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LDTs: HHS Clears the Way for Use of New COVID-19 Tests without FDA Emergency Use Authorization

One of the unforeseen results of the coronavirus public health emergency has been to bring the perennial controversy over U.S. Food and Drug Administration (FDA) premarket regulation of laboratory developed tests (LDTs) to a head. As the crisis has deepened, the agency has found itself in the position of backing away from its hands-on approach and has allowed laboratories and test makers greater discretion in launching LDTs detecting the SARS-CoV-2 virus. And now a new Administration pronouncement carries that policy to a new and significant level.

The Controversy Over FDA LDTs Regulation

Laboratory tests were not included in the original legislation that created the FDA and current regulatory system of medical drug

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New ACOG Guidelines: Recommend cfDNA-Based NIPT for All Pregnancies, Not Just Risky Ones

The American College of Obstetricians and Gynecologists (ACOG) has revised its position on noninvasive prenatal testing (NIPT) and is now recommending prenatal aneuploidy screening for all pregnant patients regardless of age or other risk factors. ACOG previously recommended use of screening only in individuals 35 and older or with other known risk factors.

The Diagnostic Challenge

NIPT analyzes the free-floating cell-free DNA (cfDNA) fragments from the blood of a pregnant woman to estimate the risk that the fetus will be born with certain genetic abnormalities, the most common target being chromosomal disorders like Down syndrome that are caused by the presence of an extra or missing copy

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LDTs: HHS Clears the Way for Use of New COVID-19 Tests without FDA Emergency Use Authorization, *from page 1*

and device regulation. So, the agency has relied on its powers to regulate devices. Accordingly, LDTs must obtain premarket approval through the 510(k) pathway for medical devices.

In addition to challenging the FDA's authority over LDTs, the laboratory industry has long objected to the agency's practice of skirting the regulatory process and relying on guidance, website statements and other informal issuances to make regulatory policy.

The HHS Decision

And now the U.S. Department of Health and Human Services (HHS) has taken the same position. On Aug. 19, HHS announced that the FDA will no longer be able to regulate by informal decrees but will have to go through the customary notice and comment rulemaking process required for new regulations to regulate LDTs.

One result of the HHS decision, which is part of the Administration's broader policy to cut government regulation over business, is that laboratories will now be able to offer LDTs for SARS-CoV-2 without going through the FDA's Emergency Use Authorization (EUA) process. "Those with an active EUA to use an LDT to detect the virus causing COVID-19 or its antibodies are unaffected by this announcement," HHS added.

And Don't Forget the VALID Act

The unexpected HHS announcement is the most recent in a series of efforts to rein in FDA regulation over LDTs. After several aborted attempts, last March, legislators in the U.S. House of Representatives and Senate reintroduced the Verifying Accurate Leading-edge IVCT Development Act (VALID) creating a new system for FDA review of in vitro clinical tests (IVCTs). VALID would establish a risk-based framework, with high-risk tests, like novel assays, required to go through premarket review; lower-risk tests could go to market after passing through technological certification. Specific features that VALID would implement:

- Establishment of a technology certification program for lower-risk tests;
- Requirement that high-risk tests undergo premarket review to verify analytical and clinical validity;
- Authority of the FDA to require that any test undergo premarket review after providing the developer an opportunity to address issues identified by the agency; and
- Creation of a new system to allow hospitals and laboratories to submit their tests electronically to the FDA for approval.

The law would also grandfather in existing LDTs being used clinically.

DTET

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Takeaway

The pandemic has exposed the problems with the FDA's current makeshift premarket control over LDTs and how it stifles innovation and keeps desperately needed new tests from reaching the market. It has also accelerated the efforts to impose a modern, more transparent and workable system not only for the rest of the pandemic but the long-term future.

FDA WATCH

Saliva COVID-19 Tests Offer Way Around Nasopharyngeal Swab Shortage Bottlenecks

Shortages of the nasopharyngeal swabs used to collect respiratory samples for reverse transcription polymerase chain reaction (RT-PCR) tests has impeded the efforts of laboratories to meet the unprecedented demands for COVID-19 testing. So, the Aug. 15 announcement that a saliva-based from the Yale School of Public Health has received emergency use authorization (EUA) from the U.S. Food and Drug Administration (FDA) is welcome news.

The Yale SalivaDirect test uses a new sample processing method allowing for collection of saliva samples in a sterile container, eliminating the need for nasopharyngeal swabs. The method also cuts out the separate nucleic acid extraction step, for which kits have also been in short supply. SalivaDirect allows for dualplex RT-qPCR method testing of low volumes of saliva treated with proteinase K followed by a heat inactivation. While the EUA allows for laboratories designated by the Yale School of Public Health, Yale will provide the SalivaDirect protocol freely to interested laboratories. "Providing this type of flexibility for processing saliva samples to test for COVID-19 infection is groundbreaking in terms of efficiency and avoiding shortages of crucial test components like reagents," noted FDA Commissioner **Stephen Hahn** in a statement.

SalivaDirect is the fifth saliva test for SARS-CoV-2 to receive EUA from the FDA. The others are produced by (in order of EUA issuance):

- Rutgers Clinical Genomics Laboratory, with the original April EUA expanded in May to allow for at-home collection;
- Phosphorous Diagnostics;
- P23 Labs; and
- Clinical Reference Laboratory.

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FDA Watch, *from page 3*

Here are other key new FDA EUAs and clearances announced in August:

New FDA Emergency Use Authorizations (EUAs) & Approvals

Manufacturer(s)	Product
LumiraDx	EUA for LumiraDx SARS-CoV-2 Ag Test (third antigen test authorized for SARS-CoV-2)
LumiraDx	EUA for LumiraDx SARS-CoV-2 RNA STAR assay
Sinochips Bioscience	EUA for COVID-19 Nucleic Acid RT-PCR Test Kit
BioCheck	EUA for BioCheck SARS-CoV-2 IgM and IgG Combo Test (serology)
23andMe	510(k) clearance for CYP2C19 Drug Metabolism Report, informing customers if their genotypes may influence their ability to respond to clopidogrel and citalopram without need for confirmatory testing
Diazyme Laboratories	EUA for Diazyme DZ-Lite SARS-CoV-2 IgM test (serology)
Biomeme	EUA for SARS-CoV-2 Real-Time RT-PCR Test
Solaris Diagnostics	EUA for Solaris Multiplex SARS-CoV-2 Assay
Alpha Genomix Laboratories	EUA for TaqPath SARS-CoV-2 Combo Assay based on Thermo Fisher's Applied Biosystems TaqPath COVID-19 Combo Kit
George Washington University	EUA for GWU COVID-19 RT-PCR test
BioMérieux	EUA for Vidas SARS-CoV-2 IgM test used with firm's Vidas SARS-CoV-2 IgG test (serology)
Beijing Wantai Biological Pharmacy	EUA for Wantai SARS-CoV-2 Ab ELISA test (serology)
Helix	EUA for next-generation sequencing-based test to detect SARS-CoV-2 spike protein gene
Guardant Health	Clearance for Guardant360 CDx, targeted next-generation sequencing liquid biopsy assay, for tumor mutation profiling in advanced cancer patients with solid malignant neoplasm
Adaptive Biotechnologies	Expanded clearance for its clonoSeq assay to assess minimal residual disease in patients with chronic lymphocytic leukemia
Roche	Clearance for Cobas Epstein-Barr Virus test
Quest Diagnostics	EUA for technique that speeds extraction of viral RNA from patient samples
Eli Lilly and Company	EUA for Lilly SARS-CoV-2 Assay
Sandia National Laboratories	EUA for SNL-NM 2019 nCoV Real-Time RT-PCR Diagnostic Assay

Manufacturer(s)	Product
Xiamen Biotime Biotechnology	EUA for Biotime SARS-CoV-2 IgG/IgM Rapid Qualitative Test, serology assay detecting and IgG and IgM antibodies
LabCorp	Reissued EUA for COVID-19 RT-PCR Test for testing asymptomatic patients and pooled sample testing
CoWin Biotech	EUA for Novel Coronavirus Fast Nucleic Acid Detection Kit run on Thermo Fisher's Applied Biosystems 7500 RT-PCR system
Helix OpCo	EUA for Helix COVID-19 Test detecting SARS-CoV-2 nucleocapsid, ORF1ab and spike protein genes
Thermo Fisher Scientific	Clearance for ImmunoCAP Specific IgE alpha-Gal Allergen Component blood test detecting sensitization to alpha-gal carbohydrate in red meat and assessing risk for an anaphylactic reaction

Minority Report: UK Antibodies Prevalence Study Suggests that Minorities Contract COVID-19 at Disproportionately Higher Rates

Many have suggested that minority populations have suffered adverse effects from COVID-19 disproportionate numbers. An August study from the United Kingdom provides powerful evidence to support this theory based on SARS-CoV-2 antibody prevalence. Here is the low down.

The Diagnostic Challenge

England experienced a particularly large outbreak of SARS-CoV-2 infection. The country's first COVID-19 death occurred on Feb. 28. By June, England had the highest excess mortality in Europe by June, with in-hospital deaths peaking at 800 per day within six weeks. Hospital admission and mortality data showed that the highest rates of deaths were in older people including those living in long-term care, and in people of minority ethnic groups, particularly Black and Asian (mainly South Asian) individuals.

Was there any scientific evidence to support these demographic patterns? That is the question the researchers set out to answer, focusing on antibody data which provides a measure of SARS-CoV-2 exposure. Most infected people mount an IgG antibody response detectable after 14 to 21 days after exposure, although levels may start to wane after approximately 90 days. The study authors hoped to use antibody prevalence data from a large community-based evaluation based on unsupervised use of lateral

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Minority Report: UK Antibodies Prevalence Study Suggests that Minorities Contract COVID-19 at Disproportionately Higher Rates, *from page 5*

flow immunochromatographic assay (LFIA) tests at home of people in England up to July 2020. Specifically, their goals were to:

- Estimate the cumulative community seroprevalence of IgG antibodies for SARSCoV-2;
- Identify those at most risk of infection; and
- Estimate the total number of infected individuals in England and the infection fatality ratio (IFR).

How the Study Was Conducted

The testing was carried out as part of the government-funded National Real-time Assessment of Community Transmission-2 (REACT-2) seroprevalence study and led by investigators at the Imperial College London. Personalized invitations were sent to 315,000 individuals aged 18 years and over. The 121,000 participants who signed up registered via an online portal or by telephone.

The registered participants received a test kit by mail that contained a self-administered point-of-care LFIA test and instructions with links to an online video. Participants also completed a short registration questionnaire online or via phone and a further survey upon completion of their self-test providing information on demographics, household composition, recent symptoms and a photo of the result.

Between June 20 and July 13, the volunteers tested themselves at home to determine if they had developed antibodies against the SARS-CoV-2 virus that causes COVID-19 using a finger prick lateral flow immunoassay manufactured by Fortress Diagnostics, an in vitro diagnostics manufacturer based in Antrim, Northern Ireland.

Findings: Ethnicity Does Matter

Of the 121,976 people who were sent LFIA test kits, 109,076 (89.4 percent) completed the questionnaire, of whom 105,651 also completed the test; 5,743 (5.4 percent) reported an invalid or unreadable result, leaving 99,908 (94.6 percent) individuals. Of these, 5,544 tested IgG positive and 94,364 IgG negative, giving a crude prevalence of 5.6 percent.

After adjusting for the performance characteristics of the test and re-weighting, the authors estimated that overall prevalence for England was 6.0 percent during the period from June 20 to July 13, 2020. This equates to 3.36 million adults in England who had been infected with SARS-CoV-2 in England.

Prevalence was highest for people ages 18 to 24 years and in London. While 7.9 percent of those age 18 to 34 had antibodies, just 3.3 percent of those over age 75 did. Antibody prevalence among Londoners was

13.0 percent, as compared to under 3 percent in the less populated southwestern areas of the country.

By ethnic group, the highest prevalence was found in people of Black (including Black Caribbean, African and Black British) (17.3 percent) and Asian (mainly South Asian) ethnicities (11.9 percent). In comparison, prevalence was only 5.0 percent in people of White ethnicity. Poorer people were also more likely to have antibody exposure than wealthier people.

Not surprisingly, the researchers also found higher prevalence among workers in nursing homes (16.5 percent found to have IgG antibodies) and other healthcare workers (11.7 percent). were more likely to have antibodies, compared to those who were not, with 16.5% of nursing home workers and 11.7% of healthcare workers showing antibodies.

Reinforcing curious findings from earlier studies, the researchers found that current smokers have a lower prevalence of SARS-CoV-2 infection than non-smokers, 3.2 percent versus 5.2 percent.

Takeaway

The study authors believe that this is the largest community-based evaluation of antibody prevalence, and the only nationwide study based on unsupervised use of LFIA tests at home. And it suggests that ethnicity is, in fact, a factor in susceptibility to infection and that members of minority populations contract the virus at significantly higher rates than persons of White ethnicity. The UK government plans to conduct a follow-up antibodies prevalence study on 200,000 in the fall.

Top of the News: Major Insurer Claims It Has No Obligation to Pay for Pooled COVID-19 Testing

Free COVID-19 testing is a powerful and very compelling policy. The problem, of course, is that *somebody* has to pay for coronavirus testing. And the insurance companies have been designated as that somebody. However, loopholes in the free testing mandate imposed on insurers are starting to emerge, first with regard to coverage of employer workplace screening tests and now on the issue of sample pooling.

The Free Testing Mandate & the Loophole

The starting point in the recent controversy is a piece of federal relief legislation called the Families First Coronavirus Response Act (FFCRA) which requires insurers to pay for COVID-19 tests without imposing any copayments, deductibles, coinsurance or other cost-sharing. Technically,

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Top of the News: Major Insurer Claims It Has No Obligation to Pay for Pooled COVID-19 Testing, *from page 7*

the requirement, i.e., Section 6001 of FFCRA) applies only to tests that a healthcare provider deems "medically appropriate."

The "medically appropriate" language has been turned into something of a loophole to get around the free testing mandate. However, it was not the insurers but the Administration that created it. On June 23, the Departments of Labor, Health and Human Services (HHS) and Treasury issued joint guidance (FAQ 5) clarifying that Section 6001 does not apply to "testing conducted to screen for general workplace health and safety (such as employee "return to work" programs, for public surveillance or any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19."

The Controversy Over Sample Pooling

And now insurance companies are attempting to use the loophole to avoid paying for sample pooling. **Explanation**: Pooling is a technique that involves mixing aliquots, i.e., sub-samples extracted from individual samples into a pool or "batch" that can be tested with a single test. If the entire pool returns a positive result, the individual samples must be retested to locate the source of the positive; but if the batch tests negative, all of the constituent samples are also deemed to be negative.

Sample pooling has been hailed as a way to increase COVID-19 testing capacity while conserving precious supplies. In July, the U.S. Food and Drug Administration (FDA) for the first time ever authorized existing assays with Emergency Use Authorization (EUA) from Quest Diagnostics and LabCorp for sample pooling use. More sampling authorizations are expected to follow.

However, at least one of the country's biggest insurers has made it known that it wants no part of paying for pooled testing. Citing the joint guidance, Cigna claims that pooled tests are screening" assays and that the free test mandate applies only to individual diagnostic tests.

The Blowback

Cigna's determination that it does not have to pay for pooled COVID-19 testing has not sat well with a number of healthcare organizations, including the American Clinical Lab Association, The American Hospital Association, and The Association of American Medical Colleges. The topic may also come up as part of a new Democratic led effort in the U.S. House of Representatives to look into the outsized profits that insurers are reportedly making during the pandemic.

Takeaway

Cigna seems to be out on an island. As of press time, we know of no other major insurer that has made a similar pronouncement about not paying for pooled COVID-19 testing. Meanwhile, insurers and laboratories have asked Congress to create a national testing fund to pay for COVID-19 testing. But so far, Congress has made no moves to advance any such legislation to cover these testing costs.

Genomic Testing: Utilization Is Low & Geographically Inconsistent but It's Not All Payors' Fault

Genomic testing is inconsistently utilized in the U.S., even in states with favorable coverage policies. Those are the findings of a report from the Personalized Medicine Coalition (PMC) released in early August. Conducted in partnership with the Blue Cross Blue Shield Association, Concert Genetics and Illumina, the project analyzed trends and potential barriers to genomic testing access and utilization across the U.S. While wide variation and lack of clarity in payer coverage policies present barriers to genomic testing, the report found that there may be other factors preventing greater adoption of such testing.

The Diagnostic Challenge

Because no two people are exactly the same, medical management must be personalized and cannot be one size fits all. But the effectiveness of personalized medicine is utilization of genomic testing and other diagnostics to inform medical decision making. The tests are there. But they are new and, at least in the eyes of many insurers and other payers, unproven. The question, then, is whether genomic tests are being utilized and, if not, what can be done to promote greater utilization?

To answer these questions, the project researchers analyzed utilization and coverage of genomic testing in three clinical areas over a three-year period:

- Noninvasive prenatal testing (NIPT) for prenatal screening;
- Whole exome sequencing (WES) for rare and undiagnosed genetic diseases; and
- Comprehensive genomic profiling (CGP) of tumors in advanced cancer patients.

To analyze utilization and coverage patterns, they drew from four sources of aggregated data:

- Test and policy catalogs;

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Genomic Testing: Utilization Is Low & Geographically Inconsistent but It's Not All Payors' Fault, *from page 9*

- U.S. census data;
- Payer claims data; and
- Plan membership data.

The Study Methodology

To analyze genomic testing utilization, the researchers used a proprietary database from Concert Genetics that includes test catalog data, claims data, health plan membership data and U.S. census data. National volume estimates included in the Concert Genetics database are based on data from a sample of 40 million commercially insured lives, extrapolated to a nationally representative estimate for current utilization for that state. Claims data are enriched with a machine learning algorithm trained to match complex, multi-CPT (current procedural terminology) code claims to the ordered tests.

The researchers also used a Concert Genetics database containing standardized, publicly available U.S. commercial medical and reimbursement policies to perform the coverage policy analysis. In addition, they used plan membership data (Kaiser Family Foundation's Insurance Market Competitiveness Tables at www.kff.org) to calculate coverage by state, weighted by the market share of each plan in the state. They assigned coverage policy scores from 0 (low coverage policy) to 10 (high coverage policy) based on medical and reimbursement policy data points for NIPT, WES and CGP.

The 3 Key Findings

The report makes three key findings:

1. Geographic Inconsistencies in Utilization

Medically appropriate genomic testing is inconsistently utilized across U.S. states, the report finds. Examples of notable inconsistencies from the 2019 annualized data documenting utilization per million members among the States of California, Florida, Illinois and Texas:

- NIPT utilization was between 36 percent and 72 percent higher in Texas than in California, Illinois and Florida;
- WES utilization in California was 71 percent higher than in Florida and 65 percent higher than in Illinois; and
- CGP utilization was between 47 percent and 69 percent higher in Florida than it was in Texas, Illinois and California.

2. Geographic Inconsistencies in Payer Coverage

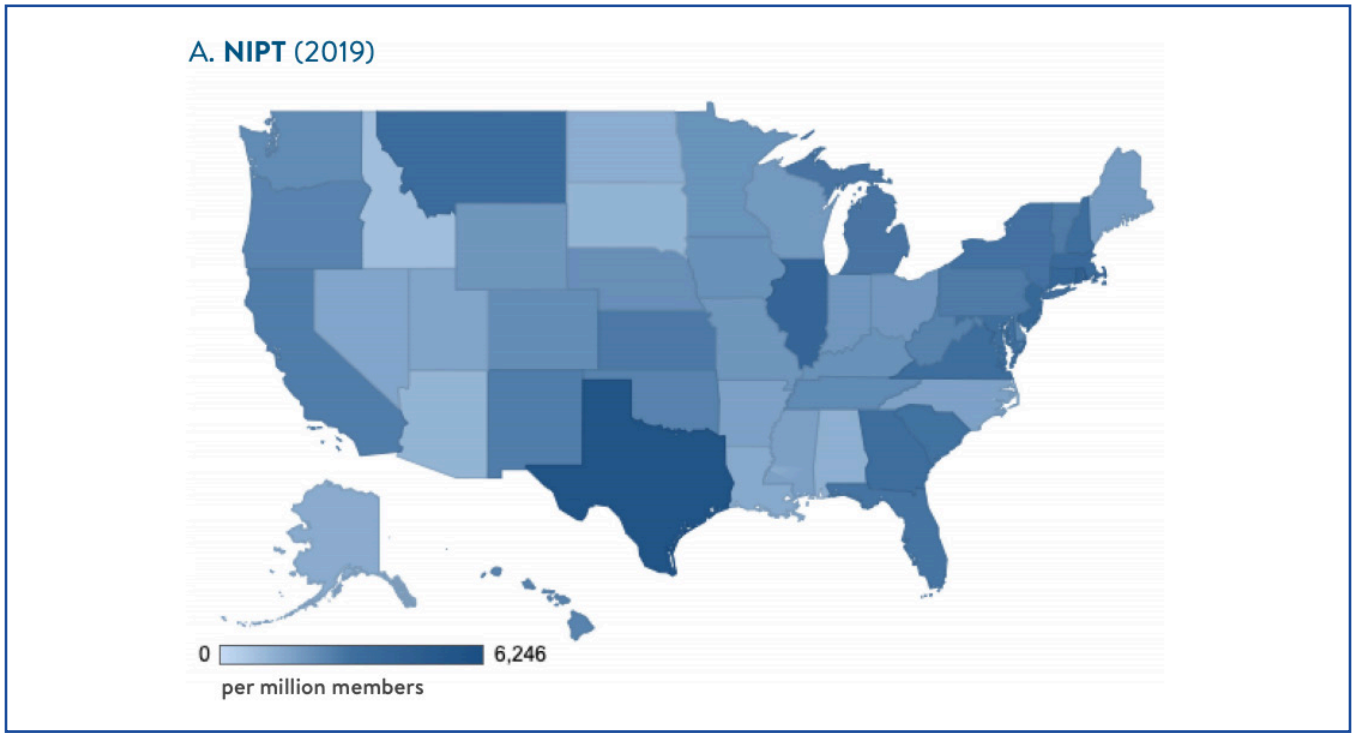
The report also finds that payer genomic testing coverage policies vary considerably among states and are inconsistent. NIPT had the highest

average policy scores and relatively consistent coverage across the U.S. But average policy scores for WES and CGP were lower and less consistent nationwide. However, coverage of all three tests has been growing over time, the report notes.

3. More Coverage Doesn't Necessarily Lead to More Utilization

Perhaps surprisingly, the report finds that favorable genomic test coverage policies do not always correlate with higher utilization rates across states. Thus, in some of the states where coverage expanded, there were no correlating increases in utilization. In Illinois, New Jersey and Texas, genomic testing utilization increased but so did utilization in all other clinical areas. Some of the states with high coverage policy scores saw low utilization, e.g., Colorado for WES and Washington for NIPT and CGP. And in still other states, utilization was high even though the coverage score was low (e.g., New York and Connecticut for NIPT; and Ohio and California for CGP and WES).

Utilization of Noninvasive Prenatal Testing (NIPT)

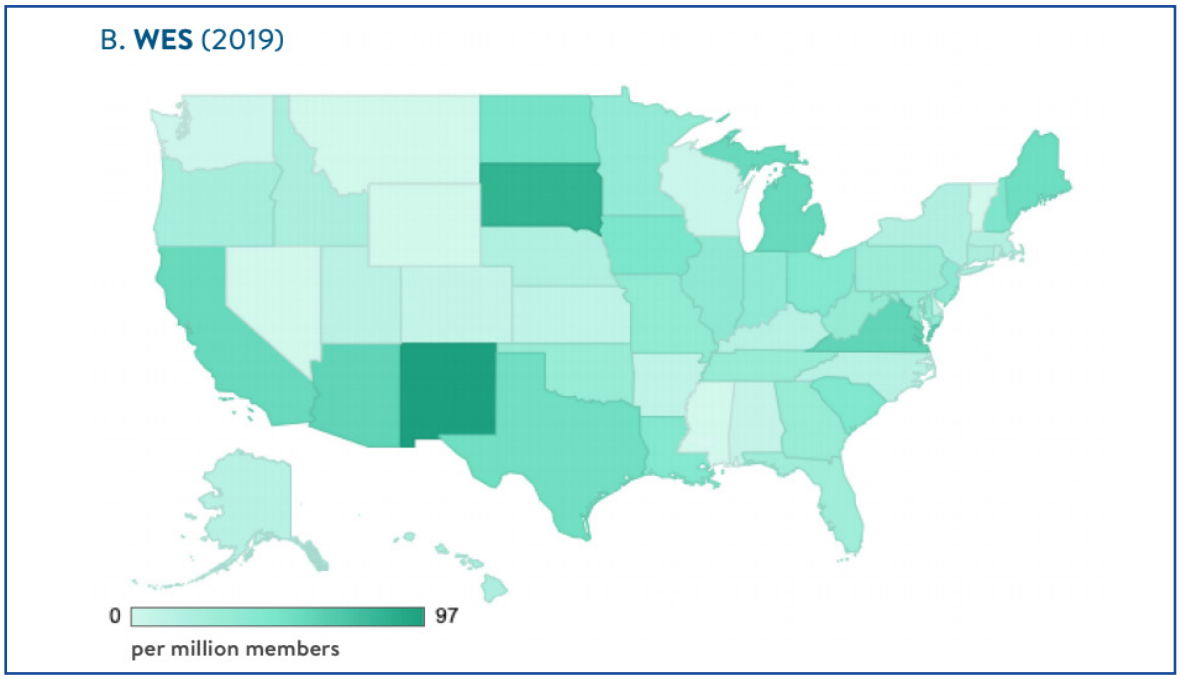


Source: PMC

Continued on page 12

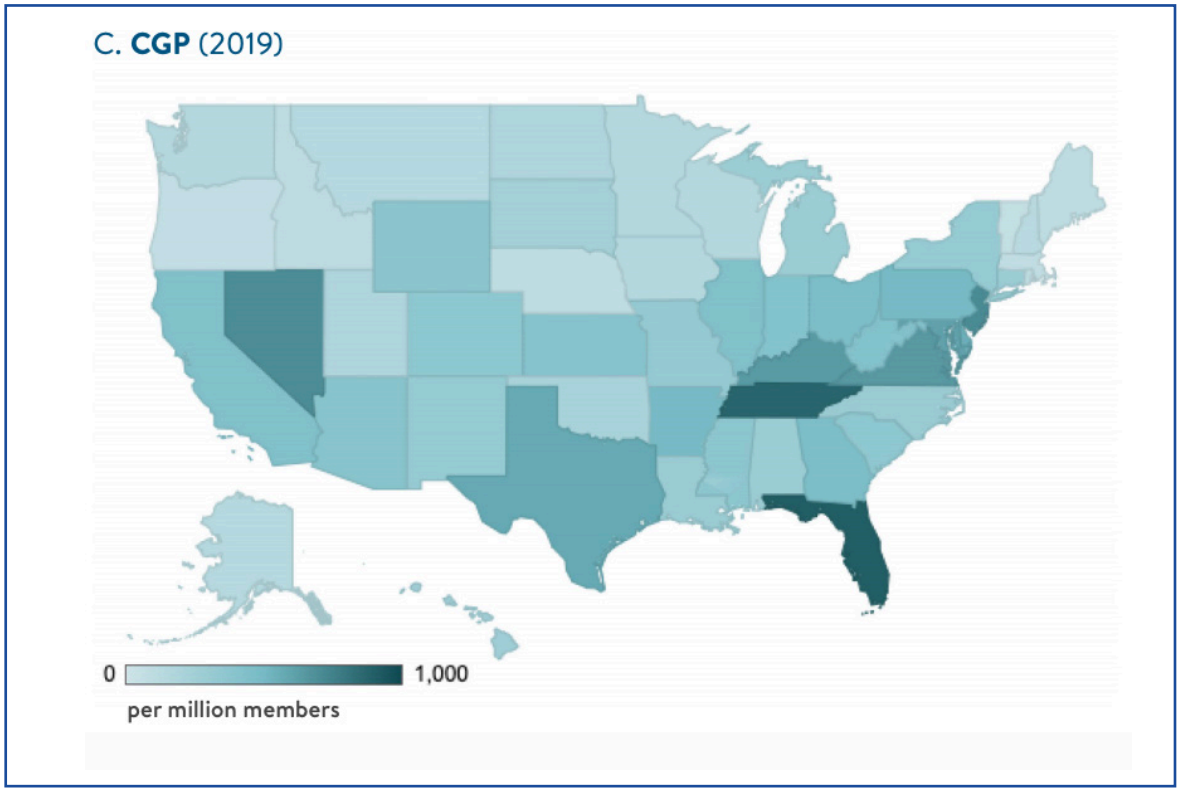
Genomic Testing: Utilization Is Low & Geographically Inconsistent but It's Not All Payors' Fault, *from page 11*

Utilization of Whole Exome Sequencing (WES)



Source: PMC

Utilization of Comprehensive Genomic Profiling (CGP)



Source: PMC

Takeaway

Utilization of genomic testing remains low and inconsistent across the country. Local payer coverage and reimbursement policies mirror that inconsistency and aggravate the problem; but they are not the only reason it exists. The PMC report concludes that there are also other access barriers that may be stifling utilization of genomic testing, including:

- *Lack of awareness and education about genomics and testing technologies;*
- *Socioeconomic disparities; and*
- *Inadequate genomic testing system processes and practices.*

So, while persuading and standardizing the payers will be an important part of the solution, these other barriers will also have to be addressed to deliver on the promise of genomic testing and personalized medicine.

Testing Trends: Laboratory Organizations Ask HHS for Permission to Focus Scarce Testing Resources on those in Medical Need

With no hope that manufacturers will pick up the slack and furnish the reagents, swabs, PPE and other desperately needed COVID-19 testing supplies before the end of the year, laboratories are in the position of having to ration the resources that they do have available. And they are calling on the U.S. Department of Health and Human Services (HHS) for help in making those difficult decisions. Specifically, they want the agency to establish new testing guidelines that prioritize testing patients who are ill, symptomatic or in other immediate medical need at the expense of the asymptomatic.

Providers to HHS: Let Us Focus on the Medically Needy

On Aug. 11, seven healthcare organizations sent a letter to HHS asking the agency to update its COVID-19 testing prioritization guidelines. "We are increasingly concerned about the serious strains being placed on testing services for COVID-19, the impact those strains have on our ability to provide timely medical care to our patients, and ultimately on our ability to contain the spread of this dangerous virus," the letter begins.

"Without improvement in available supplies, we simply do not have the resources to meet the huge demand for testing." Since we cannot test everyone, please tell us whom we should test is the basic thrust of the request. More precisely, the organizations are asking HHS to clarify that the priority should be testing those with medically indicated need for COVID-19 testing, including persons who are symptomatic, have known exposures to the virus and/or in need of pre-procedure testing.

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Testing Trends: Laboratory Organizations Ask HHS for Permission to Focus Scarce Testing Resources on those in Medical Need, *from page 13*

While acknowledging society's need for broad testing for performing medical surveillance and ensuring safe reopening, the letter recommends that testing of asymptomatic individuals without exposure to COVID-19 be assigned a lower priority. "During critical public health emergencies ... limited testing resources must first be directed towards those who need them most—those at immediate risk of infection and serious illness," urges the letter.

Takeaway

And, so here we are. After months of warnings and vain pleas for help overcoming the supplies shortages, laboratories and healthcare providers are now facing a "Sophie's Choice" about which of their patients to serve at least through the end of 2020. Adding to the dilemma is the increased demand of COVID-19 screening of the asymptomatic in connection with schools, athletics, business and other reopenings. Having failed to fix the problem, the political powers that be must step up and make some hard choices about how to deal with its consequences.

The 7 Signatories

The signatories to the HHS letter requesting COVID-19 test prioritization guidance was signed by seven of the most powerful and respected medical and laboratory organizations in the U.S., including:

- The American Medical Association
- The American College of Medical Genetics and Genomics
- The American Society for Clinical Pathology
- The Association for Molecular Pathology
- The Association of Pathology Chairs
- The College of American Pathologists
- The Infectious Diseases Society of America

New ACOG Guidelines: Recommend cfDNA-Based NIPT for All Pregnancies, Not Just Risky Ones, *from page 1*

(aneuploidy) of a chromosome. Because the only blood drawn comes from the pregnant woman, the test poses no risk to the fetus.

Concerns about its predictive value has chilled utilization of NIPT for average-risk pregnancies. NPIT is used as a screening test estimating whether risks of certain genetic conditions are increased or decreased and cannot provide a definitive answer about whether a fetus actually has the condition, creating the need for confirmatory follow-up tests like amniocentesis. And as with other screening tests, NIPT carries the potential for false positives and false negatives—although the false-positive rate of cfDNA NIPT is significantly lower than with traditional serum protein screening with or without nuchal translucency ultrasound.

The New ACOG Recommendations

The headline of the new ACOG recommendations, which came out on Aug. 17, is endorsement of screening for all pregnancies and removal of the previous 35-and-older and other-known-risk factor limitations. More precisely, ACOG endorses both serum protein screening and cfDNA NIPT assays but specifies that the latter are "the most sensitive and specific screening test for the common fetal aneuploidies." At the same time, the recommendations call on physicians to be aware of the potential for false-positives and false-negatives results and that NIPT is "not equivalent to diagnostic testing." According to the document, patients should have only one test—either NIPT or serum screen—and not have multiple tests performed simultaneously.

ACOG also recommends that patients who get a positive screening test result for fetal aneuploidy undergo genetic counseling and a comprehensive ultrasound evaluation to confirm results." Patients who get a negative screening test result should also be made aware that the negative result "substantially decreases their risk of the targeted aneuploidy but does not ensure that the fetus is unaffected." When test results are uninterpretable or cannot be reported due to a laboratory test failure, the patient should be made aware that such results may be associated with elevated risk of aneuploidy and be offered comprehensive follow-up and diagnostic testing.

Takeaway

The broader new ACOG recommendations are welcome news for laboratories that currently offer cfDNA-based NIPT tests, including Natera whose share price shot up 15 percent on news of the new guidelines which are expected to boost use of the firm's Panorama test for average-risk pregnancies just the way it did after the announcement of the previous guidelines endorsing ctDNA NIPT for high-risk pregnancies. Other big players in the ctDNA NIPT market include Roche (Harmony assay), LabCorp (MaterniT21 Plus test), Progenity (Innatal test) and Myriad Genetics (Prequel test).