

119TH CONGRESS
1ST SESSION

S. 1031

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

MARCH 13, 2025

Mr. TILLIS (for himself and Mr. PETERS) introduced the following bill; which
was read twice and referred to the Committee on Finance

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 2025” 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 scheduled 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)(4)(B)(i)(I) is furnished to a covered individual
8 during an episode of care for an included cancer
9 type, payment may be made concurrently for the
10 treatment modality under the applicable payment
11 system under this title with per episode payment
12 under this section for covered treatment during the
13 episode of 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-

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.

1 “(ii) REVISE.—The term ‘revise’
 2 means types of changes to national base
 3 rates other than rebasing, such as using
 4 different data sources, cost categories, or
 5 price proxies in the national base rates
 6 input.

7 “(D) NEW TECHNOLOGY OR SERVICES.—

8 “(i) TREATMENT UNDER THE NA-
 9 TIONAL BASE RATES.—

10 “(I) EXCLUSION DURING INITIAL
 11 PERIOD.—The Secretary shall not in-
 12 corporate a radiation therapy service
 13 that is a new technology or service (as
 14 defined in subsection (j)) into the na-
 15 tional base rates for an included can-
 16 cer type prior to the date that is 12
 17 years after such service is first identi-
 18 fied as a new technology or service.

19 “(II) INCORPORATION AFTER INI-
 20 TIAL PERIOD.—After the date speci-
 21 fied in subclause (I) with respect to a
 22 radiation therapy service that is a new
 23 technology or service, the Secretary
 24 shall, through stakeholder meetings,
 25 requests for information, and notice

1 and comment rulemaking, engage pro-
 2 viders, suppliers, radiation therapy
 3 vendors, patient groups, and the pub-
 4 lic on possible incorporation of the
 5 new technology or service into the na-
 6 tional base rates for included cancer
 7 types under paragraph (1).

8 “(ii) BEFORE INCORPORATION INTO
 9 THE NATIONAL BASE RATE.—Until incor-
 10 porated into the national base rates under
 11 clause (i)(II), any new technology or serv-
 12 ice shall be paid under the applicable pay-
 13 ment system under this title.

14 “(iii) DEVELOPMENT AND TRANSI-
 15 TIONAL PAYMENT PERIOD FOR ADAPTIVE
 16 RADIATION THERAPY PLANNING.—

17 “(I) DEVELOPMENT AND VALU-
 18 ATION FOR ADAPTIVE RADIATION
 19 THERAPY PLANNING.—Not later than
 20 the date the regulations issued pursu-
 21 ant to subsection (a)(1) become effec-
 22 tive and in consultation with the
 23 American Medical Association’s Cur-
 24 rent Procedural Terminology Editorial
 25 Panel and Specialty Society Relative

1 Value Scale Update Committee, radi-
2 ation oncology specialty societies, and
3 radiation oncology stakeholders, the
4 Secretary shall develop and value
5 codes for adaptive radiation therapy
6 planning (as defined in subsection
7 (j)).

8 “(II) TRANSITIONAL PAYMENT.—

9 “(aa) IN GENERAL.—During
10 the period beginning on the date
11 the regulations issued pursuant
12 to subsection (a)(1) become effec-
13 tive and ending on the date any
14 adaptive radiation therapy plan-
15 ning code is developed and val-
16 ued, the Secretary shall provide a
17 separate payment under the ap-
18 plicable payment system, in addi-
19 tion to the per episode payment
20 amount, for any medically nec-
21 essary online and offline adaptive
22 radiation therapy planning fur-
23 nished to a covered individual
24 after the initial treatment plan
25 for a covered individual.

1 “(bb) MODIFIER.—The Sec-
 2 retary shall establish a modifier
 3 to identify claims for the transi-
 4 tional payment for adaptive radi-
 5 ation therapy planning for a cov-
 6 ered individual.

7 “(iv) ASSESSMENT OF CERTAIN CRI-
 8 TERIA.—Prior to incorporating a new tech-
 9 nology or service into the national base
 10 rates pursuant to clause (i)(II), the Sec-
 11 retary shall consider market penetration
 12 and adoption, costs relative to base rates,
 13 clinical benefits of the new technology or
 14 service, and the clear consensus of the
 15 stakeholder community.

16 “(3) ADJUSTMENTS TO NATIONAL BASE
 17 RATES.—

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

24 “(i) in the case of the professional
 25 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

1 1985 (2 U.S.C. 900 et seq.), radiation therapy providers
2 and radiation therapy suppliers shall collect coinsurance
3 for services furnished under the ROCR Program subject
4 to the following rules:

5 “(1) IN GENERAL.—Radiation therapy pro-
6 viders and radiation therapy suppliers may collect
7 coinsurance applicable under subsection (b)(1) for
8 covered treatment furnished to a covered individual
9 under the ROCR Program in multiple installments
10 under a payment plan.

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

17 “(3) TIMING OF PROVISIONS OF INFORMA-
18 TION.—Radiation therapy providers and radiation
19 therapy suppliers offering a payment plan for such
20 coinsurance may inform the covered individual of the
21 availability of the payment plan prior to or during
22 the initial treatment planning session and as nec-
23 essary thereafter.

24 “(4) BENEFICIARY COINSURANCE PAYMENT.—
25 The beneficiary coinsurance payment shall equal 20

1 percent of the payment amount to be paid to the ra-
2 diation therapy provider or radiation therapy sup-
3 plier prior to the application of any sequestration
4 order issued under the Balanced Budget and Emer-
5 gency Deficit Control Act of 1985 (2 U.S.C. 900 et
6 seq.) for the billed ROCR Program episode of care,
7 except as provided in paragraph (5).

8 “(5) INCOMPLETE EPISODE OF CARE.—In the
9 case of an incomplete episode of care, the beneficiary
10 coinsurance payment shall equal 20 percent of the
11 amount that would have been paid in the absence of
12 the ROCR Program for the radiation therapy serv-
13 ices furnished by the radiation therapy provider or
14 radiation therapy supplier that initiated the profes-
15 sional component and, if applicable, the radiation
16 therapy provider or radiation therapy supplier that
17 initiated the technical component.

18 “(f) MANDATORY PARTICIPATION.—

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

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

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

8 “(B) is not required to participate in the
9 ROCR Program.

10 “(3) SIGNIFICANT HARDSHIP EXEMPTION.—

11 “(A) IN GENERAL.—The Secretary may,
12 on a case-by-case basis, exempt a radiation
13 therapy provider or radiation therapy supplier
14 from the ROCR Program if the Secretary de-
15 termines that application of the program would
16 result in a significant hardship, such as in the
17 case of a natural disaster, for such radiation
18 therapy provider or radiation therapy supplier
19 or for beneficiaries in the geographic area of
20 the radiation therapy provider or radiation ther-
21 apy supplier.

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

1 bility and the procedure for applying for a sig-
2 nificant hardship exemption.

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

5 “(1) IN GENERAL.—Pursuant to paragraph (2)
6 and subject to paragraph (7), the Secretary shall ad-
7 just the per episode payment amount in the amount
8 of a health equity achievement in radiation therapy
9 add-on payment to advance health equity and sup-
10 port covered individuals in accessing and completing
11 their radiation therapy treatments for covered treat-
12 ments of included cancer types through the provision
13 of transportation services, subject to the succeeding
14 provisions of this subsection.

15 “(2) ELIGIBILITY.—

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

21 “(B) DETERMINATION OF REPORTING
22 CODE.—The radiation therapy provider or radi-
23 ation therapy supplier shall follow the following
24 procedures to determine if the ICD–10 diag-

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

3 “(i) The radiation therapy provider or
4 radiation therapy supplier shall ask the pa-
5 tient at the time of patient intake during
6 the initial patient consultation if, within
7 the previous 2 months, a lack of reliable
8 transportation has kept the patient from
9 attending medical appointments, meetings,
10 or work, or from completing activities of
11 daily living.

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

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

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

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

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

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

12 “(6) DOCUMENTATION.—

13 “(A) IN GENERAL.—Radiation therapy
14 providers and radiation therapy suppliers who
15 receive the health equity achievement in radi-
16 ation therapy add-on payment shall maintain all
17 documentation related to the spending of such
18 payment on transportation services per covered
19 individual for a period of 5 years after the end
20 of the episode of care of the applicable covered
21 individual.

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

1 “(7) NO MODIFICATION OF COINSURANCE.—

2 The Secretary may not modify any coinsurance obli-
 3 gation when implementing the health equity achieve-
 4 ment in radiation therapy add-on payment.

5 “(h) QUALITY INCENTIVES IN THE ROCR VALUE
 6 BASED PAYMENT PROGRAM.—

7 “(1) IN GENERAL.—

8 “(A) INITIAL INCREASE IN PAYMENT.—

9 With respect to covered treatment for an in-
 10 cluded cancer type furnished to a covered indi-
 11 vidual on or after the date the regulations
 12 issued pursuant to subsection (a)(1) become ef-
 13 fective and before the date that is 2 years after
 14 such date, in the case of a radiation therapy
 15 provider or radiation therapy supplier that
 16 meets the requirements described in paragraph
 17 (2), payments otherwise made to such radiation
 18 therapy provider or radiation therapy supplier
 19 under the ROCR Program for the technical
 20 component of such services shall be increased
 21 by 1 percent (or 0.25 percent in the case of
 22 such a provider or supplier that is a limited re-
 23 source radiation therapy supplier or limited re-
 24 source radiation therapy provider).

25 “(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-

1 ation therapy supplier’ mean, with respect
2 to a radiation therapy provider or radiation
3 therapy supplier, a provider or supplier
4 that meets the criteria specified by the
5 Secretary that may include criteria relating
6 to the volume and socioeconomic status of
7 patients treated by the radiation therapy
8 provider or radiation therapy supplier, the
9 geographic area or medically-underserved
10 area served by the radiation therapy pro-
11 vider or radiation therapy supplier, includ-
12 ing rural areas, or such other criteria as
13 the Secretary determines is appropriate,
14 through notice and comment rulemaking
15 and in consultation with radiation therapy
16 stakeholder organizations.

17 “(ii) CAP ON NUMBER OF LIMITED
18 RESOURCE RADIATION THERAPY PRO-
19 VIDERS AND LIMITED RESOURCE RADI-
20 ATION THERAPY SUPPLIERS.—In speci-
21 fying the criteria for limited resource radi-
22 ation therapy providers and limited re-
23 source radiation therapy suppliers under
24 clause (i), the Secretary shall ensure that
25 the total number of such providers and

1 suppliers does not exceed 10 percent of the
2 total number of all radiation therapy pro-
3 viders and radiation therapy suppliers.

4 “(2) ACCREDITATION REQUIREMENTS.—

5 “(A) IN GENERAL.—The requirements de-
6 scribed in this subparagraph with respect to a
7 radiation therapy provider or radiation therapy
8 supplier (other than such a provider or supplier
9 that is a limited resource radiation therapy pro-
10 vider or limited resource radiation therapy sup-
11 plier) are that the supplier or provider must—

12 “(i) maintain or be in the process of
13 obtaining accreditation by the American
14 College of Radiology, American College of
15 Radiation Oncology, or American Society
16 for Radiation Oncology (referred to in this
17 section as ‘covered radiation oncology ac-
18 creditation organizations’);

19 “(ii) comply with certified electronic
20 health record technology requirements as
21 determined by the Secretary with excep-
22 tions that are consistent with those of the
23 Merit-Based Incentive Payment System es-
24 tablished under section 1848(q); and

1 “(iii) submit to the Secretary proof of
2 the accreditation described in clause (i) in
3 such form and manner as specified by the
4 Secretary.

5 “(B) REQUIREMENTS FOR LIMITED RE-
6 SOURCE RADIATION THERAPY PROVIDERS AND
7 LIMITED RESOURCE RADIATION THERAPY SUP-
8 PLIERS.—A radiation therapy provider or radi-
9 ation therapy supplier that is a limited resource
10 radiation therapy provider or limited resource
11 radiation therapy supplier may elect to satisfy
12 the accreditation requirement under this para-
13 graph by—

14 “(i) meeting the requirements of sub-
15 paragraph (A);

16 “(ii) using an external audit that en-
17 compasses similar criteria as a nationally
18 recognized radiation oncology accreditation
19 organization and submit the outcome of
20 such external audit to the Secretary; or

21 “(iii) complying with certified elec-
22 tronic health record technology require-
23 ments as determined by the Secretary with
24 exceptions that are consistent with those of

1 the Merit-Based Incentives Payment Sys-
2 tem established under section 1848(q).

3 “(C) NEW PROVIDERS.—A new radiation
4 therapy provider or new radiation supplier shall
5 complete an initiation of accreditation or exter-
6 nal audit not later than the date that is 1 year
7 after such provider or supplier begins fur-
8 nishing covered treatment to covered individ-
9 uals.

10 “(D) RADIATION ONCOLOGY ACCREDITA-
11 TION ORGANIZATION QUALITY STANDARDS.—
12 Each covered radiation oncology accreditation
13 organization (and any successor organization)
14 shall develop quality standards for radiation
15 therapy providers and radiation therapy sup-
16 pliers to ensure covered treatments are deliv-
17 ered using adequate and modern linear accel-
18 erator technology, staffing, and other compo-
19 nents that protect patient safety and quality
20 by—

21 “(i) consulting with radiation therapy
22 manufacturers and key stakeholders;

23 “(ii) soliciting public comment on pro-
24 posed quality standards, including from

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

3 “(iii) updating quality standards not
4 later than every 5 to 7 years in partner-
5 ship with stakeholders;

6 “(iv) ensuring quality standards for
7 linear accelerator technology are adequate
8 and on par with current technological ad-
9 vances and modern requirements for staff-
10 ing and other procedures associated with
11 the delivery of safe and effective radiation
12 therapy;

13 “(v) collecting timely information
14 from radiation therapy providers and radi-
15 ation therapy suppliers for each linear ac-
16 celerator owned or used on or after the ef-
17 fective date of the regulations issued pur-
18 suant to subsection (a)(1); and

19 “(vi) giving sufficient weight to com-
20 pliance with quality standards among other
21 accreditation standards in determining ac-
22 creditation status for radiation therapy
23 providers or radiation therapy suppliers.

24 “(i) REPORTING REQUIREMENTS.—

1 “(1) REPORT ON THE ROCR PROGRAM.—Not
2 earlier than 7 years after the date of the enactment
3 of this section, the Comptroller General of the
4 United States (referred to in this subsection as the
5 ‘Comptroller General’) shall, after seeking out the
6 perspectives of radiation oncology stakeholders, sub-
7 mit to the appropriate committees of jurisdiction of
8 the Senate and the House of Representatives a re-
9 port that—

10 “(A) evaluates—

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

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

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

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

1 “(B) includes any recommendations for ad-
2 ministrative and legislative changes.

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

10 “(A) Radiation therapy deserts.

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

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

1 “(3) DETERMINATION AND DEFINITION OF RA-
2 DIATION THERAPY DESERTS.—

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

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

17 “(j) DEFINITIONS.—In this section:

18 “(1) ADAPTIVE RADIATION THERAPY PLAN-
19 NING.—The term ‘adaptive radiation therapy plan-
20 ning’ means any new technology or services identi-
21 fied, as of the date that the regulations issued pur-
22 suant to subsection (a)(1) become effective, by the
23 following HCPCS codes (and as subsequently modi-
24 fied by the Secretary) performed after the initial
25 treatment plan for a covered individual:

1 “(A) 77295, 3-dimensional radiotherapy
2 plan, including dose-volume histograms.

3 “(B) 77300, basic radiation dosimetry cal-
4 culation, central axis depth dose calculation,
5 TDF, NSD, gap calculation, off axis factor, tis-
6 sue inhomogeneity factors, calculation of non-
7 ionizing radiation surface and depth dose, as re-
8 quired during course of treatment, only when
9 prescribed by the treating physician.

10 “(C) 77301, intensity modulated radio-
11 therapy plan, including dose-volume histograms
12 for target and critical structure partial toler-
13 ance specifications.

14 “(D) 77338, multi-leaf collimator (MLC)
15 devices for intensity modulated radiation ther-
16 apy (IMRT), design and construction per IMRT
17 plan.

18 “(E) 77334, Treatment devices, design
19 and construction; complex (irregular blocks,
20 special shields, compensators, wedges, molds or
21 casts).

22 “(F) 77293, Respiratory motion manage-
23 ment simulation (List separately in addition to
24 code for primary procedure).

1 “(2) APPLICABLE RADIATION THERAPY PLAN-
 2 NING TRIGGER CODE.—The term ‘applicable radi-
 3 ation therapy planning trigger code’ means services
 4 identified, as of the date that the regulations issued
 5 pursuant to subsection (a)(1) become effective, by
 6 the following HCPCS codes (and as subsequently
 7 modified by the Secretary):

8 “(A) 77261, therapeutic radiology treat-
 9 ment planning, simple.

10 “(B) 77262, therapeutic radiology treat-
 11 ment planning, intermediate.

12 “(C) 77263, therapeutic radiology treat-
 13 ment planning, complex.

14 “(3) COVERED INDIVIDUAL.—The term ‘cov-
 15 ered individual’ means an individual who—

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

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

20 “(C) is diagnosed with an included cancer
 21 type.

22 “(4) COVERED TREATMENT.—

23 “(A) IN GENERAL.—The term ‘covered
 24 treatment’ means, subject to subparagraph (B),

1 radiation therapy services furnished to a cov-
2 ered individual.

3 “(B) EXCLUSIONS.—

4 “(i) IN GENERAL.—Such term does
5 not include—

6 “(I) subject to clause (ii), during
7 the period beginning on the date on
8 which the regulation issued pursuant
9 to subsection (a)(1) become effective
10 and ending on the date that is 12
11 years after such date, brachytherapy,
12 proton beam radiation therapy serv-
13 ices, intraoperative radiotherapy, su-
14 perflcial radiation therapy,
15 hyperthermia, and therapeutic radio-
16 pharmaceuticals;

17 “(II) inpatient radiation therapy
18 services furnished in a subsection (d)
19 hospital or ambulatory surgical center;

20 “(III) radiation therapy services
21 furnished in cancer hospitals that are
22 exempt from the hospital outpatient
23 prospective payment system under
24 section 1833(t);

1 “(IV) physician services that are
2 furnished or supervised by the physi-
3 cian or the physician practice fur-
4 nishing radiation therapy or by an-
5 other physician, including any surgical
6 procedures, chemotherapy, and other
7 services;

8 “(V) physician and technical
9 services that are furnished using tech-
10 nology represented by Healthcare
11 Common Procedure Coding System
12 codes that are not included in the M-
13 code national base rates identified in
14 table 75 (including in HCPCS Codes
15 for radiation therapy services and
16 supplies) of the Federal Register on
17 November 16, 2021, 86 Fed. Reg.
18 63485, 63925; or

19 “(VI) durable medical equipment
20 (as defined in section 1861(n)).

21 “(ii) INCLUSION OF CERTAIN TREAT-
22 MENT.—After the date that is 12 years
23 after the date on which the regulation
24 issued pursuant to subsection (a)(1) be-
25 come 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

1 not later than 30 days after the day such radi-
 2 ation therapy planning service is furnished; and

3 “(B) ends—

4 “(i) for treatment of all included can-
 5 cer types except bone and brain metastases
 6 treatment, the day that is 90 days after
 7 the day the episode of care begins under
 8 clause (i); and

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

13 “(6) INCLUDED CANCER TYPES.—The term ‘in-
 14 cluded cancer type’ means any of the following types
 15 of cancer:

16 “(A) Anal.

17 “(B) Bladder.

18 “(C) Bone Metastases.

19 “(D) Brain Metastases.

20 “(E) Breast.

21 “(F) Cervical.

22 “(G) Central Nervous System Tumors.

23 “(H) Colorectal.

24 “(I) Head and Neck.

25 “(J) Lung.

1 “(K) Lymphoma.

2 “(L) Pancreatic.

3 “(M) Prostate.

4 “(N) Upper Gastrointestinal.

5 “(O) Uterine.

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

12 “(8) INCOMPLETE EPISODE OF CARE.—The
 13 term ‘incomplete episode of care’ means, with re-
 14 spect to a covered individual, an episode of care that
 15 is not completed because—

16 “(A) the individual being treated ceases to
 17 be a covered individual, including in the case
 18 where the individual loses benefits under this
 19 title, at any time after the initial treatment
 20 planning service is furnished and before the epi-
 21 sode of care for the covered treatment is com-
 22 plete; or

23 “(B) a covered individual switches radi-
 24 ation therapy provider or radiation therapy sup-
 25 plier before all included radiation therapy serv-

1 ices in the episode of care for the covered treat-
2 ment have been furnished.

3 “(9) NEW TECHNOLOGY OR SERVICES.—The
4 term ‘new technology or services’ means any tech-
5 nology or services that, after the date of enactment
6 of this section, receives a Category 1 Current Proce-
7 dural Terminology code or is established in the year-
8 ly update to the Medicare physician fee schedule di-
9 rect practice expense inputs or any successor reposi-
10 tory of the direct practice expense input for the de-
11 livery of radiation therapy services.

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

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

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

1 “(13) RADIATION THERAPY SERVICES.—The
2 term ‘radiation therapy services’ means the treat-
3 ment planning, technical preparation, special serv-
4 ices (such as simulation), treatment delivery, and
5 treatment management services associated with can-
6 cer treatment that uses high doses of radiation to
7 kill cancer cells and shrink tumors.

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

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

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

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

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

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

11 (3) by adding at the end the following new sub-
 12 clause:

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

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

23 Section 1128A of the Social Security Act (42 U.S.C.
 24 1320a-7a) is amended—

25 (1) in subsection (i)(6)—

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

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

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

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

10 “(i) the availability of the transpor-
 11 tation services—

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

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

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

23 “(iii) the driver who provides the
 24 transportation services does not market
 25 health care items or services during the

1 course of the transportation or at any
2 time;

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

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

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

14 “(II) resides—

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

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

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

1 “(vi) the eligible entity that makes the
 2 transportation services available bears the
 3 costs of the transportation services and
 4 does not shift the burden of those costs
 5 onto any Federal health care program,
 6 other payers, or individuals.”; and

7 (2) by adding at the end the following new sub-
 8 section:

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

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

16 “(2) The term ‘established patient’ means an
 17 individual who—

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

21 “(B) has attended an appointment with
 22 such provider or supplier.

23 “(3) The terms ‘radiation therapy provider’,
 24 ‘radiation therapy services’, and ‘radiation therapy

1 supplier' have the meaning given such terms in sec-
 2 tion 1866G(j).

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

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

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

10 “(B) includes car services, ride shares, and
 11 public transportation; and

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

14 “(6) The term ‘urban area’ means—

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

18 “(B) Litchfield County, Connecticut;

19 “(C) York County, Maine;

20 “(D) Sagadahoc County, Maine;

21 “(E) Merrimack County, New Hampshire;

22 and

23 “(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.”.

○