Radiation Oncology Case Rate Value-Based Program Act of 2024

Section-by-Section Summary

Section 1. Short Title

ROCR Value-Based Program Act

Section 2. Findings

- More than 60 percent of people with cancer receive safe and effective radiation therapy.
- Medicare Part B spent $4.2 billion on radiation therapy in 2021.
- Current payment systems incentivize volume over value.
- CMS has recognized that Medicare payment systems were not adequately addressing radiation oncology services and suggested an alternative payment model utilizing bundled payments.
- The CMS proposed RO Model was delayed by Congress due to significant payment reductions and onerous reporting requirements.
- It is necessary to create a payment program for radiation oncology services that recognizes their value, while containing costs and providing patient-centered care.

Section 3. ROCR Value Based Payment Program

Directs the HHS Secretary to issue notice and comment rulemaking establishing the ROCR Program for radiation therapy providers (hospital outpatient department) and suppliers (physician group practice or freestanding center) provided to Medicare FFS beneficiaries during an episode of care.

- Directs the Secretary not to reduce payment rates for radiation therapy services between the date of ROCR Program Act enactment and the effective date of regulations.
- Describes ROCR Program Goals, including creation of unified, stable payments, reduction in disparities, enhancement of quality, technology to improve outcomes.

Describes per-episode payments and health equity add-on payments to providers and suppliers. Payments shall cover each covered individual for an included cancer type for all professional and technical payments furnished during an episode of care, subject to deductible and coinsurance amounts.

- Describes the amount and timing of two prospective payments for each covered individual, including a shorter episode for metastatic cancer episodes. Clarifies payment for individuals that pass away during treatment, which involves full episode payment, or have an incomplete treatment, in which payments are made under fee for service. Clarifies that the technical payment shall be unified for both sites of service.
- Summarizes the per episode payment methodology for professional and technical services based on national rates adjusted for geography, inflation, savings, health equity, and practice accreditation.

Clarifies payments for incomplete and multiple episodes, as well as concurrent treatments.

Describes the determination of national base rates based on M-Codes and corresponding HCPCS codes identified in Table 75 Nov. 16, 2021, Federal Register and annual updates using the Medicare Economic Index and Hospital Market Basket Update.

Prevents the Secretary from reducing base rates annually. Directs the Secretary to issue rulemaking, with significant stakeholder input, to rebase and revise the base rates every 5 years, while not reducing the base rates by more than 1 percent because of rebasing.

Defines and creates a process for incorporation of new technology and services into the ROCR Program after 10 years. Directs Secretary to assess and consider incorporating new technology and services through rulemaking after significant input from radiation therapy stakeholders. Describes how new technology and services will be paid under current payment systems until incorporated.

Describes adjustments to the national base rates, including:

- Geographic adjustments consistent with the physician fee schedule and hospital outpatient department payment systems
- Savings adjustment reductions to professional and technical payments, with the goal of achieving approximately $200 million in Medicare savings over 10 years.

Describes rules for the collection of coinsurance after the adjustments, including use of multiple installments under a payment plan, limitations on use of payment plans as marketing tool, provision of information to individuals, and beneficiary copayment of 20 percent of payment amount, including incomplete episodes of care.

Describes requirements for all providers and suppliers to participate in the ROCR program, unless covered under an exception, including participation in state-based Medicare Innovation Center models or a significant hardship exemption, as determined by the Secretary.

Defines and describes a Health Equity Achievement in Radiation Therapy (HEART) payment to support individuals in accessing and completing radiation treatments through transportation assistance.

- Determines eligibility based on standardized transportation insecurity questionnaire and sets payment amount of $500 per episode to the technical payment, with $10 annual increases. Ensures no duplication of payment and requires availability to the Secretary of documentation of services. There is no coinsurance on the HEART payment.

Creates ROCR Program quality incentives for radiation oncology practice accreditation, with separate requirement for small practices.

- Increases technical payment by .5 percent for pursuing or maintaining accreditation in the first 3 years.
- Decreases technical payment by 1.0 percent for not obtaining practice accreditation after 3 years.

- Defines small suppliers and providers and describes alternative means to satisfy the accreditation requirement using an external audit. Small practices may receive a .25 percent increase to technical payments, but no decrease.
- Accreditation status will be submitted to the Secretary. Describes process for new providers and suppliers to meet accreditation requirements. Requires compliance with certified electronic health record requirements under Merit-based Incentive Payment System (MIPS).

Requires reports from the Comptroller General evaluating the ROCR program, access to radiation therapy technology in rural and underserved areas.

Defines key ROCR Program terms:

- Billing codes that trigger the episode payment;
- Covered individuals under Medicare Part B diagnosed with an included cancer type;
- Covered treatments;
    - Exclusions, including:
        - Brachytherapy, proton therapy, intraoperative radiotherapy, superficial radiation therapy, hyperthermia, and radiopharmaceuticals,
        - Inpatient radiation therapy services, ambulatory surgery centers, and PPS-exempt cancer hospitals,
        - Other physician services supervised or performed by the radiation oncology or another physician, and
        - Physician services furnished using technology represented by codes not included in M codes,
- Episode of care, including timing of radiation therapy planning, treatment delivery, and time following end of treatment;
- 15 included cancer types;
- Incomplete episodes of care due to death, loss of benefits, changing in provider or supplier;
- Professional and technical components;
- Radiation therapy provider and suppliers; and
- Transportation services.

Excludes ROCR Program radiation therapy suppliers, providers, and physicians from participating in MIPS.

Section 4. Revision to Civil Monetary Penalties For ROCR Program Transportation Services

Allows for the provision of transportation services under ROCR by eligible entities consistent with the local transportation safe harbor under the federal anti-kickback statute.

Section 5. Exemption of ROCR Program From Budget Neutrality Adjustment Requirements.

Ensures that the creation of the ROCR Program will not result in budget neutrality adjustments that reduce expenditures under the Medicare physician fee schedule or hospital outpatient department payment system.