

# LUCD Earnings Call Transcript

**Date: 2025-11-12**

**Quarter: 3**

Operator: Good morning, and welcome to the Lucid Diagnostics Inc. Third Quarter 2025 Business Update Conference Call. Please note this event is being recorded. I would now like to turn the conference over to Matthew Riley, Director, Investor Relations. Please go ahead, sir.

Matthew Riley: Thank you, operator, and good morning, everyone. Thank you for participating in today's business update call. Joining me today on the call are Dr. Lishan Aklog, Chairman and CEO of Lucid Diagnostics Inc., along with Dennis McGrath, CFO. The press release announcing our business update and financial results is available on Lucid's website. Please take a moment to read the disclaimers about forward-looking statements in the press release. The business update, press release, and the conference call all include forward-looking statements, and these forward-looking statements are subject to known and unknown risks and uncertainties that may cause actual results to differ materially from statements made. Factors that could cause actual results to differ are described in the disclaimer and in our filings with the SEC. For a list and description of these and other important risks and uncertainties that may affect future operations, see Part 1, Item 1A entitled Risk Factors in Lucid's most recent annual report on Form 10-K filed with the SEC and any subsequent updates filed in quarterly reports on Form 10-Q and subsequent Forms 8-K. Except as required by law, Lucid disclaims any intentions or obligations to publicly update or revise any forward-looking statements to reflect changes in expectations or events, conditions, or circumstances on which the expectations may be based, or that may affect the likelihood that actual results will differ from those contained in the forward-looking statements. I would now like to turn the call over to Dr. Lishan Aklog, Chairman, and CEO of Lucid Diagnostics Inc.

Dr. Lishan Aklog: Thank you, Matt, and good morning, everyone. Thank you for joining our quarterly update call today. As always, I'd like to thank our long-term shareholders for your ongoing support and commitment. Our team is extremely excited and remains singularly focused on driving this enterprise towards its substantial commercial potential and enhancing our long-term shareholder value. Since our last update, of course, the most significant event was the MoIDx CAC or Contract Advisory Committee meeting that was held on September 4. The meeting went extremely well. There was strong consensus among the experts on this live on-the-record call that really reinforced our confidence that we are in the final stages of securing a positive Medicare coverage policy outcome. We will obviously have more on this later. The meeting led directly to a successful subsequent financing in September. I think it gives us plenty of runway to successfully navigate these final steps and accelerate EsoGuard's commercialization once Medicare coverage is secured. So let's, as always, start with some key highlights related to our commercial execution. In the third quarter, our test volume was 2,841 tests, and our revenue is approximately \$1.2 million. Both the revenue and the volume are in line with the last quarter, with the second quarter of 2025. Our volume is within the target range that we articulated of approximately 2,500 to 3,000 tests per quarter that we need to maintain our ongoing engagement with commercial payers. We are pleased that the team continues to be successful at maintaining this volume while focusing on transitioning our targeting to include Medicare patients as well as securing event-based contracted guaranteed revenue opportunities, which we will discuss a bit further later. We are really excited that we have been able to strengthen our market access leadership team to drive payer engagement and secure broader commercial insurance coverage and expanded patient access.

We strengthened and scaled our market access infrastructure ahead of these reimbursed milestones such as Medicare. The team is going to focus on market access for our commercial payers and broad reimbursement as well as governmental affairs issues. I will be highlighting our team. We are really excited to have a best-in-class team join us. We are excited to be holding our very first firefighter esophageal cancer prevention summit event next week. Extremely excited about this. As many of you know, we have a strong partnership with fire departments across the country that's extended over several years. They have developed a really long-standing relationship with leaders in the firefighter community across the country, particularly those focused on cancer prevention in these groups. It's been a really gratifying opportunity to help firefighters as they have discussed before. Firefighters have an increased risk of esophageal cancer, a 62% increased risk, and an elevated risk of dying as well. We will talk a little bit more about this a little bit later. As we have discussed, we are continuing our momentum to drive Medicare testing. If you recall, about up to 50% of our 30 million target population are, in fact, Medicare-eligible patients. We have historically not focused on this target population, as we have been focused more on maintaining our volume to drive engagement with our commercial payers, as we have discussed repeatedly in the past. In anticipation of Medicare, we have now implemented measures and incentives to our commercial team to start targeting Medicare patients to drive our Medicare volume towards and perhaps exceeding the portion of the 50% of the target population. We are in the early stages of this. The initial target, the initial group from a subgroup of our commercial team, had initiated this a few months ago. But we are starting to see some success. This is also important because if you may recall, once we get Medicare coverage, we will be able to submit claims going back one year. So we are looking to maximize the amount of that look-back revenue that we can receive once we secure that Medicare coverage. Now let's discuss some of our recent strategic accomplishments. Again, the most important one, of course, is the Medicare Contract Advisory Committee that was held in September. The results of that were extremely positive. The panel of clinical experts unanimously endorsed EsoGuard Medicare coverage, and they cited strong clinical evidence, guideline support, and real-world experience. As we stated repeatedly, we believe this is the important final step towards securing Medicare coverage. In a moment, we will provide some additional context on this process, a little bit of an update of some additional information we have received related to what we expect to be an upcoming draft LCD. Finally, as we have announced and Dennis will discuss a little bit further later, we were able to strengthen our balance sheet with an underwritten public offering of common stock that netted approximately \$27 million in proceeds. This significantly bolstered our balance sheet. Dennis will discuss in more detail the end of the quarter with \$47 million in pro forma cash. We were encouraged. This is a fully marketed offering that reflected really strong interest and confidence, particularly boosted by the positive CAC meeting. There was broad institutional and meaningful insider participation in the offering, and it extends our runway through 2026, well past many concrete reimbursement milestones. We believe it also mitigates our financing overhang and the risk from some other external factors. It provides us sufficient resources in addition to accelerating our commercial efforts once we receive Medicare approval. Before turning it over to Dennis, I want to provide some updates related to and a little bit more detail on reimbursement and also on our commercial efforts. Let's start with reimbursement. As we announced back in September, we have recruited a world-class market access team led by Danielle Shelfo. She brought in two of her long-term colleagues, John Lincoln and Cynthia Hyer. Together, they have over 75 years of combined experience, as you can see here, at major diagnostics companies with a focus on precision medicine as well as payer strategy across some of the more respected names in the industry. They really bring strong relationships in the commercial payer space. This is going to be extremely important for us to start securing coverage and reimbursement across major insurers as we proceed and secure Medicare. So we could not be more excited about having Danielle, John, and Cynthia join our team, and their work will really be central to executing our national coverage strategy for EsoGuard. So let's talk a little bit about a more detailed update on Medicare. We believe the next steps following this CAC meeting are the publication of a draft local coverage determination that would be a positive response to our request for reconsideration of coverage of EsoGuard under the existing local coverage determination. As I said repeatedly, we are very confident that we are very close and in the final stages of this based on the public CAC meeting as well as our ongoing conversations with the MolDX team.

That confidence was strengthened following a recent meeting of the California Clinical Laboratory Association. If you recall, our laboratory is located in Orange County, California. We are members of the CCLA. There was an important meeting following our CAC meeting, a general meeting, where MoDx leaders were present. The meeting, which is a public meeting, further corroborated our confidence that the meeting went well. Our CAC meeting was a topic of conversation. Dr. and one of his colleagues from Meridian were there. The meeting was extremely positive. It just simply highlighted and reinforced the positive feedback that we believe came out of the CAC meeting. It was also important to note that this is the first time that we heard directly from a medical director, one of the medical directors at Meridian, who shared the same positive feedback that the leader of MoDx did as well. So again, very confident that we are heading towards that we should be expecting a draft LCD soon. Once that draft LCD is published, we believe the following steps from that are fairly routine. There will be a mandatory 45-day public comment period. Following that, there will be a publication of a final local coverage determination from that official notice of EsoGuard coverage. Again, to reiterate, once we get final LCD coverage, that will allow us to submit claims dating and getting paid for claims dating back for a full year. So, again, that's the process. Now, we feel like we are in good shape. We are eagerly anticipating the publication of a draft LCD soon. I could talk a little bit about some of the experiences we have had in our ongoing conversations with payers. If you recall, on our last call, those of you who participated, we are pushing full steam ahead on commercial payers. We are not just waiting for Medicare coverage. That activity has really accelerated substantially with the expansion and strengthening of our Market Access team. One thing that we have noticed in addition to just simply a series of meetings with a variety of commercial payers, even over recent weeks that have gone extremely well, is that we have an opportunity to link EsoGuard coverage to existing guidelines for endoscopy. Now, we saw that in the inclusion of non-endoscopic biomarker testing such as EsoGuard in the NCCN guidelines that were published earlier this year. Those guidelines were directly linked to a recommendation, the language in that guideline that followed the existing GI guidelines for endoscopic screening of esophageal precancer. Of course, reiterated what the guideline in the NCCN guidelines reiterated what the GI guidelines say, which is that non-endoscopic biomarker testing, of which EsoGuard is the only one, is an acceptable and equivalent alternative to endoscopy. What's interesting is we have seen that now in more aggressive and more involved conversations with commercial payers. That actually manifests itself in an update and a guideline to the UnitedHealthcare guidelines that were published this summer on endoscopy, guidelines for endoscopy, and particularly guidelines for endoscopy as it relates to screening for Barrett's Esophagus. In that guideline, there actually is specific mention of EsoGuard and its role in identifying patients for EGD and specifically stating that patients who are EsoGuard positive are appropriately indicated for EGD. We believe this is actually a strong advantage in these conversations with commercial payers. In that EsoGuard is not standing alone, but it's linked to guidelines that already cover it's our endoscopy guidelines that are already covered by payers. So being able to link to those guidelines that are already covered really gives us a great starting point in our conversations. In fact, the UnitedHealthcare language is sufficiently strong, we have had conversations with medical directors there that we feel confident proceeding directly to contracting discussions with UnitedHealthcare. So lots of activity on the commercial side. We have a team that's really operating on all cylinders, and we look forward to starting to convert positive policy coverage for commercial payers, actually in advance of us securing Medicare coverage, final Medicare coverage. As I mentioned earlier, we have continued our momentum and that we are focused on driving Medicare as well as our event-based contracted testing. So let's flesh out some of those details as well. As I mentioned, we are really excited to host our very first firefighter esophageal cancer prevention summit. This is the culmination of, as I mentioned, a long history and strengthening our relationships with fire departments across the country and testing the firefighters for this deadly cancer that has increased incidence in this population. This event that we are hosting will have 60 attendees, and these include a variety of members of the firefighter community, including fire service leaders and those that are directly involved in decision-making about hosting contracted firefighter testing events, as well as survivors with those families, and physicians who are within the space. It's really focused on shaping and advancing the prevention of cancer through early detection in the fire service and highlighting EsoGuard's role for preventing the second most deadly cancer that these firefighters face.

From a business impact point of view, we are confident that this will help us continue to bolster what's already a very strong pipeline of contracted Check Your Food Tube events targeting fire departments. We have steadily been able to increase the number and the size of the pipeline of our contracted event-based testing throughout 2025, and we continue that momentum to continue and expand and accelerate through events like this. So with that, I'm going to pass it on to Dennis for our financial update.

Dennis McGrath: Thanks, Lishan, and good morning, everyone. The summary financial results for the third quarter were reported in our press release that has been distributed. On the next three slides, I'll emphasize a few key financial highlights from the third quarter, but I encourage you to consider these remarks in the context of the full disclosures covered in our quarterly report on Form 10-Q. With regard to the balance sheet, cash at quarter-end September 30, was \$47.3 million. During the quarter, as Lishan mentioned, we completed a CMPO with proceeds just under \$27 million. The quarterly burn rate was \$10.3 million, which is slightly better than the average burn rate for the four preceding quarters of \$10.5 million and exactly the same as the prior quarter. The burn in the third quarter included \$7.2 million from ongoing operations and \$3.1 million from the quarterly MSA with PAVmed. You will recall at the end of last year, we refinanced our convertible debt into a \$22 million five-year note, interest only at 12% with a \$1 conversion price, which is held by long-term shareholders. The fair value of the convertible notes and the amount of \$22.3 million at quarter-end is really the only other substantive change from the previously reported balances at the end of the second quarter. The fair value decrease of \$3 million reflects a mark-to-market quarterly adjustment in parallel with common stock price changes between the periods. The fair value decrease also drives a corresponding income pickup of \$2.3 million reflected in other income in the P&L.; Shares outstanding, unvested RSAs as of last week, are approximately 138 million. The GAAP outstanding shares as of September 30 of 130.9 million are reflected on the slide as well as on the face of the balance sheet in the 10-Q. GAAP shares do not reflect unvested restricted stock orders. At present, PAVmed continues to be the single largest common shareholder of Lucid Diagnostics Inc. with ownership of approximately 23% of the common shares outstanding. Although PAVmed no longer has voting control of Lucid, PAVmed together with the board and management still have significant influence over Lucid with approximately 28% voting interest. Lucid has convertible preferred securities whereby the preferred shareholders are incentivized to delay conversion of the preferred shares and the common shares until 2026, namely the second anniversary from closing. If all of the preferred shares outstanding were converted into common shares as of today, there would be an additional 49.6 million common shares outstanding. Next slide. With regard to the P&L;, this slide compares this year's third quarter to last year's third quarter and year-over-year on certain key items. I trust you'll review the information on my comments in light of the cautionary disclosure on the bottom of the slide about supplemental information, particularly non-GAAP information. One additional high-level summary comment, if you were to place the sequential second and third quarters side by side, you would see they're nearly identical. On a GAAP and a non-GAAP basis, relatively the same test volume, same recognized revenue, the same OpEx levels, both GAAP and non-GAAP, the same burn rate. With that, and for consistency, a few comments on the normal things that I do touch upon. With over 2,800 tests for the third quarter, we invoiced over \$7 million and recognized revenue of \$1.2 million reflecting a 4% sequential revenue increase and a 3% year-over-year increase. With new investors once again joining us for the call, it's worth repeating what we've communicated in past quarters about revenue recognition. A key determinant in how revenue is recognized at this point in our reimbursement journey is the probability of collection. Therefore, due to the fact that we are in this transitional stage of our reimbursement process means revenue recognition for the majority of our claims submitted to both traditional government or private health insurers will be recognized when the claim is actually collected versus when the patient report is delivered, invoiced, and submitted for reimbursement. As you will see in our 10-Q, it's called variable consideration in the jargon of GAAP's ASC 606 revenue recognition guidelines. Presently, there is insufficient predictive data to reflect revenue from all of our quarterly test volume at the point where the test report is delivered to the referring physician. For billable amounts contracted directly with employers or through concierge medicine that are fixed and determinable, will be recognized as revenue when our contracted service is delivered. Generally, that means when the report is delivered to the referring physician. It's

important to note that pending Medicare approval decision impacts about 40% of our addressable patient population, and therefore, will have a significant impact on our future revenue recognition analysis. Furthermore, for tests performed on Medicare patients with dates of service within twelve months of the final positive Medicare policy, will also get paid within a reasonable time frame after the final policy is issued. On a non-GAAP basis, our non-GAAP loss for the third quarter of \$10.3 million is relatively flat sequentially and slightly better than the trailing fourth quarter of \$10.5 million. The non-GAAP net loss per share of \$0.10 is flat sequentially as well as better than the trailing April average loss of \$0.16 per share. On a GAAP basis, net loss and EPS are just about the same as the non-GAAP metrics, namely \$10.3 million loss and a net loss per share of \$0.10. Next slide. With regard to our operating expenses, this slide is a graphic illustration of our operating expenses after eliminating non-cash expenses for the periods reflected. Non-GAAP operating expenses of \$11.5 million are lower than the average \$11.6 million for the last four quarters. Let me close with a few reimbursement highlights for the third quarter. In this most recent completed quarter, third quarter, we billed 2,841 tests reflecting about \$7.1 million in pro forma revenue. During the third quarter, we recognized revenue of about 17% of that amount or \$1.2 million. Of that amount, about 49% was from claims submitted in prior quarters with the longest dated item from twenty-four months ago. Of the claims submitted in the third quarter, about 76% have been adjudicated. 24% are pending. Out of the 76% that have been adjudicated, about 38% resulted in an allowable amount by the insurance company with an average around \$1,600 per test, which bumps up against the Medicare rate. Obviously, the majority of tests are out of network. Of those denied, most fit into one of three buckets: A, medically not necessary or deemed medically not necessary, or B, require a prior authorization, or C, required additional medical records. The balance are deemed to be non-covered. With that, operator, let's open it up for questions. Thank you.

Operator: Ladies and gentlemen, we will now begin the question and answer session. You will hear a prompt that your hand has been raised. Should you wish to decline from the polling process, please press the star followed by the number two. And if you are using a speakerphone, please lift the handset before pressing any keys. One moment, please, for your first question. Your first question comes from Mark Massaro with BTIG. Please go ahead.

Mark Massaro: Morning, Mark. Hey, good morning, guys. Thanks for taking the questions. So, yeah, it's super interesting that you guys mentioned the CCLA meeting recently. Because I just wanted to get a sense, you know, obviously, there are a couple of significant leaders of Medicare contractors present. I'm just curious if you could share a little bit more about any dialogue you might have had. And then related to that, assuming you get a positive draft LCD, is it your opinion that the final, which would likely happen thereafter, I would think, would be probably a formality or at least consistent with the draft?

Dr. Lishan Aklog: Yes, great. Thanks, Mark. Yeah, let's talk about the California meeting. Just to be clear, this is a regular meeting that's held by the California Clinical Laboratory Association, CCLA. We attend this meeting, actually Danielle, our new head of market access attended this meeting, and it was a general meeting. It's basically an opportunity for the leaders of MoIDx contractors to engage in an open conversation. So everything that was stated was stated in public. It was not private one-on-one conversations. That's frankly why we found it to be very positive in that a significant amount of time was actually spent based on audience questions on us and our CAC meeting. It was twenty or thirty minutes of a two-hour meeting dedicated to that. The responses from the head of MoIDx were very direct, very consistent with the internal conversations that we've had, and very positive. They were all sort of reaffirming of our general perspective on how things are going and sort of the paradigm under which he's operating. I mean, he explicitly upon questioning by third parties, described the meeting, described the purpose of the meeting, said the meeting went well, conversations went nicely, and he explicitly said that we got the information needed to move forward with drafting policy. So we couldn't have asked for more. He did add a few things that were also quite positive and encouraging. He got a little bit in the weeds on how they view this process. He spent some time on how important guidelines are and how important it is from their perspective to align with guidelines when at all possible to maintain so they don't put physicians in a difficult position with contrary opinions between the LCDs and existing guidelines. He also talked about the whole history. We've talked about this in previous meetings about how he wrote this policy to be non-covered, but still was explicit as to what would be required for

coverage. So that would allow the reconsideration process, which is what we're in right now, to occur more quickly. That the companies like us could understand well in advance what the expectations are with regard to converting a non-coverage policy to a coverage policy. He said, you know, if we ask him to do this, and we won't come back and just say it's non-covered, just kidding, and require more evidence. So that was really great. What was frankly, again, most of that was reaffirmation although there was some level of specificity, particularly in public comments that were extremely encouraging. What was rather new was that one of the medical directors at Meridian, which is one of the other MoIDx participating Medicare contractors, was also present and also commented. She really corroborated very similar sentiment with regard to the meeting and with regard to the entire process. So that's a very good sign. As we've discussed before, the MoIDx process is designed to bring the four Medicare contractors together. We believe that one of the purposes of the meeting, the public meeting, was in fact to provide the MoIDx director with the information on the public record that the other MAC leaders could use to come to a consensus on proceeding with the draft policy. Noridian is the most important of the others because our laboratory is located in a Noridian jurisdiction. So, yeah, it was a bit unexpected. It was a regular scheduled meeting, and it was frankly other people who were asking, you know, the industry stakeholders and others who initiated the conversation. It was great to see that spontaneously both medical directors were just extremely positive about where things are. So, it really puts us makes us feel confident about where this is heading. So, yeah, the second question, Mark, was around once the draft gets issued, the process between the draft and the final. Yeah, we really do feel that that's a formality for a variety of reasons. The draft policy has already is basically a reconsideration of an existing final policy. So the vetting of the body of the coverage determination, the specific criteria and other language in there, everybody's already signed off on that. That already went through a public comment period. We are happy with the language of the final. So this reconsideration is just simply flip it from non-coverage to coverage. I think I might have mentioned in previous meetings that part of our submission for reconsideration is literally a red line of the existing final LCD. The proposed red line just simply removes the term non-covered and maintains everything else. It obviously adds additional data, our data in the summary of the evidence, but the actual policy itself is identical. So because we're not asking for a reconsideration of the substance of the policy just to flip it, we believe that the public comment period will be a formality. There's strong support for this, not just obviously from us, but from other stakeholders. We expect there'll be support from trade associations and from others, patient associations and so forth. Just like there was the last time. So we really do view that the process, the public comment period, the process of converting the draft to a final to, in fact, be a formality. It's one that has a certain time window when it takes some time to move from A to B. But it's a we would I think that's the right word, Mark, formality.

Mark Massaro: Okay. Great. That's very helpful and good to hear. I know you guys indicated just today that you feel confident that you're getting very close. I recognize I don't think there's any clock per se. But would it be reasonable to think that, you know, perhaps by year-end 2025, we might see a draft? I mean, what's your latest thinking on timing?

Dr. Lishan Aklog: I think our thinking hasn't changed. I mean, you and others have projected that. We think that's a reasonable estimate. It's really about workload. There was some thought and concern that the shutdown could have influenced that process and, you know, and slowed down the process of issuing LCDs. We have no reason to believe that was actually the case. LCDs continue to get issued. It's important for people to remember that MoIDx and Palmetto, the underlying MAC, are private contractors. So there was no and I believe they explicitly stated at this, even at the CCLA meeting that the shutdown did not slow them down at all. There was a period of a few weeks when the coverage advisory group at Medicare at CMS proper was furloughed, but they were brought back rather quickly. They were issuing NCDs and LCDs along the way. So, it's just sort of a pipeline workflow issue. We think there's a this is a fairly straightforward reconsideration because the data has been in their hands now coming on a year. The CAC meeting was universally positive. So this is just a workflow issue, and we think that that's a reasonable timeline.

Mark Massaro: Alright. And then maybe just one more for me. Since the you know, since the last call in the CAC meeting, I'd be curious if you could perhaps expand on any dialogue you've had with any commercial payers. Are you seeing anything move there, or do you think it's more of a wait and see on

the

Dr. Lishan Aklog: Yeah. Definitely. Yes. So I think I made the point during our last call that prior to I would say in the first quarter or second quarter of this year, we were of the thought that for the most part, with, you know, the occasional Highmark policy issued in the second quarter. That for the most part commercial payers would wait until Medicare. Our thinking on that has changed quite a bit over the last couple of quarters. Fact is that for example, the Highmark policy moved forward quickly because we had the data. It's important to remind people that the package of data that we submitted for the reconsideration for Medicare wasn't completed until the fourth quarter of last year. So we weren't really out there talking to commercial payers with a full dataset until the first half of this year. So the answer to your direct question is yes, we have a lot of meetings going on, a lot of activity. We're fully engaged with larger payers and smaller payers. We are seeing positive movement. So the meetings are going well. The specific points of discussion around the clinical evidence both CV and CU as well as healthcare economics, which does come into play on the commercial side, are positive. Those conversations are very much strengthened by the published guidelines, particularly an important factor for commercial payers. So, moving forward well. Now we have our team has really beefed up and is pursuing these aggressively. So I would not I would expect frankly that we'll be we'll start seeing positive coverage policies from payers, small and large, sooner rather than later as we await the Medicare process to come to conclusion. It would maybe be a good time to emphasize one of the points I made during my prepared comments which is that one of the things that we're learning as we navigate the commercial side is we have to remind ourselves that payers already let me just back up, that EsoGuard fits within a paradigm. It's not a test that's done in isolation. It fits in a paradigm of screening for Barrett's Esophagus for precancer that obviously includes endoscopy. It includes confirmatory endoscopy. It includes surveillance endoscopy in people who have been found positive. It includes ablation. We have to remind ourselves that all of those are covered right now by payers. So, this updated guideline by United was really encouraging, not just in of itself, but a reminder of how we fit within that paradigm. We're not going to payers and saying, here's a new test that's sort of coming out of the blue. We want you to cover it. We're saying, here's a test that fits in entirely with the new paradigm that you've already accepted and that has as it relates to endoscopy, and has obviously substantial advantages both in terms of cost and in terms of invasiveness to the patient. So we're not starting from ground zero, we're starting from that baseline. The fact that United included in its latest update of its guidelines for endoscopy for Barrett's Esophagus screening. The fact that they one of the considerations with regard to covering an endoscopy is that the patient has a positive EsoGuard test. Really was an eye-opener for us and has given us confidence of pushing those dialogues a bit more aggressively. In that case, just going straight to see if we can secure a contract.

Mark Massaro: That's all great to hear. Thanks, guys. I'll hop back in the queue.

Dr. Lishan Aklog: Yeah. Great. Thanks, Mark.

Operator: Thank you. The next question comes from Kyle Mikson with Canaccord Genuity. Please go ahead.

Kyle Mikson: Good morning, Kyle. Hey, guys. Thanks for the questions.

Dr. Lishan Aklog: Hey. Good morning. So just on your point there, Lishan, about the shutdown, you know, not slowing down LCDs, draft LCDs. I'm just curious with it potentially ending here. Do you think there could be, like, an acceleration or, like, this, like, rubber band effect to maybe complete the draft now?

Dr. Lishan Aklog: Perhaps. I think the fact is I don't think it will slow down by it. The sort of the CAG group was out for a couple of weeks. The reason that's relevant is that although these policies are finalized by the contractors, there is a sort of a rubber stamp. I'll even just call it an administrative process that has to happen at CMS proper to get these things published and so forth. So sure. I think the fact that the shutdown is ramping up will, you know, make sure that things are operating full steam at CMS when it comes time to actually process finalize the administrative processes that are necessary to post the draft LCD.

Kyle Mikson: Okay. That's great. And then, you know, maybe in mid-2026, let's say, when you let's let's assume you have coverage for Medicare. What should the commercial channel mix kind of look like? You know, you have concierge, you have test centers, have, like, different panels here. They're just

curious how that's gonna change from this point to Yeah. To then, basically.

Dr. Lishan Aklog: Right. So we've been operating in anticipation of that. We described it in a little bit more detail on our last call about the fact that we are making a concerted and prospective push to drive the portion of our population that have Medicare that are Medicare. Yeah. That are Medicare-eligible patients. So that process has already started. The goal is at least 50%, which is about approximately what the target population is in terms of Medicare. That process is going well. We're turning the boat. Our reps have been focused primarily on just getting volume and on these other channels, as you said, concierge, employers, and fire departments and things like that. All of that is continuing. But there's been a concerted push by our commercial team to start the process of driving the portion of patients that are from where we are right now, which is about 10% to 15%. Ultimately towards at least where it is based on the target population. We're certainly hopeful that by mid-year, in addition to that, transition happening with regard to the target population that we'll start seeing the fruits of our efforts on the commercial side as well.

Kyle Mikson: Yeah. I think just to that was helpful. Maybe just to clarify, is there any maybe change in the call point or, like, a, you know, greater emphasis on the call point for the reps or maybe, you know, new reps, let's say.

Dr. Lishan Aklog: That's what I was kinda getting at, just given it's the call center No. I think I think yeah, the answer is yes. Yeah. So we're encouraging and we're incentivizing reps. We're actually starting with the more experienced reps and less of the new ones to shift their emphasis to calling on practices and helping those practices identify Medicare patients that would qualify for testing. So, that process is and we're seeing it bear fruit. There's also I'm glad you followed up, Kyle, because there's another aspect to this as well, which are health systems. Health systems are challenging in a variety of ways, but obviously the yield, once you can secure a health system, is, you know, can be high. Medicare is a barrier has been a barrier to many health systems. You just can't initiate a conversation of coming in. We've had some successes where that hasn't been the case. But the anticipation of Medicare coverage has actually agreed to SCIDs in terms of us being able to engage with health systems. So we're expanding that. So we've made some adjustments to our team. We've actually brought in some more experienced director-level folks who have experience calling on health systems with regard to GI technologies. We're looking to see the, you know, bear the fruits of that. The fact that Medicare believe Medicare coverage is imminent has helped drive those conversations.

Kyle Mikson: Perfect. And then just a quick housekeeping question, maybe for Dennis. The cost of goods per test increased to, like, \$600 per so. It's like a 5% increase quarter over quarter. You know, anything in the quarter that would have elevated COGS or actually we kind of think about that going forward? Is that gonna I feel like you kind of thought that was gonna decrease over The variable cost  
Dennis McGrath: has remained unchanged. The cost of EsoCheck is in the \$50 range, and the cost to process through the lab the variable cost to process a test through the lab is still unchanged in the \$120 to \$125, so less than \$200. The rest are fixed costs. They could adjust upper pretty consistent quarter to quarter.

Kyle Mikson: Perfect. Thanks, guys.

Operator: Thank you. The next question comes from Anthony Vendetti with Maxim Group. Please go ahead.

Anthony Vendetti: Good morning, Anthony. Good morning, Anthony. Morning, Dennis. Good morning, Lishan. So just as a reminder, how many commercial payers right now cover EsoGuard? And

Dr. Lishan Aklog: We have. And then maybe go ahead. And then I have a follow-up. Yeah. We have one positive policy, which is Highmark New York. That policy was issued in the second quarter. We're in the process of engaging with them on contracting. We billed 400 plus, and I would say our pipeline of conversations active conversations with commercial payers, small and large is in the order of dozens.

Anthony Vendetti: Okay. Great. Okay. And you've billed 400 of them now. So they're aware. It's a lengthy process. It's just it's just Mhmm. I know it's it's

Dr. Lishan Aklog: Yeah. Exactly. That goes back to the basically, the pattern with the stance we've had for the last couple of years, which is that we need to do enough volume so that we can engage, we can submit claims, we can get denials, we can appeal denials and make the case for transitioning now that we have the data to formal positive policy, so they're not stuck in out of network.

Anthony Vendetti: Sort of a nuisance strategy. Right. Okay. And then can you talk about the Dr. Lishan Aklog: the ordering behavior from the physicians that use EsoGuard? And for the ones that are your, let's say, higher volume users, what the repeat ordering kind of rate do you if you track that? Yeah. We don't track that sufficiently to report it, but we know what's going on in the field clearly. There is just no issue with that. When we engage with a physician that's able to order the test that buys into the paradigm, that understands the guidelines, that understands the opportunity, have an impact on their patients. It's sticky business. So really, we don't spend a lot of time focused on that because ultimately we know that when we put our foot in the gas and we go out and try to drive when we have sufficient coverage to justify throwing more commercial firepower at this. That they'll respond. We know that for years now with engagement with the physicians. This is not a difficult call point to walk in and educate the physicians and make the case. Once we do, we have good with that. In fact, some of that's actually we've been making some tweaks to that, which still is a fundamentally solid call point process. One of the things that's just out of just interest that we're doing is we're leveraging more and more leveraging our nurses, the clinical team that we deploy to do cell collection, both for these check your food tube events, but also at physician practices. If you recall, we do these things we call satellite listed test centers where our nurses will show up on a regular basis at a physician's office and do tests. We actually had one recently where they did 30 tests in a when I said that theoretically, it's actually it actually is happening in real life. One of the things that we've done from an account maintenance point of view and relationship point of view is to actually take our nurses who are obviously clinical experts and are able are very conversant in the underlying clinical medicine to be much more directly engaged with these accounts at the beginning. Also on an ongoing basis. So that role has expanded. It's been really quite gratifying.

Anthony Vendetti: Okay. And then last question is when you actually get a referral for an EsoGuard test, if they offer it at the site, but they actually get a referral What's the conversion rate from referral? To actually getting the test done?

Dr. Lishan Aklog: Just to be clear, these are not really one-off referrals. Let me just clarify that first. When we partner with a system, and those are slightly different, I'll talk about both, it's really programmatic. It's establishing an esophageal precancer detection cancer prevention program within your practice or within your health system. We work together with them to help them find the patients, to interrogate their electronic health records, to do events with if it's a GI practice with their local primary physicians, if it's a primary care practice, again we do patient events and so forth. So it's really a partnership. It's not sort of one-off if a physician is sort of thinking, I test this patient or not? It's much more programmatic. As you might imagine, especially at the health system level, that's quite even more involved and it can be quite sophisticated. I mean, it's, you know, Hoag Health System, for example, has 200 primary care physicians that work with a cadre of gastroenterologists. Working, you know, the system that we're building there is designed to bring all of those folks in the mix. So what drives these folks is the negative predictive value. The fact that they know that if a test is negative, they can rule it out. If a test is positive, those patients will get referred for endoscopy. Now the health systems are very motivated in particular. The GIs are motivated because it drives patients to endoscopy and the ones who come to endoscopy have a higher yield. I think your narrower question is actually much more straightforward, which is that what is the yield of a patient who gets referred in terms of making its way through the process is extremely high. Patients who get referred for EsoCheck cell collection and the EsoGuard test that number is well over ninety percent in terms of people who actually follow through and get their cell collection, whether it's us or whether it's someone we've trained within the practice or the health systems, we do both. Or at one of our health events. We've also reported previously, and this is actually central to our clinical utility portion of our clinical evidence that patients who are positive, so remember EsoGuard negative patients don't need anything further done because they have a high negative predictive value. The positive patients are referred for confirmatory endoscopy. The patient compliance with that is eighty-five percent, which is double the compliance of patients who get referred for endoscopy without EsoGuard. So the patient knowing that they have a positive biomarker test is a very strong impetus, provides them a very strong impetus to go and complete the process and get their endoscopy. So they can be put in the appropriate follow-up plan, whether it's surveillance or treatment.

Anthony Vendetti: Okay, great. Thank you so much. I appreciate all the color. I'll hop back in queue.

Dr. Lishan Aklog: Yep. Sure. Thanks, Anthony.

Operator: Thank you. The next question comes from Mike Matson with Needham and Company. Please go ahead.

Mike Matson: Morning, Mike. Hey. Good morning. Lishan Dennis Good morning. Good morning. This is Joseph on for Mike today.

Dr. Lishan Aklog: Yes. Hi, Joseph. Hi. Hope you guys are doing well. So I understand, how you guys feel about positive coverage for EsoGuard. Obviously, the CAC meeting was overwhelmingly positive. But just looking at this potential, I guess, like, when you look back period, for claims, you know, once you get positive, coverage, I'm just trying to level set

Dennis McGrath: the one-year look-back period with

Joseph: just now engaging or increasing Medicare patients. You know, while I don't think it's the case, I think maybe some investors could see that and view maybe Lucid being closer to one year for reimbursement rather than a couple of months. So that I guess that central question why engage Medicare patients now or increase that rate versus maybe starting to do that, you know, last quarter or two quarters ago?

Dr. Lishan Aklog: Let me answer that at a high level. Maybe Dennis has some additional thoughts. I just want to make sure it's clear. Getting Medicare patients now first of all, they're Medicare Advantage patients, which are, you know, can pay because they could be a private insurance or are paying that. So that's one element of it. But, the you know, now that we didn't trigger this until just before the CAC meeting. Now that we have a pretty good, high level of confidence as to when this is going to happen, it's important, you know, that we feel the pipeline and try to maximize as much of that look-back as possible. So, I'm not sure to be characterizing it as a delay in reimbursement really is how we would look at it. Dennis, do you have any thoughts on that?

Dennis McGrath: I think, Joseph, what you're aiming at is since the CAC meeting was so overwhelmingly unanimous among all the clinicians, and the receptivity by the MoIDX leadership was strong. It certainly has emboldened us to be more aggressive in our pursuit of those areas where our more Medicare-rich population should think of Texas, Florida, and North Carolina. That's an expression of our confidence that we're in this zone of Medicare approval. That zone is the twelve months prior to final. Your question was, if an investor thinks it's more than a year from now, the question would be why are we pursuing Medicare patients today? The focus when under that theory we wouldn't get paid right now. Well, our confidence is just the opposite, that we are in the zone of approval. What we are now intentionally pursuing in terms of our patient pool is an indication that we are expecting draft I don't know, any day to what the expectations were. Right? Set by many of the analysts out there. That what we are incurring, we will get paid. Based upon that expectation. That's what's driving our behavior.

Dr. Lishan Aklog: Now that I understand the question, thanks, Dennis, for clarifying it. Yes. The Medicare patients that we're bringing in today, expect to get paid on.

Joseph: Okay. Yep. Crystal clear. Thank you. Then I guess just to follow-up, and then I'll ask my second question. Are you now ramping total test volume or just increasing the mix of Medicare patients and kind of still keeping that total test volume, more or less, you know, moderating? Then just on your study with the NIH looking at asymptomatic GERD patients, can you just remind us how many patients are in that study and maybe the expected readout timeline for that? I guess really, the central question, how you expect, results from that study to drive, adoption in that asymptomatic population.

Dr. Lishan Aklog: Yeah. Okay. So, the answer to the question is that we are not increasing our target volume. We're not increasing the headcount of personnel. A few here and there, but for the most part, we're keeping our headcount flat. But we're changing the nature of our headcount. So the nature of our sales team, as I mentioned, we're bringing in more experienced directors. That's really designed to be so that we can be scalable at the time we put our foot on the gas. So we're trying to maintain our test volume while shifting the portion that Medicare and that are direct sort of physician practice call points during this window between now and Medicare coverage. So this is really about building something that is easily scalable once we decide time is right to put our foot in the gas and to start investing in an increased expanding our commercial team accordingly. So that's what we're doing. It's a little bit of like I

say, sort of fixing the engine while it's running. So we're still doing plenty of larger healthcare events, which have supported our volume over time. Many of those are now being converted to contracted events, where we expect to get paid. But we've taken a portion of our commercial team, the more experienced ones, and trained them and have initiated an actual program to have them go to be incentivized to go find to go engage with practices to drive Medicare. As I said, we're seeing those. We saw one recently where one of our reps on the East Coast engaged with a practice started initiated one of these satellite testing programs where our nurses will come. On the very first meeting, the very first one of those, there were 30 patients and 28 of them were Medicare. So we know that we can actually that this process can work. That we've trained them appropriately, and we're going to shift them, but not in a way that we're still very cognizant of our burn. We're still maintaining our stance of trying to keep our burn flat and not get ahead of ourselves until we know that we have coverage and that we can justify putting additional resources to drive both volume and revenue and Medicare revenue in particular. I think your question, just to confirm, your question was about the NIH study for Is that correct, Joe?

Joseph: Yes.

Dr. Lishan Aklog: Yeah. Yeah. So that study is going well. Actually, it's enrolling pretty well. There are actually two parallel studies. There's that one and there's also one that's being run by the VA, which is also enrolling extremely well. So, we don't have a target date for the readout. The NIH study had, I think it was six hundred to nine hundred was the target sample size. It's based a bit on what the positivity rate is, so it could range somewhere I think it's actually gonna be on the lower end of that. I expect the VA will read out much more quickly. They just have a knack for, you know, for rapid enrollment. So I don't have a target date, but those studies are going extremely well. Look, at the end of the day, that we view the output of those studies as a longer-term market expansion opportunity. We're not dependent on the results of this data to drive to make substantial inroads into the existing target population. Remember the 30 million target population that we're pursuing now. That's the core population that includes symptomatic patients. We're driving that based on existing guidelines. ACG and AGA guidelines, as we articulated in the NCCN guidelines. In all of those, you're referring to typically symptomatic patients. So, we're excited about this study. Just to be clear, it's an opportunity to expand that 30 million target population to likely closer to 50 million in terms of long-term commercial opportunity. But we're not dependent on the read of this study for our near-term significant commercial opportunity that happens in the near term.

Joseph: Of course. Okay. Well, I appreciate you taking our questions.

Dr. Lishan Aklog: Yeah. Thanks. Thanks, Joseph.

Operator: Thank you. The next question comes from Ed Woo with Ascendant Capital. Please go ahead. Morning, Ed. Hi, Ed.

Ed Woo: Yes. Congratulations on all the progress. Dennis, I think earlier you mentioned that the variable costs of these tests are about \$200. Has there been any significant inflation impact on this cost?

Dennis McGrath: Or do you think it'll be pretty steady going forward? We think it's pretty steady. That pricing piece of check particularly is over a large manufacturing level. So I'm not expecting it to change very much. I think we've got a good economic number at this point. We \$50 the inflationary impact will be negligible. As far as the last buys that are consumed during the processing of the test. Don't expect that the a significant needle mover, particularly when you think about, you know, a \$2,000 test and a \$200, and I'm rounding up from a \$185. You've got some a lot of room in terms of absorbing costs. By the way, while we're at it, there's also, in the future, an opportunity to get those costs down, especially the laboratory portion of it. There's opportunities with automation to get it down. We're just not pursuing that yet. Until we get back to talk to them. AI is another tool that can be used in various aspects of the process of running the assay that can lower costs over time.

Ed Woo: Great. Well, thanks for answering my questions, and I wish you guys good luck.

Dr. Lishan Aklog: Thank you.

Dennis McGrath: Thanks, Ed.

Operator: There are no further questions at this time. I will now turn the call over to Dr. Lishan Aklog for closing remarks. Please go ahead, sir.

Dr. Lishan Aklog: Great. Thanks, operator, and thank you all for taking the time and for your attention this morning. We really, as always, appreciate the thoughtful and informed questions by our covering analysts. It gives us an opportunity to provide additional color along the way. So hopefully, you got a sense that we're it may feel like we're in a bit of a holding pattern here, but that's really a function of our fiscal discipline with regard to holding our burn. We remain very confident that we're in the near-term processes for securing Medicare coverage. Not a matter of when, it's a matter of if the CCLA meeting was just a sort of another confirmation and validation of that confidence. As we've talked about in several specific ways, we are working to lay the groundwork for a growth phase once we secure Medicare coverage. So, hopefully, that was clear. So with that, we appreciate your time. We encourage you to keep abreast of our progress. Please follow our news releases and follow-up on these calls as well through our website and social media. Feel free to reach out to us if you have any specific additional questions. So thanks again, and everybody have a great day.

Operator: Thank you.

Operator: Ladies and gentlemen, this concludes today's conference call. Thank you for your participation. You may now disconnect.