119TH CONGRESS
1ST SESSION

S. _____

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.

IN THE SENATE OF THE UNITED STATES

Mr. TILLIS introduced the following bill; which was read twice and referred to the Committee on _____

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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Radiation Oncology Case Rate Value Based Program Act of 2025'' or the ''ROCR Value Based Program Act''.

SEC. 2. FINDINGS.

(a) FINDINGS.—Congress finds the following:

(1) Radiation therapy is the careful use of various forms of radiation, such as external beam radiation therapy, to treat cancer and other diseases safely and effectively. Radiation oncologists develop radiation treatment plans and coordinate with highly specialized care teams to deliver radiation therapy. Nearly 60 percent of cancer patients will receive radiation therapy during their treatment.

(2) In 2021, the Centers for Medicare & Medicaid Services reported approximately $4,200,000,000 in total spending for radiation oncology services between the Medicare physician fee schedule and hospital outpatient departments.

(3) The Centers for Medicare & Medicaid Services has historically faced challenges in determining accurate pricing for services that involve costly capital equipment, resulting in fluctuating payment rates under the Medicare physician fee schedules for services involving external beam radiation therapy. Additionally, the Medicare physician fee schedule

has inadequately recognized the professional expertise physicians and nonphysician professionals need to deliver radiation therapy.

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

(5) In 2017, the Centers for Medicare & Medicaid Services recognized that the Medicare payment systems were not adequately addressing radiation oncology services, and the Center for Medicare & Medicaid Innovation released a congressionally requested report on the pursuit of an alternative payment model for radiation oncology (referred to in this section as the ''Radiation Oncology Model'') that addresses the issues in the Medicare physician fee schedule and the Medicare hospital outpatient prospective payment system payment methods.

(6) Concerns regarding the proposed Radiation Oncology Model included the significant payment reductions proposed in the model that would jeopardize access to high-quality radiation therapy services and the onerous reporting requirements for participating providers. The Radiation Oncology Model saw indefinite implementation delays.

(7) It is necessary, therefore, to create a payment program for radiation oncology services that appropriately recognizes the value of quality radiation oncology services through its financial incentives while containing costs and providing patient-centered care.

SEC. 3. RADIATION ONCOLOGY CASE RATE VALUE BASED PAYMENT PROGRAM.

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

"SEC. 1899C. RADIATION ONCOLOGY CASE RATE VALUE BASED PAYMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of the ROCR Value Based Program Act, the Secretary shall promulgate regulations, using the procedures described in paragraph (5), establishing a Radiation Oncology Case Rate Value Based Payment Program (referred to in this section as the 'ROCR Program') under which per episode payments are provided to radiation therapy providers or radiation therapy suppliers for covered treatment furnished to a covered individual during

an episode of care (as such terms are defined in subsection (j)) in accordance with this section.

''(2) MAINTAINING PAYMENT RATES DURING PERIOD PRIOR TO EFFECTIVE DATE OF REGULATIONS.—The Secretary shall not reduce the established payment rates for radiation therapy services under the physician fee schedule under section 1848 or the hospital outpatient prospective payment system under section 1833(t) during the time period beginning on the date of enactment of the ROCR Value Based Program Act and ending on the date that the regulations issued by the Secretary pursuant to paragraph (1) become effective.

''(3) ROCR PROGRAM GOALS.—The ROCR Program shall seek to—

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

''(B) reduce disparities in radiation therapy care for Medicare beneficiaries by increasing access to radiation therapy services close to the homes of beneficiaries;

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

"(D) leverage and encourage the utilization of state-of-the-art technology to improve care and outcomes; and

"(E) protect Medicare resources by achieving reasonable spending reductions in Medicare for radiation therapy services.

"(4) PAYMENTS.—Under this section, with respect to covered treatment furnished to covered individuals, payments shall include—

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

"(B) the health equity achievement in radiation therapy add-on payment described in subsection (g).

"(5) NOTICE AND COMMENT RULEMAKING.—The Secretary shall promulgate the regulations described in paragraph (1) in accordance with section 553 of title 5, United States Code, and issue an advanced notice of proposed rulemaking and notice of proposed rulemaking with a comment period of not less than 60 days for each.

"(b) PER EPISODE PAYMENTS.—

"(1) IN GENERAL.—

"(A) PAYMENTS.—The Secretary shall pay to a radiation therapy provider or radiation therapy supplier an amount equal to 80 percent of the per episode payment amount determined under paragraph 3 (referred to in this section as 'the per episode payment amount') for each covered individual furnished covered treatment for an included cancer type to cover all professional and technical services furnished during such treatment by the radiation therapy provider or radiation therapy supplier during an episode of care (as defined in subsection (j)).

"(B) DEDUCTIBLES AND COINSURANCE.—Subject to subsection (e), the Secretary shall pay the per episode payment amount (subject to any deductible and coinsurance otherwise applicable under part B) to the radiation therapy provider or radiation therapy supplier for an episode of care, as described in subsection (c).

"(2) PER EPISODE PAYMENT REQUIREMENTS AND TIMING.—

"(A) IN GENERAL.—Subject to subparagraph (B), for each episode of care furnished to a covered individual:

"(i) FIRST-HALF OF PAYMENT.—The Secretary shall issue ½ of the payment amount under paragraph (1) prospectively not later than 30 days after the day of the first delivery of covered treatment.

"(ii) SECOND-HALF OF PAYMENT.—The Secretary shall issue, with the exception of an episode of care for treatment of bone or brain metastases and subject to clause (iii), the remaining half of the payment amount under paragraph (1) on the date that is the earlier of—

"(I) the day the course of covered treatment is scheduled to end; or

"(II) the 90th day of the episode of care.

"(iii) SECOND-HALF OF PAYMENT FOR BONE AND BRAIN METASTASES.—The Secretary shall issue the remaining half of the payment amount under paragraph (1) for an episode of care for treatment of bone or brain metastases on the date that is the earlier of—

"(I) the day the course of covered treatment is schedule to end; or

"(II) the 30th day of the episode of care.

"(B) PATIENT DEATH.—If a covered individual dies during treatment, both episode of care payments under subparagraphs (A) and (B) shall be paid to the radiation therapy provider or radiation therapy supplier not later than 30 days after the day of the final delivery of radiation therapy treatment to the covered individual.

"(C) CONSISTENCY OF PAYMENT.—

"(i) IN GENERAL.—The per episode payment amount shall not change depending on the site of service.

"(ii) SITE OF SERVICE DEFINED.—For the purposes of this subparagraph, the term 'site of service' means the hospital outpatient department or physician office in which radiation therapy treatment is furnished by the radiation therapy provider or radiation therapy supplier.

"(3) DETERMINATION OF PER EPISODE PAYMENT AMOUNT.—

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

the professional component and technical component of treatment for each included cancer type.

"(B) AMOUNT.—The Secretary shall determine the per episode payment amount based on national base rates, as described in subsection (d)(1) and as updated in subsection (d)(2).

"(C) ADJUSTMENTS.—The per episode payment amount shall be subject to—

"(i) the adjustments as described in subsection (d)(2) and (d)(3);

"(ii) a geographic adjustment, as described in subsection (d)(3)(A);

"(iii) an inflation adjustment, pursuant to which the Secretary shall adjust the per episode payment amount by the percentage increase in the Medicare Economic Index (as described in section 1842 for the professional component payments and the applicable percentage increase in the Hospital Inpatient Market Basket Update (as described in section 1886(b)(3)(B)(i)) for the technical component payments during each 12-month period, and which varies for

the professional and technical components of the service;

"(iv) a savings adjustment, as described in subsection (d)(3)(B);

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

"(vi) a practice accreditation adjustment, as described in subsection (h), that is only applicable to technical component payments.

"(c) TREATMENT OF INCOMPLETE EPISODES OF CARE; CONCURRENT TREATMENT.—

"(1) INCOMPLETE EPISODE OF CARE.—In the case of an incomplete episode of care, payment shall be made to the radiation therapy provider or radiation therapy supplier for services furnished under the physician fee schedule under section 1848 or the hospital outpatient prospective payment system under section 1833(t), as applicable.

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

same course of therapy by providing another radiation therapy treatment planning service and billing under an applicable radiation therapy planning trigger code (as defined in subsection (j)).

''(3) CONCURRENT TREATMENTS.—In the case where a treatment modality described in subsection (j)(4)(B)(i)(I) is furnished to a covered individual during an episode of care for an included cancer type, payment may be made concurrently for the treatment modality under the applicable payment system under this title with per episode payment under this section for covered treatment during the episode of care.

''(d) NATIONAL BASE RATE.—

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

"(2) UPDATES TO THE NATIONAL BASE RATES.—

"(A) ANNUAL UPDATES.—

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

"(I) in the case of the professional component of the covered treatment, the percentage increase in the Medicare Economic Index; and

"(II) in the case of the technical component of the covered treatment, the applicable percentage increase described in section 1886(b)(3)(B)(i).

"(ii) PAYMENT FLOOR.—For each annual update, the Secretary shall not reduce the national base rates below the established rates from the prior year.

"(B) PERIODIC UPDATES.—

"(i) IN GENERAL.—The Secretary shall, through notice and comment rulemaking, rebase or revise the national base rates in 5-year intervals, beginning on the day that is 5 years after the date the regu-

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

"(ii) REBASING LIMIT.—The Secretary shall not reduce the national base rates through the process of rebasing by more than 1 percent every 5 years.

"(iii) INPUT FROM PROVIDERS AND SUPPLIERS.—In rebasing or revising the national base rates pursuant to clause (i), the Secretary shall seek significant input from radiation therapy providers, radiation therapy suppliers, and other stakeholders to ensure that such rates are sufficient, particularly for any new technology or service and any treatment modality described in clause (i)(I) of subsection (j)(4)(B) that is determined to be a covered treatment by the Secretary under clause (ii) of such subsection.

"(C) REBASE AND REVISE DEFINED.—In this subsection:

"(i) REBASE.—The term 'rebase' means to move the base year for the structure of costs of the national base rates.

''(ii) REVISE.—The term 'revise' means types of changes to national base rates other than rebasing, such as using different data sources, cost categories, or price proxies in the national base rates input.

''(D) NEW TECHNOLOGY OR SERVICES.—

''(i) TREATMENT UNDER THE NATIONAL BASE RATES.—

''(I) EXCLUSION DURING INITIAL PERIOD.—The Secretary shall not incorporate a radiation therapy service that is a new technology or service (as defined in subsection (j)) into the national base rates for an included cancer type prior to the date that is 12 years after such service is first identified as a new technology or service.

''(II) INCORPORATION AFTER INITIAL PERIOD.—After the date specified in subclause (I) with respect to a radiation therapy service that is a new technology or service, the Secretary shall, through stakeholder meetings, requests for information, and notice

and comment rulemaking, engage providers, suppliers, radiation therapy vendors, patient groups, and the public on possible incorporation of the new technology or service into the national base rates for included cancer types under paragraph (1).

''(ii) BEFORE INCORPORATION INTO THE NATIONAL BASE RATE.—Until incorporated into the national base rates under clause (i)(II), any new technology or service shall be paid under the applicable payment system under this title.

''(iii) DEVELOPMENT AND TRANSITIONAL PAYMENT PERIOD FOR ADAPTIVE RADIATION THERAPY PLANNING.—

''(I) DEVELOPMENT AND VALUATION FOR ADAPTIVE RADIATION THERAPY PLANNING.—Not later than the date the regulations issued pursuant to subsection (a)(1) become effective and in consultation with the American Medical Association's Current Procedural Terminology Editorial Panel and Specialty Society Relative

Value Scale Update Committee, radiation oncology specialty societies, and radiation oncology stakeholders, the Secretary shall develop and value codes for adaptive radiation therapy planning (as defined in subsection (j)).

''(II) TRANSITIONAL PAYMENT.—

''(aa) IN GENERAL.—During the period beginning on the date the regulations issued pursuant to subsection (a)(1) become effective and ending on the date any adaptive radiation therapy planning code is developed and valued, the Secretary shall provide a separate payment under the applicable payment system, in addition to the per episode payment amount, for any medically necessary online and offline adaptive radiation therapy planning furnished to a covered individual after the initial treatment plan for a covered individual.

"(bb) MODIFIER.—The Secretary shall establish a modifier to identify claims for the transitional payment for adaptive radiation therapy planning for a covered individual.

"(iv) ASSESSMENT OF CERTAIN CRITERIA.—Prior to incorporating a new technology or service into the national base rates pursuant to clause (i)(II), the Secretary shall consider market penetration and adoption, costs relative to base rates, clinical benefits of the new technology or service, and the clear consensus of the stakeholder community.

"(3) ADJUSTMENTS TO NATIONAL BASE RATES.—

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

"(i) in the case of the professional component payment rates, the geographic

adjustment processes described in the Medicare Physician Fee Schedule Geographic Practice Cost Index; and

''(ii) in the case of the technical component payment rates, the geographic adjustment processes in the hospital outpatient prospective payment system under section 1833(t).

''(B) SAVINGS ADJUSTMENT.—

''(i) IN GENERAL.—The Secretary shall apply a savings adjustment under this subparagraph after the geographic adjustments have been applied under subparagraph (A).

''(ii) SAVINGS ADJUSTMENT DEFINED.—The term 'savings adjustment' means the percentage by which the professional component and technical component payment rates are each reduced to achieve Medicare savings.

''(e) AVAILABILITY OF PAYMENT PLANS FOR PAYMENT OF COINSURANCE.—Following the application of the adjustments described in subsection (d), but before the application of any sequestration order issued under the Balanced Budget and Emergency Deficit Control Act of

1985 (2 U.S.C. 900 et seq.), radiation therapy providers and radiation therapy suppliers shall collect coinsurance for services furnished under the ROCR Program subject to the following rules:

''(1) IN GENERAL.—Radiation therapy providers and radiation therapy suppliers may collect coinsurance applicable under subsection (b)(1) for covered treatment furnished to a covered individual under the ROCR Program in multiple installments under a payment plan.

''(2) LIMITATION ON USE AS A MARKETING TOOL.—Radiation therapy providers and radiation therapy suppliers may not use the availability of payment plans for such coinsurance as a marketing tool to influence the choice of health care provider by covered individuals.

''(3) TIMING OF PROVISIONS OF INFORMATION.—Radiation therapy providers and radiation therapy suppliers offering a payment plan for such coinsurance may inform the covered individual of the availability of the payment plan prior to or during the initial treatment planning session and as necessary thereafter.

''(4) BENEFICIARY COINSURANCE PAYMENT.—The beneficiary coinsurance payment shall equal 20

percent of the payment amount to be paid to the radiation therapy provider or radiation therapy supplier prior to the application of any sequestration order issued under the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900 et seq.) for the billed ROCR Program episode of care, except as provided in paragraph (5).

''(5) INCOMPLETE EPISODE OF CARE.—In the case of an incomplete episode of care, the beneficiary coinsurance payment shall equal 20 percent of the amount that would have been paid in the absence of the ROCR Program for the radiation therapy services furnished by the radiation therapy provider or radiation therapy supplier that initiated the professional component and, if applicable, the radiation therapy provider or radiation therapy supplier that initiated the technical component.

''(f) MANDATORY PARTICIPATION.—

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

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

"(A) shall not be prohibited from also participating in the ROCR Program; and

"(B) is not required to participate in the ROCR Program.

"(3) SIGNIFICANT HARDSHIP EXEMPTION.—

"(A) IN GENERAL.—The Secretary may, on a case-by-case basis, exempt a radiation therapy provider or radiation therapy supplier from the ROCR Program if the Secretary determines that application of the program would result in a significant hardship, such as in the case of a natural disaster, for such radiation therapy provider or radiation therapy supplier or for beneficiaries in the geographic area of the radiation therapy provider or radiation therapy supplier.

"(B) PROCEDURE.—The Secretary shall promulgate regulations, using the procedures described in subsection (a)(5), regarding eligi-

bility and the procedure for applying for a significant hardship exemption.

''(g) HEALTH EQUITY ACHIEVEMENT IN RADIATION THERAPY ADD-ON PAYMENT.—

''(1) IN GENERAL.—Pursuant to paragraph (2) and subject to paragraph (7), the Secretary shall adjust the per episode payment amount in the amount of a health equity achievement in radiation therapy add-on payment to advance health equity and support covered individuals in accessing and completing their radiation therapy treatments for covered treatments of included cancer types through the provision of transportation services, subject to the succeeding provisions of this subsection.

''(2) ELIGIBILITY.—

''(A) IN GENERAL.—The health equity achievement in radiation therapy add-on payment shall be made when the ICD–10 diagnosis code Z59.82, transportation insecurity is reported pursuant to subparagraph (B).

''(B) DETERMINATION OF REPORTING CODE.—The radiation therapy provider or radiation therapy supplier shall follow the following procedures to determine if the ICD–10 diag-

nosis code Z59.82, transportation insecurity needs to be reported:

''(i) The radiation therapy provider or radiation therapy supplier shall ask the patient at the time of patient intake during the initial patient consultation if, within the previous 2 months, a lack of reliable transportation has kept the patient from attending medical appointments, meetings, or work, or from completing activities of daily living.

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

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

''(A) for services furnished during the year following the date the regulations issued pursuant to subsection (a)(1) become effective, $500 per patient per episode of care; and

''(B) for services furnished in subsequent years, the amount determined under this paragraph for the preceding year, increased by $10.

"(4) PAYMENT RECIPIENT.—The health equity achievement in radiation therapy add-on payment shall be paid to the radiation therapy provider or radiation therapy supplier that provides the technical component of the radiation therapy services.

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

"(6) DOCUMENTATION.—

"(A) IN GENERAL.—Radiation therapy providers and radiation therapy suppliers who receive the health equity achievement in radiation therapy add-on payment shall maintain all documentation related to the spending of such payment on transportation services per covered individual for a period of 5 years after the end of the episode of care of the applicable covered individual.

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

"(7) NO MODIFICATION OF COINSURANCE.—The Secretary may not modify any coinsurance obligation when implementing the health equity achievement in radiation therapy add-on payment.

"(h) QUALITY INCENTIVES IN THE ROCR VALUE BASED PAYMENT PROGRAM.—

"(1) IN GENERAL.—

"(A) INITIAL INCREASE IN PAYMENT.—With respect to covered treatment for an included cancer type furnished to a covered individual on or after the date the regulations issued pursuant to subsection (a)(1) become effective and before the date that is 2 years after such date, in the case of a radiation therapy provider or radiation therapy supplier that meets the requirements described in paragraph (2), payments otherwise made to such radiation therapy provider or radiation therapy supplier under the ROCR Program for the technical component of such services shall be increased by 1 percent (or 0.25 percent in the case of such a provider or supplier that is a limited resource radiation therapy supplier or limited resource radiation therapy provider).

"(B) REDUCTION IN PAYMENT.—

"(i) IN GENERAL.—Subject to clause (ii), with respect to covered treatment for an included cancer type furnished to a covered individual on or after the date that is 2 years after the regulations issued pursuant to subsection (a)(1) become effective, in the case of a radiation therapy provider or radiation therapy supplier that does not meet the requirements described in paragraph (2), the per episode payment to such provider or supplier under the ROCR Program shall be reduced by 2.5 percent.

"(ii) EXCLUSION OF LIMITED RESOURCE RADIATION THERAPY PROVIDERS AND LIMITED RESOURCE RADIATION THERAPY SUPPLIERS.—This subparagraph shall not apply with respect to a limited resource radiation therapy provider or a limited resource radiation therapy supplier.

"(C) DEFINITION OF LIMITED RESOURCE RADIATION THERAPY PROVIDER AND LIMITED RESOURCE RADIATION THERAPY SUPPLIER.—

"(i) IN GENERAL.—In this subsection, the terms 'limited resource radiation therapy provider' and 'limited resource radi-

ation therapy supplier' mean, with respect to a radiation therapy provider or radiation therapy supplier, a provider or supplier that meets the criteria specified by the Secretary that may include criteria relating to the volume and socioeconomic status of patients treated by the radiation therapy provider or radiation therapy supplier, the geographic area or medically-underserved area served by the radiation therapy provider or radiation therapy supplier, including rural areas, or such other criteria as the Secretary determines is appropriate, through notice and comment rulemaking and in consultation with radiation therapy stakeholder organizations.

''(ii) CAP ON NUMBER OF LIMITED RESOURCE RADIATION THERAPY PROVIDERS AND LIMITED RESOURCE RADIATION THERAPY SUPPLIERS.—In specifying the criteria for limited resource radiation therapy providers and limited resource radiation therapy suppliers under clause (i), the Secretary shall ensure that the total number of such providers and

suppliers does not exceed 10 percent of the total number of all radiation therapy providers and radiation therapy suppliers.

''(2) ACCREDITATION REQUIREMENTS.—

''(A) IN GENERAL.—The requirements described in this subparagraph with respect to a radiation therapy provider or radiation therapy supplier (other than such a provider or supplier that is a limited resource radiation therapy provider or limited resource radiation therapy supplier) are that the supplier or provider must—

''(i) maintain or be in the process of obtaining accreditation by the American College of Radiology, American College of Radiation Oncology, or American Society for Radiation Oncology (referred to in this section as 'covered radiation oncology accreditation organizations');

''(ii) comply with certified electronic health record technology requirements as determined by the Secretary with exceptions that are consistent with those of the Merit-based Incentive Payment System established under section 1848(q); and

"(iii) submit to the Secretary proof of the accreditation described in clause (i) in such form and manner as specified by the Secretary.

"(B) REQUIREMENTS FOR LIMITED RESOURCE RADIATION THERAPY PROVIDERS AND LIMITED RESOURCE RADIATION THERAPY SUPPLIERS.—A radiation therapy provider or radiation therapy supplier that is a limited resource radiation therapy provider or limited resource radiation therapy supplier may elect to satisfy the accreditation requirement under this paragraph by—

"(i) meeting the requirements of subparagraph (A);

"(ii) using an external audit that encompasses similar criteria as a nationally recognized radiation oncology accreditation organization and submit the outcome of such external audit to the Secretary; or

"(iii) complying with certified electronic health record technology requirements as determined by the Secretary with exceptions that are consistent with those of

the Merit-Based Incentives Payment System established under section 1848(q).

''(C) NEW PROVIDERS.—A new radiation therapy provider or new radiation supplier shall complete an initiation of accreditation or external audit not later than the date that is 1 year after such provider or supplier begins furnishing covered treatment to covered individuals.

''(D) RADIATION ONCOLOGY ACCREDITATION ORGANIZATION QUALITY STANDARDS.—Each covered radiation oncology accreditation organization (and any successor organization) shall develop quality standards for radiation therapy providers and radiation therapy suppliers to ensure covered treatments are delivered using adequate and modern linear accelerator technology, staffing, and other components that protect patient safety and quality by—

''(i) consulting with radiation therapy manufacturers and key stakeholders;

''(ii) soliciting public comment on proposed quality standards, including from

physicians, medical physicists, and other health professionals and experts;

"(iii) updating quality standards not later than every 5 to 7 years in partnership with stakeholders;

"(iv) ensuring quality standards for linear accelerator technology are adequate and on par with current technological advances and modern requirements for staffing and other procedures associated with the delivery of safe and effective radiation therapy;

"(v) collecting timely information from radiation therapy providers and radiation therapy suppliers for each linear accelerator owned or used on or after the effective date of the regulations issued pursuant to subsection (a)(1); and

"(vi) giving sufficient weight to compliance with quality standards among other accreditation standards in determining accreditation status for radiation therapy providers or radiation therapy suppliers.

"(i) REPORTING REQUIREMENTS.—

"(1) REPORT ON THE ROCR PROGRAM.—Not earlier than 7 years after the date of the enactment of this section, the Comptroller General of the United States (referred to in this subsection as the 'Comptroller General') shall, after seeking out the perspectives of radiation oncology stakeholders, submit to the appropriate committees of jurisdiction of the Senate and the House of Representatives a report that—

"(A) evaluates—

"(i) the implementation of the ROCR Program, and the impact such Program has had on Federal healthcare spending;

"(ii) the impact the ROCR Program has had on the ability of covered individuals to access covered treatment;

"(iii) whether any cancer types or radiation therapy services, such as brachytherapy, proton therapy, or therapeutic radiopharmaceuticals, should be added or removed from the ROCR Program; and

"(iv) the potential application of the ROCR Program to benefits provided under part C of this title; and

"(B) includes any recommendations for administrative and legislative changes.

"(2) REPORT ON ACCESS TO RADIATION THERAPY IN RURAL AND UNDERSERVED AREAS.—Not later than 3 years after the date of the enactment of this section, the Comptroller General shall submit a report to the appropriate committees of jurisdiction of the Senate and the House of Representatives that identifies the following:

"(A) Radiation therapy deserts.

"(B) Methods to increase access to new radiation therapy technologies in rural and underserved areas, including technologies required for clinical treatment planning, simulation, dosimetry, medical radiation physics, radiation treatment devices, radiation treatment delivery, radiation treatment management, and such other items as the Comptroller General may determine are medically necessary.

"(C) A program to provide assistance in the form of grants or loans to radiation therapy providers or radiation therapy suppliers for the purpose of ensuring access to the most current radiation therapy technology.

''(3) DETERMINATION AND DEFINITION OF RADIATION THERAPY DESERTS.—

''(A) DEFINITION.—For purposes of this subsection, the term 'radiation therapy desert' means a region determined by the Comptroller General under subparagraph (B) with a mismatch between radiation therapy resources and oncologic need.

''(B) DETERMINATION.—In determining whether a region qualifies as a radiation therapy desert, the Comptroller General shall take into account the ratio or density of radiation therapy providers and radiation therapy suppliers practicing in a geographic area as compared to the population size in that geographic area.

''(j) DEFINITIONS.—In this section:

''(1) ADAPTIVE RADIATION THERAPY PLANNING.—The term 'adaptive radiation therapy planning' means any new technology or services identified, as of the date that the regulations issued pursuant to subsection (a)(1) become effective, by the following HCPCS codes (and as subsequently modified by the Secretary) performed after the initial treatment plan for a covered individual:

"(A) 77295, 3-dimensional radiotherapy plan, including dose-volume histograms.

"(B) 77300, basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician.

"(C) 77301, intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications.

"(D) 77338, multi-leaf collimator (MLC) devices for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan.

"(E) 77334, Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts).

"(F) 77293, Respiratory motion management simulation (List separately in addition to code for primary procedure).

"(2) APPLICABLE RADIATION THERAPY PLANNING TRIGGER CODE.—The term 'applicable radiation therapy planning trigger code' means services identified, as of the date that the regulations issued pursuant to subsection (a)(1) become effective, by the following HCPCS codes (and as subsequently modified by the Secretary):

"(A) 77261, therapeutic radiology treatment planning, simple.

"(B) 77262, therapeutic radiology treatment planning, intermediate.

"(C) 77263, therapeutic radiology treatment planning, complex.

"(3) COVERED INDIVIDUAL.—The term 'covered individual' means an individual who—

"(A) is enrolled for benefits under part B;

"(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894; and

"(C) is diagnosed with an included cancer type.

"(4) COVERED TREATMENT.—

"(A) IN GENERAL.—The term 'covered treatment' means, subject to subparagraph (B),

radiation therapy services furnished to a covered individual.

''(B) EXCLUSIONS.—

''(i) IN GENERAL.—Such term does not include—

''(I) subject to clause (ii), during the period beginning on the date on which the regulation issued pursuant to subsection (a)(1) become effective and ending on the date that is 12 years after such date, brachytherapy, proton beam radiation therapy services, intraoperative radiotherapy, superficial radiation therapy, hyperthermia, and therapeutic radiopharmaceuticals;

''(II) inpatient radiation therapy services furnished in a subsection (d) hospital or ambulatory surgical center;

''(III) radiation therapy services furnished in cancer hospitals that are exempt from the hospital outpatient prospective payment system under section 1833(t);

"(IV) physician services that are furnished or supervised by the physician or the physician practice furnishing radiation therapy or by another physician, including any surgical procedures, chemotherapy, and other services;

"(V) physician and technical services that are furnished using technology represented by Healthcare Common Procedure Coding System codes that are not included in the M-code national base rates identified in table 75 (including in HCPCS Codes for radiation therapy services and supplies) of the Federal Register on November 16, 2021, 86 Fed. Reg. 63485, 63925; or

"(VI) durable medical equipment (as defined in section 1861(n)).

"(ii) INCLUSION OF CERTAIN TREATMENT.—After the date that is 12 years after the date on which the regulation issued pursuant to subsection (a)(1) become effective, the Secretary may deter-

mine by regulation to include any of the treatment modalities described in clause (i)(I) as covered treatment. Before making such determination, the Secretary shall—

"(I) consider—

"(aa) market penetration;

"(bb) the cost of such items or services relative to base rates;

"(cc) the clinical benefits of such items or services; and

"(dd) the clear consensus of the stakeholder community; and

"(II) publish a notice of a proposed determination under subsection (b)(3)(B) regarding the payment amount proposed to be established with respect to such item or service.

"(5) EPISODE OF CARE.—The term 'episode of care' means, with respect to a covered individual, the period—

"(A) beginning on the day radiation therapy planning for an included cancer type, billed under an applicable radiation therapy planning trigger code, is furnished to a covered individual if radiation therapy treatment is initiated

not later than 30 days after the day such radiation therapy planning service is furnished; and

"(B) ends—

"(i) for treatment of all included cancer types except bone and brain metastases treatment, the day that is 90 days after the day the episode of care begins under clause (i); and

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

"(6) INCLUDED CANCER TYPES.—The term 'included cancer type' means any of the following types of cancer:

"(A) Anal.

"(B) Bladder.

"(C) Bone Metastases.

"(D) Brain Metastases.

"(E) Breast.

"(F) Cervical.

"(G) Central Nervous System Tumors.

"(H) Colorectal.

"(I) Head and Neck.

"(J) Lung.

"(K) Lymphoma.

"(L) Pancreatic.

"(M) Prostate.

"(N) Upper Gastrointestinal.

"(O) Uterine.

"(7) HEALTHCARE COMMON PROCEDURE CODING SYSTEM.—The term 'Healthcare Common Procedure Coding System' means the standardized coding system used by Medicare and other health insurance programs to ensure that claims are processed in an orderly and consistent manner.

"(8) INCOMPLETE EPISODE OF CARE.—The term 'incomplete episode of care' means, with respect to a covered individual, an episode of care that is not completed because—

"(A) the individual being treated ceases to be a covered individual, including in the case where the individual loses benefits under this title, at any time after the initial treatment planning service is furnished and before the episode of care for the covered treatment is complete; or

"(B) a covered individual switches radiation therapy provider or radiation therapy supplier before all included radiation therapy serv-

ices in the episode of care for the covered treatment have been furnished.

''(9) NEW TECHNOLOGY OR SERVICES.—The term 'new technology or services' means any technology or services that, after the date of enactment of this section, receives a Category 1 Current Procedural Terminology code or is established in the yearly update to the Medicare physician fee schedule direct practice expense inputs or any successor repository of the direct practice expense input for the delivery of radiation therapy services.

''(10) PROFESSIONAL COMPONENT.—The term 'professional component' means the included radiation therapy services that may only be furnished by a physician.

''(11) RADIATION THERAPY.—The term 'radiation therapy' means the careful use of various forms of radiation, such as external beam radiation therapy, to treat cancer and other diseases safely and effectively.

''(12) RADIATION THERAPY PROVIDER.—The term 'radiation therapy provider' means a hospital outpatient department enrolled under this title that furnishes radiation therapy services.

''(13) RADIATION THERAPY SERVICES.—The term 'radiation therapy services' means the treatment planning, technical preparation, special services (such as simulation), treatment delivery, and treatment management services associated with cancer treatment that uses high doses of radiation to kill cancer cells and shrink tumors.

''(14) RADIATION THERAPY SUPPLIER.—The term 'radiation therapy supplier' means a physician group practice or freestanding radiation therapy center enrolled under this title that furnishes radiation therapy services.

''(15) TECHNICAL COMPONENT.—The term 'technical component' means the included radiation therapy services that are not furnished by a physician, including the provision of equipment, supplies, personnel, and administrative costs related to radiation therapy services.

''(16) TRANSPORTATION SERVICES.—The term 'transportation services' means the provision of free or discounted transportation made available to covered individuals furnished covered treatment which are not air, luxury, or ambulance-level transportation, but may include car services, ride shares, autonomous vehicles, or public transportation.''.

(b) EXCLUSION OF PARTICIPATING RADIATION THERAPY PROVIDERS, RADIATION THERAPY SUPPLIERS, AND PHYSICIANS FROM THE MERIT-BASED INCENTIVE PAYMENT SYSTEM.—Section 1848(q)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w-4(q)(1)(c)(II)) is amended—

(1) in subclause (II), by striking ''or'' at the end;

(2) in subclause (III), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following new subclause:

''(IV) is a radiation therapy provider or radiation therapy supplier (as those terms are defined in subsection (j) of section1899C) that is participating in the Radiation Oncology Case Rate Value Based Payment Program established under that section.''.

SEC. 4. REVISION TO CIVIL MONETARY PENALTIES REGARDING RADIATION ONCOLOGY CASE RATE PATIENT TRANSPORTATION SERVICES.

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

(1) in subsection (i)(6)—

(A) in subparagraph (I), by striking ''or'' at the end;

(B) in subparagraph (J)(iii), by striking the period at the end and inserting ''; or''; and

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

''(K) the provision of transportation services by an eligible entity, as defined in subsection (t), if—

''(i) the availability of the transportation services—

''(I) is set forth in a policy that the eligible entity, as defined in subsection (t), applies uniformly and consistently; and

''(II) is not determined in a manner related to the past or anticipated volume or value of Federal health care program business;

''(ii) the eligible entity does not publicly market or advertise the transportation services;

''(iii) the driver who provides the transportation services does not market health care items or services during the

course of the transportation or at any time;

''(iv) the driver or individual arranging for the transportation services is not paid on a per-beneficiary-transported basis;

''(v) the eligible entity makes the transportation services available only to an individual who—

''(I) is an established patient, as defined in subsection (t), of the eligible entity that is providing or facilitating free or discounted transportation;

''(II) resides—

''(aa) within a 75 miles radius of the radiation therapy provider or radiation therapy supplier to or from which the patient would be transported; or

''(bb) in a rural area, as defined in subsection (t); and

''(III) is receiving radiation therapy services for the purpose of obtaining medically necessary items and services; and

''(vi) the eligible entity that makes the transportation services available bears the costs of the transportation services and does not shift the burden of those costs onto any Federal health care program, other payers, or individuals.''; and

(2) by adding at the end the following new subsection:

''(t) For purposes of subsection (i)(6)(K), the following definitions apply:

''(1) The term 'eligible entity' means any individual or entity, or any individual or entity acting on behalf of such individual or entity that does not supply health care items as the primary occupation of the individual or entity.

''(2) The term 'established patient' means an individual who—

''(A) has selected and scheduled an appointment with a radiation therapy provider or radiation therapy supplier; or

''(B) has attended an appointment with such provider or supplier.

''(3) The terms 'radiation therapy provider', 'radiation therapy services', and 'radiation therapy

supplier' have the meaning given such terms in section 1866G(j).

''(4) The term 'rural area' means an area that is not an urban area.

''(5) The term 'transportation services'—

''(A) means the provision of free or discounted transportation made available to Federal health care program beneficiaries receiving radiation therapy services;

''(B) includes car services, ride shares, and public transportation; and

''(C) does not include air, luxury, or ambulance-level transportation.

''(6) The term 'urban area' means—

''(A) a Metropolitan Statistical Area or New England County Metropolitan Area, as defined by the Office of Management and Budget;

''(B) Litchfield County, Connecticut;

''(C) York County, Maine;

''(D) Sagadahoc County, Maine;

''(E) Merrimack County, New Hampshire; and

''(F) Newport County, Rhode Island.''.

SEC. 5. EXEMPTION OF RADIATION ONCOLOGY CASE RATE VALUE BASED PAYMENT PROGRAM FROM BUDGET NEUTRALITY ADJUSTMENT REQUIREMENTS.

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

''(23) NON BUDGET NEUTRAL APPLICATION OF REDUCED EXPENDITURES RESULTING FROM THE RADIATION ONCOLOGY CASE RATE VALUE BASED PAYMENT PROGRAM.—The Secretary shall not take into account the reduced expenditures that result from the implementation of section 1899C in making any budget neutrality adjustments under this subsection.''.

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

(1) in clause (iv)—

(A) in subclause (V), by striking ''and'' at the end;

(B) in subclause (VI), by striking the period at the end and inserting ''; and''; and

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

"(VII) section 1899C shall not be taken into account in applying clause (ii)(II) for a year following the enactment of section 1899C."; and

(2) in clause (v), by adding at the end the following new subclause:

"(XII) REDUCED EXPENDITURES ATTRIBUTABLE TO THE RADIATION ONCOLOGY CASE RATE VALUE BASED PAYMENT PROGRAM.—Effective for fee schedules established following the enactment of section 1899C, reduced expenditures attributable to the Radiation Oncology Case Rate Value Based Payment Program under section 1899C.".