NAPT Executive Summary of
the Radiation Oncology Case Rate (ROCR) Legislation

Key Points

- The ROCR legislation was introduced by Sen. Thom Tillis (R-NC) in the US Senate and Reps. Brian Fitzpatrick (R-PA), Jimmy Panetta (D-CA), John Joyce, MD (R-PA), and Paul Tonko (D-NY) in the House of Representatives in May 2024.
- This legislation if passed would direct the Secretary of the Department of Health & Human Services (HHS) to establish a mandatory ROCR value-based payment program under which per-episode payments would be made to radiation therapy providers and suppliers for furnishing services to covered Medicare Part B beneficiaries with one of 15 cancer types (the same ones in the original radiation oncology model)
- ROCR requires 100% participation for all radiation oncology practices and is not a pilot program.
- Initially excludes brachytherapy, proton therapy, intraoperative radiotherapy, superficial radiation therapy, hyperthermia, and therapeutic radiopharmaceuticals for 10 years from the date of implementation.
- After seven years, requires a report from the Government Accountability Office to evaluate if services such as proton therapy should be included or excluded after seeking out the perspectives of radiation oncology stakeholders.
- **Establishes one payment rate for all modalities. As currently written, the bill allows for proton therapy to potentially be included at the same base rates as all other radiation therapy modalities after 10 years.**
- New technology (any technology that gets a Category I code) would be included after 10 years with consideration of market penetration and adoption, costs relative to base rates, clinical benefits of the new technology or service, and consensus of stakeholders.

Payment Under ROCR

- Payment for covered treatment to a covered Medicare Part B beneficiary includes
  - Per-episode payment
  - Health equity achievement add-on payment
- Per-episode payment amount for each covered individual for each covered treatment for included cancer types would be comprehensive to cover all professional and technical services furnished by that radiation therapy provider or supplier during an episode of care
- Payment to radiation therapy provider or supplier is 80% of the per-episode payment amount with the remaining 20% paid by beneficiary through coinsurance
  - May be collected via multiple payments through a payment plan, which may not be used as a marketing tool and for which availability must be disclosed prior to or during the initial

treatment planning session

- Payment split into two:
  - First-half of payment issued prospectively within 30 days of the first delivery of radiation therapy and
  - Second-half of payment:
    - For bone and brain metastases, payment issued at the earlier of (i) the end of the treatment or (ii) 30 days after the initiation of the episode of care
    - For all other cancers, payment issued at the earlier of (i) the end of the treatment or (ii) 90 days after the initiation of the episode of care
- Payment still issued if patient dies during therapy
- No site of service payment differential between physician office, hospital outpatient department
- Mandatory model except if participating in State-based CMMI model (may opt out) or hardship exemption as decided by HHS on a case-by-case basis

Determination of Per-Episode Payment Amount

- For each included cancer type, Secretary is to determine payment based on national base payment rates (based on the M codes that were originally developed as part of the radiation oncology case rate model) subject to the following adjustments:
  - Annual increases (based on the Medicare Economic Index for professional and hospital market basket for technical component; payment floor prohibiting reductions in national base rates from one year to another)
  - Revising and rebasing (once every 5 years, no more than 1% reduction to base rates for each 5 year period)
  - Incorporation of new technology services
  - Geographic adjustment (GPCI for professional, market basket for technical), applied before the savings adjustment
  - Savings adjustment (percentage by which the professional component and technical component payment rates are each reduced to achieve Medicare savings)
  - Health equity adjustment (specific to facilitating transportation to address transportation insecurity) ($500 per patient per episode for the initial year and $10 increase each year, paid to provider or supplier furnishing the technical component of the services)
  - Quality incentive adjustment
- Incomplete episodes would be reimbursed under the applicable payment system (Physician Fee Schedule, Hospital Outpatient Prospective Payment System)
- Multiple and concurrent episodes under ROCR are permitted
- New technology services – any technology that gets a Category I code or for which a direct practice expense input is established
  - Excluded for 10 years after service is identified as a new technology

  - After that timeframe, CMS would seek feedback via notice-and-comment on the inclusion of the new technology in the national base rates for an included cancer type and would consider market penetration and adoption, costs relative to base rates, clinical benefits of the new technology or service, and consensus of stakeholders
  - Until CMS incorporates new technology services into the model, providers would receive reimbursement for these new services under the applicable payment system
- Quality incentive adjustment – Increase to the technical component of payment (0.5 percent (or 0.25 for small providers and supplier)) for the first 3 years of ROCR, or decrease to per episode payment by 1.0 percent after the first 3 years (excluding small providers and suppliers) for meeting accreditation requirement
  - Small provider and small supplier could be defined a number of different ways including the number of LINACs, volume of patients, or other criteria as defined by the Secretary and must meet specific criteria
  - Accreditation requirement met by maintaining or being in the process of obtaining accreditation by American College of Radiology, American College of Radiation Oncology, or American Society for Radiation Oncology, complying with CERT requirements consistent with MIPS, submitting proof of accreditation to the Secretary
  - Small providers and suppliers can satisfy requirements through external audit
  - New providers must complete initiation of accreditation or audit no later than 1 year after beginning to furnish services

Payment Rates Prior to ROCR Establishment

- Prohibits the Secretary from reducing payment rates for RT services under the Physician Fee Schedule or Outpatient Prospective Payment System during the period between enactment and the effective date of the regulations implementing ROCR

Rulemaking

- Requires the Secretary to promulgate rules establishing the ROCR no later than 1 year after enactment
- Requires both an advanced notice of proposed rulemaking and a notice of proposed rulemaking, each of which must have a comment period of no less than 60 days

Required Reports

- 7+ years after enactment: GAO to evaluate if services such as proton therapy should be included or excluded
- 3+ years after enactment: GAO to identify RT deserts and methods to increase access to radiation therapy services

Definitions

Radiation treatment planning trigger codes	77261-77263
Covered individual	Covered by Medicare Part B, not in an MA plan and has an included cancer type
Covered treatment	Excludes: (i) brachytherapy, proton therapy, intraoperative radiotherapy, superficial radiation therapy, hyperthermia and therapeutic radiopharmaceuticals (ii) inpatient hospital services (iii) non-radiation therapy physician services
Included cancer types	1. Anal. 2. Bladder. 3. Bone Metastases. 4. Brain Metastases. 5. Breast. 6. Cervical. 7. Central Nervous System Tumors. 8. Colorectal. 9. Head and Neck. 10. Lung. 11. Lymphoma. 12. Pancreatic. 13. Prostate. 14. Upper Gastrointestinal. 15. Uterine.
Radiation therapy services	Treatment planning, technical preparation, special services (such as simulation), treatment delivery, and treatment management services associated with cancer treatment
Episode of care	Begins on the date radiation therapy planning for an included cancer type, billed under an applicable trigger code, is furnished if radiation therapy treatment is initiated within 30 days. Ends 90 days later for all included cancer types except for bone and brain metastases treatment, or 30 days later for bone and brain metastases treatment.