POINT OF CARE TESTING ASSOCIATION

PAMA Reform Proposal Summary

Topic	PAMA/Social Security Act § 1834A	The RESULTS Act
Reporting frequency	Restarting in 2026, all labs subject to CDLT reporting requirements must report every three years.	Suspends CDLT reporting through 2027; restarts in 2028; also 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.	Would leave in place existing reporting protocols, but exempt from those protocols data for "widely available" CDLTs, which will be collected from a third-party vendor. Defines a "widely available" CDLT would be any test that is not an ADLT and for which CLFS payment is made during the first six months of the year immediately preceding the data collection period to more than 100 labs. Requires the Secretary to identify and contract with an independent vendor that maintains a "comprehensive claims database" to obtain data for "widely available tests" that are not ADLTs. Defines a qualifying database vendor as one that (1) collects and maintains a comprehensive claims database, (2) is a non-profit, (3) is not affiliated with any governmental agency, insurance issuer, group health plan, provider or supplier of services, among other qualifying criteria. Defines a qualifying database as a dataset of private payor claims data which (1) includes >50B claims from >50 private payors and claims administrators, and (2) includes representative data from all 50 states and the District of Columbia, among other attributes. Labs would not be required to submit payment data from Medicaid managed care organizations; labs would continue to report Medicare Advantage rates.
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.	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 six 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.)

(June 2025)

Topic	PAMA/Social Security Act § 1834A	The RESULTS Act
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 2021-2025 rates at 2020 levels, and delays (up to) 15% cuts until 2026-2028.	Beginning January 2028, if CMS has not contracted for a claims database, and updated rates for widely available tests using the revised data collection methodology (as well as for periods after rates are established using the revised data collection methodology, but for which there is no claims data in the independent database), existing CLFS rates would be increased by CPI-U. For non-new non-widely available tests that are not ADLTs for which no data is reported by applicable labs, rates would be established by cross-walk or gapfill. Includes limits on payment decreases: Current rates would be frozen through 2028; beginning in 2029, rates could not decrease by more than 5%. There is no limit on year-over-year payment rate increases.