FAQ on PAMA Reform: The RESULTS Act

What is the Reforming and Enhancing Sustainable Updates to Laboratory Testing Services (RESULTS) Act?

The RESULTS Act (H.R. 5269 / S. 2761) is bipartisan, bicameral legislation that would reform the rate-setting process under the Medicare Clinical Laboratory Fee Schedule (CLFS) to create a more accurate and sustainable system by improving commercial market data inputs used to set rates, while significantly reducing the administrative and reporting burden on both clinical laboratories and CMS. The legislation also would address pending payment reductions and mitigate future cuts.

How would the RESULTS Act reform the Protecting Access to Medicare Act (PAMA)?

The RESULTS Act would improve the way Medicare reimbursement rates for clinical laboratories paid under the CLFS are determined by:

- **Ensuring CMS has access to robust commercial market data to use in the establishment of Medicare CLFS rates:**
  - For widely available tests, which comprise about 99 percent of total CLFS volume, the bill would direct CMS to use a large-scale, independent commercial claims database to determine laboratory payment rates. The database would be required to include at least 50 billion paid claims reported to it by at least 50 private insurers, so the data would be more representative of all laboratory segments (independent, hospital outreach, and physician office laboratories) than the limited data that would be reported under PAMA as written.
  - For non-widely available tests, such as proprietary tests and those for rare diseases, clinical laboratories would report private payor rate data directly to CMS.
- **Excluding Medicaid managed care data:** The bill would exclude Medicaid managed care payment data, which does not reflect true market rates.
- **Establishing guardrails to prevent steep cuts:** Annual payment reductions would be limited to 5 percent per year to protect laboratories from sudden destabilizing rate changes that could reduce patient access to innovative testing services.
- **Improving stability by adjusting update frequency:** Rate-setting would change from every three years to every four years, easing the administrative burden on both CMS and clinical laboratories.

How would CMS and laboratories transition to the new system?

If enacted, the RESULTS Act would cancel the pending cuts of up to 15 percent on nearly 800 tests, scheduled for January 2026, and freeze CLFS rates at current levels. CMS would select an independent, not-for-profit commercial claims database and engage in rulemaking to provide direction to laboratories for data collection and reporting for non-widely available tests. After CMS issues a final rule, data reporting from the database and laboratories that provide non-widely available tests would occur in 2028, based on data from the first six months of 2027. New rates would go into effect in 2029.

Why use claims data from an independent, not-for-profit database?

During the first data reporting period in 2017, data was reported by fewer than one percent of clinical laboratories. That was all of the data that CMS used to set CLFS payment rates, and the agency did not enforce the data reporting requirements. The limited data it used resulted in artificially low CLFS rates that were not representative of the commercial market as a whole, as Congress intended when it passed PAMA. An independent, not-for-profit database that reliably receives billions of paid claims directly from health plans each year would yield more comprehensive data for widely available tests than if laboratories report data directly to CMS, while also dramatically reducing the burden on laboratories and CMS. For non-widely available tests, or those that comprise less than 1 percent of total CLFS volume, such as proprietary tests for rare diseases, RESULTS would have laboratories continue to directly report private payor data to CMS to maximize data inputs for these often low-volume tests.

Is there precedent for CMS or other agencies using independent, not-for-profit data in payment policy?

Yes. One example is how CMS shares insights for inpatient hospital payment updates, via Global Insight, Inc., an economic forecasting firm. Several states also rely on similar databases to ensure implementation of "No Surprises" billing laws that protect consumers from unexpected high medical bills for out-of-network care.

Why not use commercial rate information shared through health plan price transparency requirements?

Health plan data made available through health plan price transparency requirements are insufficient for CMS to determine rates under the CLFS. PAMA requires CLFS rates to be determined by calculating the volume-weighted median of private payor rates. The health plan price transparency requirements mandate that health plans post only negotiated rates for all covered items and services – not actual paid claims amounts and not the volumes associated with each service. An independent, not-for-profit database that includes both claims and volume data is better suited to provide the information needed to set CLFS rates.

What happens if Congress does not act in 2025?

If Congress does not act, laboratories will face another round of payment cuts of up to 15 percent starting January 31, 2026. To date, 75 percent of laboratory tests on the CLFS already have been cut under PAMA. Additional payment cuts could force laboratories to limit services, close locations, or reduce investment in new testing capabilities. Patient access to routine and life-saving tests—such as those for cancer, heart disease, and diabetes—may be compromised. Continued payment uncertainty also will discourage innovation and weaken the infrastructure needed for public health emergencies.