realistic for FDA to estimate that at least -- wow, did I really go over that much? Geeze. I was really on a roll.

*Mr. Bucshon. The gentleman's time has expired.

*Mr. Crenshaw. I yield back. Thanks.

*Mr. Bucshon. Thank you. All right, Mr. Griffith, five minutes.

*Mr. Griffith. Thank you very much. I apologize to the witnesses and to the other members of the committee. I have been upstairs chairing on Oversight and Investigations Subcommittee hearing so I was not able to be with you all. I will probably try to go back and watch some of the testimony at a later time.

Ms. Van Meter, to your knowledge, will any allergy testing be hindered by the proposed FDA diagnostic lab rule? And let me explain. Previously some of my allergists, and I am a patient, have indicated that the FDA has said that, oh,

they have got to have a big lab in order to work on their serums that they do for shots for allergies, which tens of thousands, if not millions, of Americans take on a regular basis without any problems. So do you see any problems with where we are going here?

*Ms. Van Meter. No -- thank you for the question. I can't, unfortunately, speak specifically to allergy assays, but I can say as a general matter I am very concerned about the broad availability of all tests that Americans rely on today if the rule moves forward.

*Mr. Griffith. And that would be my concern, too. I agree that I didn't see anything that said anything about allergies, but when I look at the big picture, it looks like to me that could be either next or considered a subgroup of what is going on.

Anyway, all right. Dr. Karcher, the current center for tobacco products within the FDA got all kinds of issues. Do you think that if we go forward with what they have recommended for the FDA to regulate labs, is that going to keep them from being able to get to other work like working on some of these tobacco product issues that they haven't been able to get to, is it going to keep them from getting

their work done?

*Dr. Karcher. Thanks for the question. I certainly cannot comment about the FDA's ability to deal with tobacco products. We do know, however, if the rule goes forward as written, it will for sure inhibit laboratories, and we have all heard today how it would overwhelm parts of the FDA if it goes forward as written.

*Mr. Griffith. Well, and it -- so it is going to overwhelm the FDA so it is going to affect all aspects. And in Oversight we have had real concerns about how many inspectors they have not only in foreign lands but even in the United States getting to facilities that make our medicines or our baby formula, and so I am not sure we want to add extra things to their list. Would you agree with that?

*Dr. Karcher. I would agree with that statement.

*Mr. Griffith. And with that said, Mr. Chairman, I will yield any time that you might wish to use.

*Mr. Bucshon. Sure. Thank you for yielding. I just have a follow-up question that was -- someone asked a question about antimicrobial resistant efforts, which is a longstanding issue we have been trying to address. And, Mr.

Rothstein, under that, how do you -- how would you see a framework like VALID handle new antimicrobial resistance tests that might come available?

*Mr. Rothstein. Thank you for the question. And this is a topic that is actually very well suited for the technology certification program contemplated in VALID. Right now, antimicrobial testing, which is so important for our Nation both for patients and for ensuring that we have antibiotics available for the long term requires for each test of whether it is a bacteria or a fungus, each of those tests has to go through FDA one at a time.

Under the technology certification program in VALID, a manufacturer or a laboratory could develop a platform in which FDA looks at once and then any subsequent bacteria, fungus, or other type of microorganism that needs to be detected could go through that platform without going to FDA as long as the parameters are met within the agreement between FDA and the industry, and it would make the process for antimicrobial resistance products to come to market in an extremely efficient mechanism -- manner.

*Mr. Bucshon. Thank you for that answer, and I will yield back to Mr. Griffith.

*Mr. Griffith. And I would just say thank you, Mr. Chairman. I am sorry I missed that discussion. I understand Mrs. Harshbarger brought that up, and I am a big fan of phage therapy, but -- so I am sorry I missed that part of the discussion. I will have to go back and watch that. And I yield my time back.

*Mr. Bucshon. The gentleman yields back. I recognize Dr. Miller-Meeks, five minutes.

*Mrs. Miller-Meeks. Thank you, Mr. Chairman, and I thank the witnesses for testifying before the subcommittee today. I was in another hearing in Cannon, so I apologize for not being here for all of your testimony and all of the questions.

Dr. Aisner, your testimony describes ways in which you and your patients rely on the results of customized lab developed tests, or LDTS. How would the impacts of the proposed rule be experienced across different areas of medicine, such as for oncology versus more generalized health practices?

*Dr. Aisner. Thank you very much for the question. I think this is a very rubber hits road question. And I think, again, I will point to this JAMA Oncology paper from

2018, and I think one of the critical things to recognize from this paper is that even among labs that used FDA approved test kits, a substantial fraction of them modified them. And that is the reality of medical practice is that the constraints that come with an FDA approved test are not necessarily seen in day-to-day practice.

You sometimes have to color outside the lines to be able to get the test for your patient, and the ability to color outside the lines I think will be completely hampered.

*Mrs. Miller-Meeks. Given the increasing reliance in clinical practice on sophisticated instrumentation such as AI or software used in conjunction with genetic testing, how does your lab establish safeguards?

*Dr. Aisner. I think that is an excellent question. I am personally able to avoid that at the moment as we do not use AI and most of my colleagues that I have polled on this also do not use AI at their academic medical centers. I do think one of the big concerns is that to able -- to be able to focus on those concerns about security, about patient privacy concerns, we need resources, and if we are devoting all of our resources to an FDA review process, there will be nothing left to focus on the other important issues.

*Mrs. Miller-Meeks. Thank you.

Dr. Allen, you and your organization have been engaged on the LDT issue for years. Do you feel there are differences between the standard of validation for test kits and laboratory developed test that warrant tailored regulatory approaches?

*Dr. Allen. Yes, I do think there are differences in the current requirements that are required for lab developed tests versus in vitro diagnostic kits and hopefully that is something that we can resolve through these discussions today. I think we need to focus more on the results that the tests are providing as opposed to the place that they are being developed by.

*Mrs. Miller-Meeks. And some stakeholders have observed that the technology certification provision in the VALID Act is particularly well suited to regulate AI and software products. Do you agree?

*Dr. Allen. Yes, I think it is one component of that. I think there are a lot of complexities, and I know this committee has done a lot of work around the role of AI in healthcare. But I do think it is also well suited for things that we have been involved in around looking at how

different tests compare to one another. This is particularly true for complex diagnostic tests currently because there are so many different alterations that are incorporated into those measures to try and understand how each of those different measures contribute to the end result is important for consistency in testing. I think we will see the same thing for AI-based testing as well.

*Mrs. Miller-Meeks. Thank you. And I am -- hopefully this will be a very short answer question. If this particular rule was in place during COVID, we already saw the challenges with the CDC and the FDA getting testing approved even though the University of Washington had a test, so would this have created more difficulty in getting testing out to the public in a rapid manner if this rule was in place? Any of you.

*Mr. Rothstein. Thank you for the question. I don't believe so because tests during -- that are put into the market during public health emergencies currently are required to obtain an EUA and this rule does not address that issue.

*Mrs. Miller-Meeks. So you don't think that they would utilize the current rule that they would transfer it? I am

always concerned about government overreach.

We follow -- we continue to face a pernicious opioid substance use disorder crisis in this country. Beyond opioids, new deadly synthetics are constantly changing and must be tracked so that doctors and other caregivers can best understand how to care for those struggling with substance use disorders, and even as a state senator and a director of public health, we had to deal with this issue in Iowa.

Ms. Van Meter, can you talk about the role that LDTs serve in testing for such substances and how shifting to the medical device authorities would impact patient access?

*Ms. Van Meter. Yes. Thank you for the question. Laboratory developed test services are absolutely essential and central to toxicology testing to ensuring that public health understands what new substances are in communities, that patients can be cared for, or going through substance use disorder treatment.

*Mrs. Miller-Meeks. Thank you much -- very much, and I yield back.

*Mr. Bucshon. The gentlelady yields back. I recognize Mr. Obernolte from California for five minutes.

*Mr. Obernolte. Thank you, Mr. Chairman.

Ms. Van Meter, I would like to start with a question for you. I really enjoyed reading the ACLA's response to the FDA proposed rule, and in particular you had a section in that response in which you highlighted your belief that the FDA's methodology for evaluating laboratory developed tests was deeply flawed. Can you give us a couple of examples of cases in the FDA's rulemaking that -- where you think the data was cherrypicked?

*Ms. Van Meter. Thank you for the question. Yeah, so the FDA offers a de minimis number of examples of LDTs it suggests are problematic. We have enormous respect for the FDA and worked hand-in-glove with the agency not only through COVID and Mpox but certainly in discussions on the VALID Act, and we want to continue to do that, but we are very concerned about the prejudicial language that the agency uses to describe laboratory developed test services and the handful of examples of problematic LDTs that it offers.

Frankly, most of those are not based in scientific literature. In fact, some are taken from media reports. So I worry very much about that. Within its analysis, it

relies on a single flawed, since debunked academic article to suggest that there is a significant proportion of problematic LDTs. So again, I would offer simply there is a dearth of evidence to suggest there is a systemic problem.

*Mr. Obernolte. And did the FDA respond to your comments?

*Ms. Van Meter. Not at this point, no.

*Mr. Obernolte. Dr. Allen, I enjoyed your testimony. I thought you did a great job of highlighting the two ideas that we are talking about that are in fundamental tension. The one is that, as you say, we need the FDA to ensure the accuracy and the efficacy of these tests, and we have an obligation to our constituents to make sure that we are enforcing these rules for their safety. But as other people have testified, we are also very concerned that increased FDA involvement in LDTs is going to lead to much longer times to market, higher costs, and less affordability, and less availability of the tests. So, you know, these are the two ideas that are in tension here.

I am wondering if agencies like -- organizations like yours could provide a solution to this because what has happened in other sectors of the consumer space is that

organizations step in and provide analysis of efficacy and accuracy, and people, patients and their physicians, can use that as a guidepost in deciding which LDTs to order, and then as -- that will lead to market competition, and as Mr. Rothstein testified, competition between different LDTs to make sure that there is self-policing going on to make sure that they are providing accuracy and a good value for the patient dollar. So do you think that that is a viable solution?

*Dr. Allen. I hope that it is part of the solution. I don't that in itself it will be sufficient. But I do think that there are opportunities here, and I recognize that there is certainly the presence of competition in the market for these types of tests. But in order to achieve the goals that I think most of us have outlined today, there also needs to be collaboration and, you know, some of the issues that have been raised around rare testing and the concerns around that, I do think there has to be a new approach where perhaps different laboratories can do things like leverage common samples in order to make sure that the appropriate validity testing is able to move forward. So it has to come with a mix.

And I fully appreciate the concerns that additional regulation could come with burdens, and we don't want to see that result in a hinderance to access. But, you know, my colleagues here that are working at extremely high performing expert laboratories, I think many of their tests probably can achieve the validation standards that are -- that may be requested of them. So I think that as we move forward, you know, and I thank the -- Dr. Bucshon and Ms. DeGette for their work, you know, the flexible approach, that the VALID Act will enable all of these different approaches to be part of the mix.

*Mr. Obernolte. Well, thank you, I appreciate your perspective, and thanks to all our witnesses. I found it a fascinating hearing.

I yield back.

*Mr. Bucshon. The gentleman yields back. That concludes member questioning. I would like to thank all the witnesses for their time, first of all, I know it is a big time commitment, and for their testimony and the answers to the questions proposed by members.

I ask unanimous consent to insert into the record the documents included on the staff hearing's document list.

Without objection, that will be the order.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Bucshon. I remind members that they have 10 business days to submit questions for the record and I ask the witnesses to respond to the questions promptly. Members should submit their questions by the close of business April 4, 2024.

Without objection, the subcommittee is now adjourned.

[Whereupon, at 12:49 p.m., the subcommittee was adjourned.]