SALSA Summary

Topic	Protecting Access to Medicare Act § 216 Provision, as amended	Reform Proposal
Reporting frequency	Restarting in 2024, all labs subject to CDLT reporting requirements must report every three years.	Suspends CDLT reporting requirement through 2026; restarts in 2027; extends reporting frequency to every four years.
Data collection/reporting	PAMA requires labs subject to reporting obligations to report all rates paid by private payers, including Medicare Advantage and Medicaid managed care organizations.	The new law would leave in place existing reporting protocols, but exempt from those protocols data for "widely available" CDLTs, which will be collected through a statistical sample, rather than from all applicable labs. A "widely available" CDLT is a test (1) with payment amount less than $1,000, and (2) performed by more than 100 labs. This definition should cover most tests, thereby leaving traditional reporting methodologies to proprietary advanced molecular tests. The legislation requires that the sampling methodology (1) be representative of the range of private payor payment rates of the different types of applicable laboratories (independent labs, hospital labs, and physician office labs) that furnish the test, and (2) accurately and proportionally represent the range of private payor payment rates received by each such types of lab based on utilization of the test by each type of lab. Additionally, the methodology must be designed to reduce reporting and data collection burdens on labs to the greatest extent practicable. Labs may exclude payments not made through an electronic standard transaction (manual remittances) if these remittances do not exceed more than 10 percent of the lab's claims

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		Labs are not required to submit payment data from Medicaid managed care organizations, as it is not included in the definition of "applicable information" for reporting periods beginning January 1, 2027. (Labs would continue to report Medicare Advantage rates, however.)
Labs subject to reporting	Only labs meeting two criteria are subject to reporting obligations (and may report): Any lab that (1) receives 50% of its Medicare revenues from payments under the CLFS or PFS, and (2) has Medicare revenues from the CLFS greater than $12,500 in a six-month reporting period. Revenues are calculated at the National Provider Identifier or NPI level.	The legislation eliminates the "majority of revenues" criterion, and thus defines an applicable lab (subject to the reporting requirements) as any lab with Medicare revenues from the CLFS greater than $12,500 during the first 6 months of the calendar year immediately preceding the applicable data collection period. (This provision applies regardless of whether a lab would have been considered an "applicable lab" prior to January 1, 2025.)
Phase-in	PAMA limited payment reductions to 10% each year between 2017 and 2019, and to 15% each year between 2020 and 2022. CMS adopted this schedule but delayed its implementation one year to 2018 to be consistent with the overall delay in the program. In the final rule, CMS limited reductions in years 2018 through 2020 to no more than 10%, and from 2021 through 2023 to no more than 15%. Subsequent legislation froze 2021, 2022 and 2023 rates at 2020 levels, and delays (up to) 15% cuts until 2024-2026.	There are "guardrails" in place limiting both the amount of increase and decrease for CDLTs in a given year. These guardrails limit the annual rate of increase for widely available CDLTs to 2.5% for years 2024-2025, 3.75% for years 2026-2027, and 5% in 2028 and each subsequent year. For all other CDLTs, the limit on the rate of increase is 5%. (Under current law, there is no cap on the rate of rate increases.) The annual rate of decrease for all CDLTs is limited to 0% in 2024, 2.5% in 2025 and 5% in 2026 and subsequent years.