

118TH CONGRESS  
2D SESSION

# H. R. 8404

To amend title XVIII of the Social Security Act to create a Radiation Oncology Case Rate Value Based Payment Program exempt from budget neutrality adjustment requirements, and to amend section 1128A of title XI of the Social Security Act to create a new statutory exception for the provision of free or discounted transportation for radiation oncology patients to receive radiation therapy services.

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## IN THE HOUSE OF REPRESENTATIVES

MAY 15, 2024

Mr. FITZPATRICK (for himself, Mr. PANETTA, Mr. JOYCE of Pennsylvania, and Mr. TONKO) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend title XVIII of the Social Security Act to create a Radiation Oncology Case Rate Value Based Payment Program exempt from budget neutrality adjustment requirements, and to amend section 1128A of title XI of the Social Security Act to create a new statutory exception for the provision of free or discounted transportation for radiation oncology patients to receive radiation therapy services.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Radiation Oncology  
3 Case Rate Value Based Program Act of 2024” or the  
4 “ROCR Value Based Program Act”.

5 **SEC. 2. FINDINGS.**

6 (a) FINDINGS.—Congress finds the following:

7 (1) Radiation therapy is the careful use of var-  
8 ious forms of radiation, such as external beam radi-  
9 ation therapy, to treat cancer and other diseases  
10 safely and effectively. Radiation oncologists develop  
11 radiation treatment plans and coordinate with highly  
12 specialized care teams to deliver radiation therapy.  
13 Nearly 60 percent of cancer patients will receive ra-  
14 diation therapy during their treatment.

15 (2) In 2021, the Centers for Medicare & Med-  
16 icaid Services reported approximately  
17 \$4,200,000,000 in total spending for radiation on-  
18 cology services between the Medicare physician fee  
19 schedule and hospital outpatient departments.

20 (3) The Centers for Medicare & Medicaid Serv-  
21 ices has historically faced challenges in determining  
22 accurate pricing for services that involve costly cap-  
23 ital equipment, resulting in fluctuating payment  
24 rates under the Medicare physician fee schedules for  
25 services involving external beam radiation therapy.  
26 Additionally, the Medicare physician fee schedule

1 has inadequately recognized the professional exper-  
2 tise physicians and nonphysician professionals need  
3 to deliver radiation therapy.

4 (4) The current payment systems incentivize  
5 greater volumes of care while bundled payments  
6 incentivize patient centered, efficient, and high value  
7 care.

8 (5) In 2017, the Centers for Medicare & Med-  
9 icaid Services recognized that the Medicare payment  
10 systems were not adequately addressing radiation  
11 oncology services, and the Center for Medicare &  
12 Medicaid Innovation released a congressionally re-  
13 quested report on the pursuit of an alternative pay-  
14 ment model for radiation oncology (referred to in  
15 this section as the “Radiation Oncology Model”)  
16 that addresses the issues in the Medicare physician  
17 fee schedule and the Medicare hospital outpatient  
18 prospective payment system payment methods.

19 (6) Concerns regarding the proposed Radiation  
20 Oncology Model included the significant payment re-  
21 ductions proposed in the model that would jeop-  
22 ardize access to high-quality radiation therapy serv-  
23 ices and the onerous reporting requirements for par-  
24 ticipating providers. The Radiation Oncology Model  
25 saw indefinite implementation delays.

1           (7) It is necessary, therefore, to create a pay-  
2           ment program for radiation oncology services that  
3           appropriately recognizes the value of quality radi-  
4           ation oncology services through its financial incen-  
5           tives while containing costs and providing patient-  
6           centered care.

7   **SEC. 3. RADIATION ONCOLOGY CASE RATE VALUE BASED**  
8                           **PAYMENT PROGRAM.**

9           (a) IN GENERAL.—Title XVIII of the Social Security  
10          Act (42 U.S.C. 1395 et seq.) is amended by adding at  
11          the end the following:

12   **“SEC. 1899C. RADIATION ONCOLOGY CASE RATE VALUE**  
13                           **BASED PAYMENT PROGRAM.**

14          “(a) ESTABLISHMENT.—

15               “(1) IN GENERAL.—Not later than 1 year after  
16          the date of enactment of the ROCR Value Based  
17          Program Act, the Secretary shall promulgate regula-  
18          tions, using the procedures described in paragraph  
19          (5), establishing a Radiation Oncology Case Rate  
20          Value Based Payment Program (referred to in this  
21          section as the ‘ROCR Program’) under which per  
22          episode payments are provided to radiation therapy  
23          providers or radiation therapy suppliers for covered  
24          treatment furnished to a covered individual during

1 an episode of care (as such terms are defined in sub-  
2 section (j)) in accordance with this section.

3 “(2) MAINTAINING PAYMENT RATES DURING  
4 PERIOD PRIOR TO EFFECTIVE DATE OF REGULA-  
5 TIONS.—The Secretary shall not reduce the estab-  
6 lished payment rates for radiation therapy services  
7 under the physician fee schedule under section 1848  
8 or the hospital outpatient prospective payment sys-  
9 tem under section 1833(t) during the time period  
10 beginning on the date of enactment of the ROCR  
11 Value Based Program Act and ending on the date  
12 that the regulations issued by the Secretary pursu-  
13 ant to paragraph (1) become effective.

14 “(3) ROCR PROGRAM GOALS.—The ROCR  
15 Program shall seek to—

16 “(A) create stable, unified payments for  
17 radiation therapy services under this title;

18 “(B) reduce disparities in radiation ther-  
19 apy care for Medicare beneficiaries by increas-  
20 ing access to radiation therapy services close to  
21 the homes of beneficiaries;

22 “(C) enhance quality of radiation therapy  
23 care through practice accreditation and shorter  
24 courses of treatment, when appropriate;

1           “(D) leverage and encourage the utilization  
2 of state-of-the-art technology to improve care  
3 and outcomes; and

4           “(E) protect Medicare resources by achiev-  
5 ing reasonable spending reductions in Medicare  
6 for radiation therapy services.

7           “(4) PAYMENTS.—Under this section, with re-  
8 spect to covered treatment furnished to covered indi-  
9 viduals, payments shall include—

10           “(A) per episode payments, as described in  
11 subsection (b), to radiation therapy providers or  
12 radiation therapy suppliers of radiation therapy  
13 services which meet such requirements as the  
14 Secretary shall establish by regulation; and

15           “(B) the health equity achievement in radi-  
16 ation therapy add-on payment described in sub-  
17 section (g).

18           “(5) NOTICE AND COMMENT RULEMAKING.—  
19 The Secretary shall promulgate the regulations de-  
20 scribed in paragraph (1) in accordance with section  
21 553 of title 5, United States Code, and issue an ad-  
22 vanced notice of proposed rulemaking and notice of  
23 proposed rulemaking with a comment period of not  
24 less than 60 days for each.

25           “(b) PER EPISODE PAYMENTS.—

1 “(1) IN GENERAL.—

2 “(A) PAYMENTS.—The Secretary shall pay  
3 to a radiation therapy provider or radiation  
4 therapy supplier an amount equal to 80 percent  
5 of the per episode payment amount determined  
6 under paragraph 3 (referred to in this section  
7 as ‘the per episode payment amount’) for each  
8 covered individual furnished covered treatment  
9 for an included cancer type to cover all profes-  
10 sional and technical services furnished during  
11 such treatment by the radiation therapy pro-  
12 vider or radiation therapy supplier during an  
13 episode of care (as defined in subsection (j)).

14 “(B) DEDUCTIBLES AND COINSURANCE.—  
15 Subject to subsection (e), the Secretary shall  
16 pay the per episode payment amount (subject to  
17 any deductible and coinsurance otherwise appli-  
18 cable under part B) to the radiation therapy  
19 provider or radiation therapy supplier for an  
20 episode of care, as described in subsection (c).

21 “(2) PER EPISODE PAYMENT REQUIREMENTS  
22 AND TIMING.—

23 “(A) IN GENERAL.—Subject to subpara-  
24 graph (B), for each episode of care furnished to  
25 a covered individual:

1           “(i) FIRST-HALF OF PAYMENT.—The  
2 Secretary shall issue  $\frac{1}{2}$  of the payment  
3 amount under paragraph (1) prospectively  
4 not later than 30 days after the day of the  
5 first delivery of covered treatment.

6           “(ii) SECOND-HALF OF PAYMENT.—  
7 The Secretary shall issue, with the excep-  
8 tion of an episode of care for treatment of  
9 bone or brain metastases and subject to  
10 clause (iii), the remaining half of the pay-  
11 ment amount under paragraph (1) on the  
12 date that is the earlier of—

13                   “(I) the day the course of cov-  
14 ered treatment is scheduled to end; or

15                   “(II) the 90th day of the episode  
16 of care.

17           “(iii) SECOND-HALF OF PAYMENT FOR  
18 BONE AND BRAIN METASTASES.—The Sec-  
19 retary shall issue the remaining half of the  
20 payment amount under paragraph (1) for  
21 an episode of care for treatment of bone or  
22 brain metastases on the date that is the  
23 earlier of—

24                   “(I) the day the course of cov-  
25 ered treatment is schedule to end; or

1                   “(II) the 30th day of the episode  
2                   of care.

3                   “(B) PATIENT DEATH.—If a covered indi-  
4                   vidual dies during treatment, both episode of  
5                   care payments under subparagraphs (A) and  
6                   (B) shall be paid to the radiation therapy pro-  
7                   vider or radiation therapy supplier not later  
8                   than 30 days after the day of the final delivery  
9                   of radiation therapy treatment to the covered  
10                  individual.

11                  “(C) CONSISTENCY OF PAYMENT.—

12                  “(i) IN GENERAL.—The per episode  
13                  payment amount shall not change depend-  
14                  ing on the site of service.

15                  “(ii) SITE OF SERVICE DEFINED.—  
16                  For the purposes of this subparagraph, the  
17                  term ‘site of service’ means the hospital  
18                  outpatient department or physician office  
19                  in which radiation therapy treatment is  
20                  furnished by the radiation therapy provider  
21                  or radiation therapy supplier.

22                  “(3) DETERMINATION OF PER EPISODE PAY-  
23                  MENT AMOUNT.—

24                  “(A) IN GENERAL.—The Secretary shall  
25                  determine a per episode payment amount for

1 the professional component and technical com-  
2 ponent of treatment for each included cancer  
3 type.

4 “(B) AMOUNT.—The Secretary shall deter-  
5 mine the per episode payment amount based on  
6 national base rates, as described in subsection  
7 (d)(1) and as updated in subsection (d)(2).

8 “(C) ADJUSTMENTS.—The per episode  
9 payment amount shall be subject to—

10 “(i) the adjustments as described in  
11 subsection (d)(2) and (d)(3);

12 “(ii) a geographic adjustment, as de-  
13 scribed in subsection (d)(3)(A);

14 “(iii) an inflation adjustment, pursu-  
15 ant to which the Secretary shall adjust the  
16 per episode payment amount by the per-  
17 centage increase in the Medicare Economic  
18 Index (as described in section 1842 for the  
19 professional component payments and the  
20 applicable percentage increase in the Hos-  
21 pital Inpatient Market Basket Update (as  
22 described in section 1886(b)(3)(B)(i)) for  
23 the technical component payments during  
24 each 12-month period, and which varies for

1 the professional and technical components  
2 of the service;

3 “(iv) a savings adjustment, as de-  
4 scribed in subsection (d)(3)(B);

5 “(v) a health equity achievement in  
6 radiation therapy adjustment applicable  
7 only to the technical component payments,  
8 as described in subsection (g); and

9 “(vi) a practice accreditation adjust-  
10 ment, as described in subsection (h), that  
11 is only applicable to technical component  
12 payments.

13 “(c) TREATMENT OF INCOMPLETE EPISODES OF  
14 CARE; CONCURRENT TREATMENT.—

15 “(1) INCOMPLETE EPISODE OF CARE.—In the  
16 case of an incomplete episode of care, payment shall  
17 be made to the radiation therapy provider or radi-  
18 ation therapy supplier for services furnished under  
19 the physician fee schedule under section 1848 or the  
20 hospital outpatient prospective payment system  
21 under section 1833(t), as applicable.

22 “(2) MULTIPLE EPISODES OF CARE FOR THE  
23 SAME COVERED INDIVIDUAL.—A radiation therapy  
24 provider or radiation therapy supplier may initiate a  
25 new episode of care for the same beneficiary for the

1 same course of therapy by providing another radi-  
2 ation therapy treatment planning service and billing  
3 under an applicable radiation therapy planning trig-  
4 ger code (as defined in subsection (j)).

5 “(3) CONCURRENT TREATMENTS.—In the case  
6 where a treatment modality described in subsection  
7 (j)(3)(B)(i) is furnished to a covered individual dur-  
8 ing an episode of care for an included cancer type,  
9 payment may be made concurrently for the treat-  
10 ment modality under the applicable payment system  
11 under this title with per episode payment under this  
12 section for covered treatment during the episode of  
13 care.

14 “(d) NATIONAL BASE RATE.—

15 “(1) DETERMINATION OF NATIONAL BASE  
16 RATES.—For purposes of the Secretary determining  
17 the per episode payment amount under subsection  
18 (b)(3), the national base rates for the professional  
19 component and technical component of radiation  
20 therapy services for each included cancer type are  
21 based on the M-Code national base rates identified  
22 in table 75 (including HCPCS Codes for radiation  
23 therapy services and supplies) of the Federal Reg-  
24 ister on November 16, 2021, 86 Fed. Reg. 63458,  
25 63925.

1           “(2) UPDATES TO THE NATIONAL BASE  
2 RATES.—

3           “(A) ANNUAL UPDATES.—

4                   “(i) IN GENERAL.—Subject to clause  
5 (ii), the Secretary shall annually update  
6 the initial national base rates by—

7                           “(I) in the case of the profes-  
8 sional component of the covered treat-  
9 ment, the percentage increase in the  
10 Medicare Economic Index; and

11                           “(II) in the case of the technical  
12 component of the covered treatment,  
13 the applicable percentage increase de-  
14 scribed in section 1886(b)(3)(B)(i).

15                   “(ii) PAYMENT FLOOR.—For each an-  
16 nual update, the Secretary shall not reduce  
17 the national base rates below the estab-  
18 lished rates from the prior year.

19           “(B) PERIODIC UPDATES.—

20                   “(i) IN GENERAL.—The Secretary  
21 shall, through notice and comment rule-  
22 making, rebase or revise the national base  
23 rates in 5-year intervals, beginning on the  
24 day that is 5 years after the date the regu-

1 lations issued pursuant to subsection  
2 (a)(1) become effective.

3 “(ii) REBASING LIMIT.—The Sec-  
4 retary shall not reduce the national base  
5 rates through the process of rebasing by  
6 more than 1 percent every 5 years.

7 “(iii) INPUT FROM PROVIDERS AND  
8 SUPPLIERS.—In rebasing or revising the  
9 national base rates pursuant to clause (i),  
10 the Secretary shall seek significant input  
11 from radiation therapy providers, radiation  
12 therapy suppliers, and other stakeholders.

13 “(C) REBASE AND REVISE DEFINED.—In  
14 this subsection:

15 “(i) REBASE.—The term ‘rebase’  
16 means to move the base year for the struc-  
17 ture of costs of the national base rates.

18 “(ii) REVISE.—The term ‘revise’  
19 means types of changes to national base  
20 rates other than rebasing, such as using  
21 different data sources, cost categories, or  
22 price proxies in the national base rates  
23 input.

24 “(D) NEW TECHNOLOGY OR SERVICES.—

1           “(i) IN GENERAL.—For purposes of  
2 this subparagraph, the term ‘new tech-  
3 nology or services’ means any technology  
4 or services that, after the date of enact-  
5 ment of this section, receives a Category 1  
6 Current Procedural Terminology code or is  
7 established in the yearly update to the  
8 Medicare physician fee schedule direct  
9 practice expense inputs or any successor  
10 repository of the direct practice expense  
11 input for the delivery of radiation therapy  
12 services.

13           “(ii) TREATMENT UNDER THE NA-  
14 TIONAL BASE RATES.—

15           “(I) EXCLUSION DURING INITIAL  
16 PERIOD.—The Secretary shall not in-  
17 corporate a radiation therapy service  
18 that is a new technology or service  
19 into the national base rates for an in-  
20 cluded cancer type prior to the date  
21 that is 10 years after such service is  
22 first identified as a new technology or  
23 service described in clause (i).

24           “(II) INCORPORATION AFTER INI-  
25 TIAL PERIOD.—After the date speci-

1           fied in subclause (I) with respect to a  
2           radiation therapy service that is a new  
3           technology or service, the Secretary  
4           shall, through stakeholder meetings,  
5           requests for information, and notice  
6           and comment rulemaking, engage pro-  
7           viders, suppliers, radiation therapy  
8           vendors, patient groups, and the pub-  
9           lic on possible incorporation of the  
10          new technology or service into the na-  
11          tional base rates for included cancer  
12          types under paragraph (1).

13           “(iii) BEFORE INCORPORATION INTO  
14          THE NATIONAL BASE RATE.—Until incor-  
15          porated into the national base rates under  
16          clause (ii)(II), any new technology or serv-  
17          ice shall be paid under the applicable pay-  
18          ment system under this title.

19           “(iv) ASSESSMENT OF CERTAIN CRI-  
20          TERIA.—Prior to incorporating a new tech-  
21          nology or service into the national base  
22          rates pursuant to clause (ii)(II), the Sec-  
23          retary shall consider market penetration  
24          and adoption, costs relative to base rates,  
25          clinical benefits of the new technology or

1 service, and the clear consensus of the  
2 stakeholder community.

3 “(3) ADJUSTMENTS TO NATIONAL BASE  
4 RATES.—

5 “(A) GEOGRAPHIC ADJUSTMENT.—Prior to  
6 applying the savings adjustment described in  
7 subparagraph (B), the Secretary shall adjust  
8 the national base rates for local cost and wage  
9 indices based on where the radiation therapy  
10 services are furnished—

11 “(i) in the case of the professional  
12 component payment rates, the geographic  
13 adjustment processes described in the  
14 Medicare Physician Fee Schedule Geo-  
15 graphic Practice Cost Index; and

16 “(ii) in the case of the technical com-  
17 ponent payment rates, the geographic ad-  
18 justment processes in the hospital out-  
19 patient prospective payment system under  
20 section 1833(t).

21 “(B) SAVINGS ADJUSTMENT.—

22 “(i) IN GENERAL.—The Secretary  
23 shall apply a savings adjustment under  
24 this subparagraph after the geographic ad-

1 justments have been applied under sub-  
2 paragraph (A).

3 “(ii) SAVINGS ADJUSTMENT DE-  
4 FINED.—The term ‘savings adjustment’  
5 means the percentage by which the profes-  
6 sional component and technical component  
7 payment rates are each reduced to achieve  
8 Medicare savings.

9 “(e) AVAILABILITY OF PAYMENT PLANS FOR PAY-  
10 MENT OF COINSURANCE.—Following the application of  
11 the adjustments described in subsection (d), but before the  
12 application of any sequestration order issued under the  
13 Balanced Budget and Emergency Deficit Control Act of  
14 1985 (2 U.S.C. 900 et seq.), radiation therapy providers  
15 and radiation therapy suppliers shall collect coinsurance  
16 for services furnished under the ROCR Program subject  
17 to the following rules:

18 “(1) IN GENERAL.—Radiation therapy pro-  
19 viders and radiation therapy suppliers may collect  
20 coinsurance applicable under subsection (b)(1) for  
21 covered treatment furnished to a covered individual  
22 under the ROCR Program in multiple installments  
23 under a payment plan.

24 “(2) LIMITATION ON USE AS A MARKETING  
25 TOOL.—Radiation therapy providers and radiation

1 therapy suppliers may not use the availability of  
2 payment plans for such coinsurance as a marketing  
3 tool to influence the choice of health care provider  
4 by covered individuals.

5 “(3) TIMING OF PROVISIONS OF INFORMA-  
6 TION.—Radiation therapy providers and radiation  
7 therapy suppliers offering a payment plan for such  
8 coinsurance may inform the covered individual of the  
9 availability of the payment plan prior to or during  
10 the initial treatment planning session and as nec-  
11 essary thereafter.

12 “(4) BENEFICIARY COINSURANCE PAYMENT.—  
13 The beneficiary coinsurance payment shall equal 20  
14 percent of the payment amount to be paid to the ra-  
15 diation therapy provider or radiation therapy sup-  
16 plier prior to the application of any sequestration  
17 order issued under the Balanced Budget and Emer-  
18 gency Deficit Control Act of 1985 (2 U.S.C. 900 et  
19 seq.) for the billed ROCR Program episode of care,  
20 except as provided in paragraph (5).

21 “(5) INCOMPLETE EPISODE OF CARE.—In the  
22 case of an incomplete episode of care, the beneficiary  
23 coinsurance payment shall equal 20 percent of the  
24 amount that would have been paid in the absence of  
25 the ROCR Program for the radiation therapy serv-

1 ices furnished by the radiation therapy provider or  
2 radiation therapy supplier that initiated the profes-  
3 sional component and, if applicable, the radiation  
4 therapy provider or radiation therapy supplier that  
5 initiated the technical component.

6 “(f) MANDATORY PARTICIPATION.—

7 “(1) IN GENERAL.—Except as provided under  
8 paragraph (2) or (3), a radiation therapy provider or  
9 radiation therapy supplier that is participating in  
10 the program under this title and furnishes a covered  
11 treatment to a covered individual shall be required  
12 to participate in the ROCR Program.

13 “(2) CONCURRENT PARTICIPATION IN THE  
14 ROCR PROGRAM AND OTHER MODELS.—A radiation  
15 therapy provider or radiation therapy supplier that  
16 is participating in a State-based Center for Medicare  
17 & Medicaid Innovation model—

18 “(A) shall not be prohibited from also par-  
19 ticipating in the ROCR Program; and

20 “(B) is not required to participate in the  
21 ROCR Program.

22 “(3) SIGNIFICANT HARDSHIP EXEMPTION.—

23 “(A) IN GENERAL.—The Secretary may,  
24 on a case-by-case basis, exempt a radiation  
25 therapy provider or radiation therapy supplier

1 from the ROCR Program if the Secretary de-  
2 termines that application of the program would  
3 result in a significant hardship for such radi-  
4 ation therapy provider or radiation therapy sup-  
5 plier or for beneficiaries in the geographic area  
6 of the radiation therapy provider or radiation  
7 therapy supplier.

8 “(B) PROCEDURE.—The Secretary shall  
9 promulgate regulations, using the procedures  
10 described in subsection (a)(5), regarding eligi-  
11 bility and the procedure for applying for a sig-  
12 nificant hardship exemption.

13 “(g) HEALTH EQUITY ACHIEVEMENT IN RADIATION  
14 THERAPY ADD-ON PAYMENT.—

15 “(1) IN GENERAL.—Pursuant to paragraph (2)  
16 and subject to paragraph (7), the Secretary shall ad-  
17 just the per episode payment amount in the amount  
18 of a health equity achievement in radiation therapy  
19 add-on payment to advance health equity and sup-  
20 port covered individuals in accessing and completing  
21 their radiation therapy treatments for covered treat-  
22 ments of included cancer types through the provision  
23 of transportation services, subject to the succeeding  
24 provisions of this subsection.

25 “(2) ELIGIBILITY.—

1           “(A) IN GENERAL.—The health equity  
2 achievement in radiation therapy add-on pay-  
3 ment shall be made when the ICD–10 diagnosis  
4 code Z59.82, transportation insecurity is re-  
5 ported pursuant to subparagraph (B).

6           “(B) DETERMINATION OF REPORTING  
7 CODE.—The radiation therapy provider or radi-  
8 ation therapy supplier shall follow the following  
9 procedures to determine if the ICD–10 diag-  
10 nosis code Z59.82, transportation insecurity  
11 needs to be reported:

12           “(i) The radiation therapy provider or  
13 radiation therapy supplier shall ask the pa-  
14 tient at the time of patient intake during  
15 the initial patient consultation if, within  
16 the previous 2 months, a lack of reliable  
17 transportation has kept the patient from  
18 attending medical appointments, meetings,  
19 or work, or from completing activities of  
20 daily living.

21           “(ii) If the patient answers yes to the  
22 question in clause (i), ICD–10 diagnosis  
23 code Z59.82 shall be reported.

1           “(3) AMOUNT.—The health equity achievement  
2           in radiation therapy add-on payment shall be in the  
3           amount of—

4                   “(A) for services furnished during the year  
5                   following the date the regulations issued pursu-  
6                   ant to subsection (a)(1) become effective, \$500  
7                   per patient per episode of care; and

8                   “(B) for services furnished in subsequent  
9                   years, the amount determined under this para-  
10                  graph for the preceding year, increased by \$10.

11           “(4) PAYMENT RECIPIENT.—The health equity  
12           achievement in radiation therapy add-on payment  
13           shall be paid to the radiation therapy provider or ra-  
14           diation therapy supplier that provides the technical  
15           component of the radiation therapy services.

16           “(5) NOT TO BE USED IN ADDITION TO OR IN  
17           LIEU OF OTHER SERVICES.—The health equity  
18           achievement in radiation therapy add-on payment  
19           shall not be made in addition to or in lieu of any  
20           other State or Federal program benefits that may be  
21           used for transportation services.

22           “(6) DOCUMENTATION.—

23                   “(A) IN GENERAL.—Radiation therapy  
24                   providers and radiation therapy suppliers who  
25                   receive the health equity achievement in radi-

1           ation therapy add-on payment shall maintain all  
2           documentation related to the spending of such  
3           payment on transportation services per covered  
4           individual for a period of 5 years after the end  
5           of the episode of care of the applicable covered  
6           individual.

7                   “(B) AVAILABILITY TO THE SECRETARY.—  
8           The documentation described in subparagraph  
9           (A) shall be made available to the Secretary  
10          upon request.

11                   “(7) NO MODIFICATION OF COINSURANCE.—  
12          The Secretary may not modify any coinsurance obli-  
13          gation when implementing the health equity achieve-  
14          ment in radiation therapy add-on payment.

15                   “(h) QUALITY INCENTIVES IN THE ROCR VALUE  
16          BASED PAYMENT PROGRAM.—

17                   “(1) IN GENERAL.—

18                   “(A) INITIAL INCREASE IN PAYMENT.—  
19          With respect to covered treatment for an in-  
20          cluded cancer type furnished to a covered indi-  
21          vidual on or after the date the regulations  
22          issued pursuant to subsection (a)(1) become ef-  
23          fective and before the date that is 3 years after  
24          such date, in the case of a radiation therapy  
25          provider or radiation therapy supplier that

1 meets the requirements described in paragraph  
2 (2), payments otherwise made to such radiation  
3 therapy provider or radiation therapy supplier  
4 under the ROCR Program for the technical  
5 component of such services shall be increased  
6 by 0.5 percent (or 0.25 percent in the case of  
7 such a provider or supplier that is a small radi-  
8 ation therapy supplier or small radiation ther-  
9 apy provider.

10 “(B) REDUCTION IN PAYMENT.—

11 “(i) IN GENERAL.—Subject to clause  
12 (ii), with respect to covered treatment for  
13 an included cancer type furnished to a cov-  
14 ered individual on or after the date that is  
15 3 years after the regulations issued pursu-  
16 ant to subsection (a)(1) become effective,  
17 in the case of a radiation therapy provider  
18 or radiation therapy supplier that does not  
19 meet the requirements described in para-  
20 graph (2), the per episode payment to such  
21 provider or supplier under the ROCR Pro-  
22 gram shall be reduced by 1.0 percent.

23 “(ii) EXCLUSION OF SMALL RADI-  
24 ATION THERAPY PROVIDERS AND SMALL  
25 RADIATION THERAPY SUPPLIERS.—This

1           subparagraph shall not apply with respect  
2           to a small radiation therapy provider or a  
3           small radiation therapy supplier.

4           “(C) DEFINITION OF SMALL RADIATION  
5           THERAPY PROVIDER AND SMALL RADIATION  
6           THERAPY SUPPLIER.—In this subsection, the  
7           terms ‘small radiation therapy provider’ and  
8           ‘small radiation therapy supplier’ mean, with  
9           respect to a radiation therapy provider or radi-  
10          ation therapy supplier, a provider or supplier  
11          that meets the criteria specified by the Sec-  
12          retary, that may include criteria relating to the  
13          number of linear accelerators owned or used by  
14          the radiation therapy provider or radiation ther-  
15          apy supplier, the volume of patients treated by  
16          the radiation therapy provider or radiation ther-  
17          apy supplier, or such other criteria as the Sec-  
18          retary determines is appropriate, in consulta-  
19          tion with radiation therapy stakeholder organi-  
20          zations.

21          “(2) ACCREDITATION REQUIREMENTS.—

22                 “(A) IN GENERAL.—The requirements de-  
23                 scribed in this subparagraph with respect to a  
24                 radiation therapy provider or radiation therapy  
25                 supplier (other than such a provider or supplier

1 that is a small radiation therapy provider or  
2 small radiation therapy supplier) are that the  
3 supplier or provider must—

4 “(i) maintain or be in the process of  
5 obtaining accreditation by the American  
6 College of Radiology, American College of  
7 Radiation Oncology, or American Society  
8 for Radiation Oncology;

9 “(ii) comply with certified electronic  
10 health record technology requirements as  
11 determined by the Secretary with excep-  
12 tions that are consistent with those of the  
13 Merit-based Incentive Payment System es-  
14 tablished under section 1848(q); and

15 “(iii) submit to the Secretary proof of  
16 the accreditation described in clause (i) in  
17 such form and manner as specified by the  
18 Secretary.

19 “(B) REQUIREMENTS FOR SMALL RADI-  
20 ATION THERAPY PROVIDERS AND SMALL RADI-  
21 ATION THERAPY SUPPLIERS.—A radiation ther-  
22 apy provider or radiation therapy supplier that  
23 is a small radiation therapy provider or small  
24 radiation therapy supplier may elect to satisfy

1 the accreditation requirement under this para-  
2 graph by—

3 “(i) meeting the requirements of sub-  
4 paragraph (A);

5 “(ii) using an external audit that en-  
6 compasses similar criteria as a nationally  
7 recognized radiation oncology accreditation  
8 organization and submit the outcome of  
9 such external audit to the Secretary; or

10 “(iii) complying with certified elec-  
11 tronic health record technology require-  
12 ments as determined by the Secretary with  
13 exceptions that are consistent with those of  
14 the Merit-Based Incentives Payment Sys-  
15 tem established under section 1848(q).

16 “(C) NEW PROVIDERS.—A new radiation  
17 therapy provider or new radiation supplier shall  
18 complete an initiation of accreditation or exter-  
19 nal audit not later than the date that is 1 year  
20 after such provider or supplier begins fur-  
21 nishing covered treatment to covered individ-  
22 uals.

23 “(i) REPORTING REQUIREMENTS.—

24 “(1) REPORT ON THE ROCR PROGRAM.—Not  
25 earlier than 7 years after the date of the enactment

1 of this section, the Comptroller General of the  
2 United States (referred to in this subsection as the  
3 ‘Comptroller General’) shall, after seeking out the  
4 perspectives of radiation oncology stakeholders, sub-  
5 mit to the appropriate committees of jurisdiction of  
6 the Senate and the House of Representatives a re-  
7 port that—

8 “(A) evaluates—

9 “(i) the implementation of the ROCR  
10 Program, and the impact such Program  
11 has had on Federal healthcare spending;

12 “(ii) the impact the ROCR Program  
13 has had on the ability of covered individ-  
14 uals to access covered treatment;

15 “(iii) whether any cancer types or ra-  
16 diation therapy services, such as  
17 brachytherapy, proton therapy, or thera-  
18 peutic radiopharmaceuticals, should be  
19 added or removed from the ROCR Pro-  
20 gram; and

21 “(iv) the potential application of the  
22 ROCR Program to benefits provided under  
23 part C of this title; and

24 “(B) includes any recommendations for ad-  
25 ministrative and legislative changes.

1           “(2) REPORT ON ACCESS TO RADIATION THER-  
2 APY IN RURAL AND UNDERSERVED AREAS.—Not  
3 later than 3 years after the date of the enactment  
4 of this section, the Comptroller General shall submit  
5 a report to the appropriate committees of jurisdic-  
6 tion of the Senate and the House of Representatives  
7 that identifies the following:

8                   “(A) Radiation therapy deserts.

9                   “(B) Methods to increase access to new ra-  
10 diation therapy technologies in rural and under-  
11 served areas, including technologies required for  
12 clinical treatment planning, simulation, dosim-  
13 etry, medical radiation physics, radiation treat-  
14 ment devices, radiation treatment delivery, radi-  
15 ation treatment management, and such other  
16 items as the Comptroller General may deter-  
17 mine are medically necessary.

18                   “(C) A program to provide assistance in  
19 the form of grants or loans to radiation therapy  
20 providers or radiation therapy suppliers for the  
21 purpose of ensuring access to the most current  
22 radiation therapy technology.

23           “(3) DETERMINATION AND DEFINITION OF RA-  
24 DIATION THERAPY DESERTS.—

1           “(A) DEFINITION.—For purposes of this  
2 subsection, the term ‘radiation therapy desert’  
3 means a region determined by the Comptroller  
4 General under subparagraph (B) with a mis-  
5 match between radiation therapy resources and  
6 oncologic need.

7           “(B) DETERMINATION.—In determining  
8 whether a region qualifies as a radiation ther-  
9 apy desert, the Comptroller General shall take  
10 into account the ratio or density of radiation  
11 therapy providers and radiation therapy sup-  
12 pliers practicing in a geographic area as com-  
13 pared to the population size in that geographic  
14 area.

15       “(j) DEFINITIONS.—In this section:

16           “(1) APPLICABLE RADIATION THERAPY PLAN-  
17 NING TRIGGER CODE.—The term ‘applicable radi-  
18 ation therapy planning trigger code’ means services  
19 identified, as of the date that the regulations issued  
20 pursuant to subsection (a)(1) become effective, by  
21 the following HCPCS codes (and as subsequently  
22 modified by the Secretary):

23           “(A) 77261, therapeutic radiology treat-  
24 ment planning, simple.

1           “(B) 77262, therapeutic radiology treat-  
2           ment planning, intermediate.

3           “(C) 77263, therapeutic radiology treat-  
4           ment planning, complex.

5           “(2) COVERED INDIVIDUAL.—The term ‘cov-  
6           ered individual’ means an individual who—

7           “(A) is enrolled for benefits under part B;

8           “(B) is not enrolled in a Medicare Advan-  
9           tage plan under part C or a PACE program  
10          under section 1894; and

11          “(C) is diagnosed with an included cancer  
12          type.

13          “(3) COVERED TREATMENT.—

14          “(A) IN GENERAL.—The term ‘covered  
15          treatment’ means, subject to subparagraph (B),  
16          radiation therapy services furnished to a cov-  
17          ered individual.

18          “(B) EXCLUSIONS.—Such term does not  
19          include—

20                 “(i) during the period beginning on  
21                 the date on which the regulation issued  
22                 pursuant to subsection (a)(1) become effec-  
23                 tive and ending on the date that is 10  
24                 years after such date, brachytherapy, pro-  
25                 ton beam radiation therapy services,

1 intraoperative radiotherapy, superficial ra-  
2 diation therapy, hyperthermia, and thera-  
3 peutic radiopharmaceuticals;

4 “(ii) inpatient radiation therapy serv-  
5 ices furnished in a subsection (d) hospital  
6 or ambulatory surgical center;

7 “(iii) radiation therapy services fur-  
8 nished in cancer hospitals that are exempt  
9 from the hospital outpatient prospective  
10 payment system under section 1833(t);

11 “(iv) physician services that are fur-  
12 nished or supervised by the physician fur-  
13 nishing radiation therapy or by another  
14 physician, such as cancer surgeries, chemo-  
15 therapy, and other services; or

16 “(v) physician services that are fur-  
17 nished using technology represented by  
18 Healthcare Common Procedure Coding  
19 System codes that are not included in the  
20 M-code national base rates identified in  
21 table 75 (including in HCPCS Codes for  
22 radiation therapy services and supplies) of  
23 the Federal Register on November 16,  
24 2021, 86 Fed. Reg. 63485, 63925.

1           “(4) EPISODE OF CARE.—The term ‘episode of  
2 care’ means, with respect to a covered individual, the  
3 period—

4           “(A) beginning on the day radiation ther-  
5 apy planning for an included cancer type, billed  
6 under an applicable radiation therapy planning  
7 trigger code, is furnished to a covered indi-  
8 vidual if radiation therapy treatment is initiated  
9 not later than 30 days after the day such radi-  
10 ation therapy planning service is furnished; and

11           “(B) ends—

12           “(i) for treatment of all included can-  
13 cer types except bone and brain metastases  
14 treatment, the day that is 90 days after  
15 the day the episode of care begins under  
16 clause (i); and

17           “(ii) for bone and brain metastases  
18 treatment, the day that is 30 days after  
19 the day the episode of care begins under  
20 clause (i).

21           “(5) INCLUDED CANCER TYPES.—The term ‘in-  
22 cluded cancer type’ means any of the following types  
23 of cancer:

24           “(A) Anal.

25           “(B) Bladder.

- 1                   “(C) Bone Metastases.
- 2                   “(D) Brain Metastases.
- 3                   “(E) Breast.
- 4                   “(F) Cervical.
- 5                   “(G) Central Nervous System Tumors.
- 6                   “(H) Colorectal.
- 7                   “(I) Head and Neck.
- 8                   “(J) Lung.
- 9                   “(K) Lymphoma.
- 10                  “(L) Pancreatic.
- 11                  “(M) Prostate.
- 12                  “(N) Upper Gastrointestinal.
- 13                  “(O) Uterine.

14                   “(6) HEALTHCARE COMMON PROCEDURE COD-  
 15                   ING SYSTEM.—The term ‘Healthcare Common Pro-  
 16                   cedure Coding System’ means the standardized cod-  
 17                   ing system used by Medicare and other health insur-  
 18                   ance programs to ensure that claims are processed  
 19                   in an orderly and consistent manner.

20                   “(7) INCOMPLETE EPISODE OF CARE.—The  
 21                   term ‘incomplete episode of care’ means, with re-  
 22                   spect to a covered individual, an episode of care that  
 23                   is not completed because—

24                   “(A) the individual being treated ceases to  
 25                   be a covered individual, including in the case

1 where the individual loses benefits under this  
2 title, at any time after the initial treatment  
3 planning service is furnished and before the epi-  
4 sode of care for the covered treatment is com-  
5 plete; or

6 “(B) a covered individual switches radi-  
7 ation therapy provider or radiation therapy sup-  
8 plier before all included radiation therapy serv-  
9 ices in the episode of care for the covered treat-  
10 ment have been furnished.

11 “(8) PROFESSIONAL COMPONENT.—The term  
12 ‘professional component’ means the included radi-  
13 ation therapy services that may only be furnished by  
14 a physician.

15 “(9) RADIATION THERAPY.—The term ‘radi-  
16 ation therapy’ means the careful use of various  
17 forms of radiation, such as external beam radiation  
18 therapy, to treat cancer and other diseases safely  
19 and effectively.

20 “(10) RADIATION THERAPY PROVIDER.—The  
21 term ‘radiation therapy provider’ means a hospital  
22 outpatient department enrolled under this title that  
23 furnishes radiation therapy services.

24 “(11) RADIATION THERAPY SERVICES.—The  
25 term ‘radiation therapy services’ means the treat-

1       ment planning, technical preparation, special serv-  
2       ices (such as simulation), treatment delivery, and  
3       treatment management services associated with can-  
4       cer treatment that uses high doses of radiation to  
5       kill cancer cells and shrink tumors.

6               “(12) RADIATION THERAPY SUPPLIER.—The  
7       term ‘radiation therapy supplier’ means a physician  
8       group practice or freestanding radiation therapy cen-  
9       ter enrolled under this title that furnishes radiation  
10      therapy services.

11              “(13) TECHNICAL COMPONENT.—The term  
12      ‘technical component’ means the included radiation  
13      therapy services that are not furnished by a physi-  
14      cian, including the provision of equipment, supplies,  
15      personnel, and administrative costs related to radi-  
16      ation therapy services.

17              “(14) TRANSPORTATION SERVICES.—The term  
18      ‘transportation services’ means the provision of free  
19      or discounted transportation made available to cov-  
20      ered individuals furnished covered treatment which  
21      are not air, luxury, or ambulance-level transpor-  
22      tation, but may include car services, ride shares, or  
23      public transportation.”.

24      (b) EXCLUSION OF PARTICIPATING RADIATION  
25      THERAPY PROVIDERS, RADIATION THERAPY SUPPLIERS,

1 AND PHYSICIANS FROM THE MERIT-BASED INCENTIVE  
 2 PAYMENT SYSTEM.—Section 1848(q)(1)(C)(ii) of the So-  
 3 cial Security Act (42 U.S.C. 1395w-4(q)(1)(c)(II)) is  
 4 amended—

5 (1) in subclause (II), by striking “or” at the  
 6 end;

7 (2) in subclause (III), by striking the period at  
 8 the end and inserting “; or”; and

9 (3) by adding at the end the following new sub-  
 10 clause:

11 “(IV) is a radiation therapy pro-  
 12 vider or radiation therapy supplier (as  
 13 those terms are defined in subsection  
 14 (j) of section 1899C) that is partici-  
 15 pating in the Radiation Oncology Case  
 16 Rate Value Based Payment Program  
 17 established under that section.”.

18 **SEC. 4. REVISION TO CIVIL MONETARY PENALTIES RE-**  
 19 **GARDING RADIATION ONCOLOGY CASE RATE**  
 20 **PATIENT TRANSPORTATION SERVICES.**

21 Section 1128A of the Social Security Act (42 U.S.C.  
 22 1320a-7a) is amended—

23 (1) in subsection (i)(6)—

24 (A) in subparagraph (I), by striking “or”  
 25 at the end;

1 (B) in subparagraph (J)(iii), by striking  
2 the period at the end and inserting “; or”;

3 (C) by adding at the end the following new  
4 subparagraph:

5 “(K) the provision of transportation serv-  
6 ices by an eligible entity, as defined in sub-  
7 section (t), if—

8 “(i) the availability of the transpor-  
9 tation services—

10 “(I) is set forth in a policy that  
11 the eligible entity, as defined in sub-  
12 section (t), applies uniformly and con-  
13 sistentl;y; and

14 “(II) is not determined in a man-  
15 ner related to the past or anticipated  
16 volume or value of Federal health care  
17 program business;

18 “(ii) the eligible entity does not pub-  
19 licly market or advertise the transportation  
20 services;

21 “(iii) the driver who provides the  
22 transportation services does not market  
23 health care items or services during the  
24 course of the transportation or at any  
25 time;

1           “(iv) the driver or individual arrang-  
2           ing for the transportation services is not  
3           paid on a per-beneficiary-transported basis;

4           “(v) the eligible entity makes the  
5           transportation services available only to an  
6           individual who—

7                   “(I) is an established patient, as  
8                   defined in subsection (t), of the eligi-  
9                   ble entity that is providing or facili-  
10                  tating free or discounted transpor-  
11                  tation;

12                  “(II) resides—

13                          “(aa) within a 75 miles ra-  
14                          dius of the radiation therapy pro-  
15                          vider or radiation therapy sup-  
16                          plier to or from which the patient  
17                          would be transported; or

18                          “(bb) in a rural area, as de-  
19                          fined in subsection (t); and

20                  “(III) is receiving radiation ther-  
21                  apy services for the purpose of obtain-  
22                  ing medically necessary items and  
23                  services; and

24                  “(vi) the eligible entity that makes the  
25                  transportation services available bears the

1 costs of the transportation services and  
2 does not shift the burden of those costs  
3 onto any Federal health care program,  
4 other payers, or individuals.”; and

5 (2) by adding at the end the following new sub-  
6 section:

7 “(t) For purposes of subsection (i)(6)(K), the fol-  
8 lowing definitions apply:

9 “(1) The term ‘eligible entity’ means any indi-  
10 vidual or entity, or any individual or entity acting on  
11 behalf of such individual or entity that does not sup-  
12 ply health care items as the primary occupation of  
13 the individual or entity.

14 “(2) The term ‘established patient’ means an  
15 individual who—

16 “(A) has selected and scheduled an ap-  
17 pointment with a radiation therapy provider or  
18 radiation therapy supplier; or

19 “(B) has attended an appointment with  
20 such provider or supplier.

21 “(3) The terms ‘radiation therapy provider’,  
22 ‘radiation therapy services’, and ‘radiation therapy  
23 supplier’ have the meaning given such terms in sec-  
24 tion 1866G(k).

1           “(4) The term ‘rural area’ means an area that  
2 is not an urban area.

3           “(5) The term ‘transportation services’—

4           “(A) means the provision of free or dis-  
5 counted transportation made available to Fed-  
6 eral health care program beneficiaries receiving  
7 radiation therapy services;

8           “(B) includes car services, ride shares, and  
9 public transportation; and

10           “(C) does not include air, luxury, or ambu-  
11 lance-level transportation.

12           “(6) The term ‘urban area’ means—

13           “(A) a Metropolitan Statistical Area or  
14 New England County Metropolitan Area, as de-  
15 fined by the Office of Management and Budget;

16           “(B) Litchfield County, Connecticut;

17           “(C) York County, Maine;

18           “(D) Sagadahoc County, Maine;

19           “(E) Merrimack County, New Hampshire;

20 and

21           “(F) Newport County, Rhode Island.”.

1 **SEC. 5. EXEMPTION OF RADIATION ONCOLOGY CASE RATE**  
2 **VALUE BASED PAYMENT PROGRAM FROM**  
3 **BUDGET NEUTRALITY ADJUSTMENT RE-**  
4 **QUIREMENTS.**

5 (a) PAYMENT OF BENEFITS.—Section 1833(t) of the  
6 Social Security Act (42 U.S.C. 1395l(t)) is amended by  
7 adding at the end the following new paragraph:

8 “(23) NON BUDGET NEUTRAL APPLICATION OF  
9 REDUCED EXPENDITURES RESULTING FROM THE  
10 RADIATION ONCOLOGY CASE RATE VALUE BASED  
11 PAYMENT PROGRAM.—The Secretary shall not take  
12 into account the reduced expenditures that result  
13 from the implementation of section 1899C in making  
14 any budget neutrality adjustments under this sub-  
15 section.”.

16 (b) PAYMENT FOR PHYSICIANS’ SERVICES.—Section  
17 1848(c)(2)(B) of the Social Security Act (42 U.S.C.  
18 1395w-4(c)(2)(B)) is amended—

19 (1) in clause (iv)—

20 (A) in subclause (V), by striking “and” at  
21 the end;

22 (B) in subclause (VI), by striking the pe-  
23 riod at the end and inserting “; and”; and

24 (C) by adding at the end the following new  
25 subclause:

1                   “(VII) section 1899C shall not be  
2                   taken into account in applying clause  
3                   (ii)(II) for a year following the enact-  
4                   ment of section 1899C.”; and

5                   (2) in clause (v), by adding at the end the fol-  
6                   lowing new subclause:

7                   “(XII) REDUCED EXPENDITURES  
8                   ATTRIBUTABLE TO THE RADIATION  
9                   ONCOLOGY CASE RATE VALUE BASED  
10                  PAYMENT PROGRAM.—Effective for  
11                  fee schedules established following the  
12                  enactment of section 1899C, reduced  
13                  expenditures attributable to the Radi-  
14                  ation Oncology Case Rate Value  
15                  Based Payment Program under sec-  
16                  tion 1899C.”.

○