

The Right Partner for the Cancer Program

How Bridge Oncology is helping hospitals meet the 2027 payment rules



By Jordan Johnson

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From "can we build this?" to "who is best at this?"

For years, hospitals across the country aimed to be the one-stop shop for every healthcare need. They owned every part of the care journey: hospitals, physician practices, imaging centers and labs. The instinct was to build or acquire capabilities internally, on the assumption that ownership was the only reliable path to quality and control.

C-suites are now focused on a different question. Executives across system types have stopped asking "can we build this?" and started asking "who is the best in the world at this, and how do we build a deep relationship with them?"

The change is not about cutting corners. It is a recognition that ownership carries costs in capital, time and management attention that strategic partnerships can avoid. Often the fastest path to serving patients runs through an organization that has spent years getting exceptionally good at something your system has not.

Benjamin Schwartz, MD, president of academic delivery at Banner Health in Phoenix, said his integrated academic enterprise has "moved completely past" the instinct to own every capability. "Today, we believe the fastest path to helping patients is knowing which partners are the best in the world at what they do and building deep, strategic relationships with them," he said. Banner credits a decade-old partnership with the University of Arizona with an estimated \$59 billion in economic impact to the state.

Marty Mann, senior vice president and chief development officer of Lifepoint Health in Brentwood, Tenn., framed it as intellectual honesty. "Scale is valuable, but it does not automatically make us the subject matter expert in every area required to operate and grow a complex healthcare organization," he said.

At Emerson Health, an independent system in Concord, Mass., President and CEO Christine Schuster put it simply: “Remaining independent does not mean operating in isolation. It means having the flexibility to choose the right partners and design arrangements that benefit our patients, our organization, and the broader healthcare system.”

Why oncology is where the question bites hardest

Nowhere is the partnership question sharper than in the cancer service line. Oncology is among a hospital’s most complex, capital-intensive and regulation-sensitive businesses. It spans radiation oncology, medical oncology, infusion, pharmacy, imaging and now theranostics, and each of those runs on its own payment rules.

That complexity is accelerating. Radioligand therapies demand coordination between nuclear medicine, radiation oncology, pharmacy and revenue cycle that most programs have never built. Workforce gaps mean many community hospitals struggle to keep physicians on site. And every fall, Medicare’s payment rules can move millions of dollars between departments inside the same cancer center.

For most hospitals, building deep, current expertise across all of these internally would take years. That is the gap Bridge Oncology was built to fill.

What the 2027 rules change for cancer programs

The CY 2027 outpatient and physician fee schedule rules redistribute money inside the cancer center more than they cut it. CMS released both proposals in July 2026, comments closed Aug. 31, and the final rules are expected this fall for a Jan. 1, 2027 start. The proposals below could still shift in the final versions.

Change	What CMS proposed	Who feels it in oncology
340B drug payment	340B-acquired drugs paid at ASP minus 33.4%, down from ASP plus 6%; about \$4.55B less in Medicare drug payments in year one	Infusion and pharmacy margins at 340B hospitals
Budget-neutral offset	OPPS conversion factor for non-drug services rises about 8.44%	Hospital-based radiation therapy, procedures and visits
340B remedy offset	Annual non-drug reduction rises from 0.5% to 3% for affected hospitals, about \$2.3B	Hospitals that received the 340B remedy payments
340B claim modifiers	Mandatory line-level identification of 340B and non-340B drugs	Pharmacy, nuclear pharmacy, charge capture and billing

Change	What CMS proposed	Who feels it in oncology
Site-neutral expansion	Imaging without contrast at excepted off-campus departments paid at roughly 40% of the OPPS rate; drug administration already site-neutral since 2026	Off-campus infusion and imaging sites
Provider-based attestation	New attestations for off-campus departments, due by Dec. 31, 2027	Every off-campus cancer site
Physician fee schedule	Radiation oncology about +3% overall and +5% freestanding; planning, management and SBRT down roughly 3–6%; hematology/oncology about -1.5%	Freestanding centers and physician groups

Figures reflect the CY 2027 OPPS and MPFS proposed rules released July 2026.

The net effect inside a single cancer program can point in opposite directions. A 340B hospital may see its radiation department gain while its infusion center loses drug margin. A freestanding radiation center may gain on treatment delivery while losing on planning and SBRT.

The 2026 cycle showed why modeling matters. CMS projected the new radiation treatment delivery codes would be roughly neutral, yet an ASTRO survey found many practices losing 10% or more of revenue after implementation.

Drug pricing: three pressures, one window

Oncology is the most drug-dependent service line in the hospital, so it takes the brunt when drug pricing changes. Three shifts converge on Jan. 1, 2027, on top of the 340B cut.

ASP –33.4%

340B drug payment

Proposed Medicare rate for 340B-acquired drugs, down from ASP +6%

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Cancer drugs at negotiated prices

Xtandi, Pomalyst, Ibrance and Calquence at new Medicare Part D prices Jan. 1, 2027

25%

GLOBE model

Share of Original Medicare beneficiaries in Part B most-favored-nation rebate model

- **GLOBE, Medicare's most-favored-nation model for Part B.** CMS finalized it on Sept. 30, 2026. It launches Jan. 1, 2027, with performance years starting April 1. It ties manufacturer rebates on high-spend, single-source Part B drugs to prices in 19 comparable countries, in randomly selected ZIP codes covering about 25% of Original Medicare beneficiaries. The final model is far narrower than proposed: projected savings dropped to about \$298 million from nearly \$12 billion, and orphan drugs, some cell and gene therapies, and biosimilars with their reference biologics are excluded.
- **Negotiated Part D prices for four cancer drugs.** Xtandi, Pomalyst, Ibrance and Calquence are among the 15 drugs whose Medicare negotiated prices take effect Jan. 1, 2027. Their negotiated prices run about 40% to 60% below 2024 list prices. Programs with specialty pharmacies that dispense oral oncolytics should expect lower revenue per prescription.

- **Physician-administered drugs are next.** Negotiation for prices starting in 2028 can include Part B drugs for the first time, which brings the infusion center into scope.

GLOBE works through manufacturer rebates, not hospital payment rates, so its direct effect on providers is limited. The indirect effect matters more. Lower Part B prices can pull down average sales price, and with it 340B savings and drug margins built on ASP-based payment. Hospitals should model each of these changes alongside the OPPS rule, not separately.

Surgical volume is moving too. CMS proposes taking 637 more procedures off the inpatient-only list in 2027, with the list fully phased out by 2028. Some surgical volume that feeds the cancer program may follow to hospital outpatient departments and ambulatory surgery centers, including competitors' sites, along with the referrals that come with it.

Radiation oncology: a decade of cuts meets rising costs

The 2027 proposals give hospital-based radiation a reprieve, not a reversal. ASTRO estimates Medicare reimbursement for radiation therapy has fallen 27% since 2013, while the cost of delivering it has climbed.

27%

Decline in Medicare radiation therapy reimbursement since 2013 (ASTRO)

23%

Rise in practice operating costs vs. pre-pandemic (ASTRO staffing survey)

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Radiation oncologists reporting 2026 revenue declines of 10% or more

The payment pressure has not let up:

- **The 2026 code overhaul cut deeper than projected.** CMS expected about a 1% impact. By September 2026, more than two-thirds of radiation oncologists in an ASTRO survey reported declines of 10% or more.
- **2027 gives with one hand and takes with the other.** Treatment delivery codes rise, but planning, management and SBRT would fall roughly 3–6%. The temporary 2.5% conversion factor increase for 2026 also expires, an immediate 2.5% cut under current law.
- **Shorter courses mean less revenue.** Evidence-based hypofractionation is good medicine, but per-fraction payment means fewer treatments bring in fewer dollars for the same patient.
- **Reform is still pending.** The bipartisan Radiation Oncology Case Rate (ROCR) Act would pay per episode rather than per fraction and is projected to save Medicare about \$200 million over 10 years. It has not passed.

Operating costs are moving the other way. In ASTRO's staffing survey, practice operating costs were up 23% on average versus before the pandemic, and 77% of respondents named professional staffing as

the main driver. Vacancies are easing but remain real: the ASRT's 2026 survey put radiation therapist vacancies at 11.4% and dosimetrist vacancies at 6.8%.

"The operational costs are soaring and continue to soar."

JORDAN JOHNSON, AS TOLD TO ONCOLOGY NEWS CENTRAL

I see this squeeze firsthand in the programs we work with. As I told Oncology News Central, that was the reality when the 2026 code shift arrived, and salaries and wages top the list of rising costs. Equipment service, software and the added billing work the new codes demand all add to the load.

The stakes reach beyond margins. ASTRO estimates more than 50 million Americans now live in counties without a radiation oncology clinic. For community hospitals, getting staffing models, charge capture and throughput right is increasingly what keeps radiation therapy close to home.

The cost of waiting

Waiting for the final rules to plan means planning after budgets lock. Cancer programs that wait tend to react, and those that plan early can lead.

Reacting

WHEN THE GAP SHOWS UP

Mid-year, as drug margin and radiation revenue miss budget

HOW CUTS ARE MADE

Across the board, often hitting navigation, support services and access

WHAT HAPPENS TO STAFF

Layoffs and vacancies left open, in a field where therapists, dosimetrists and physicists are already scarce

WHAT IT COSTS

Clinicians, referral relationships and community trust built over years

Leading

WHEN THE GAP SHOWS UP

Before budgets lock, modeled by site and service line

HOW CUTS ARE MADE

Sequenced deliberately, protecting the services the community depends on

WHAT HAPPENS TO STAFF

Attrition, redeployment and cross-training tied to each decision

WHAT IT COSTS

Margin protected and the mission intact

For oncology the stakes are especially high. A radiation therapist or dosimetrist who leaves is hard to replace, and patients who start treatment elsewhere may not come back for follow-up care.

How Bridge Oncology works with hospitals on strategy

Bridge Oncology is helping hospitals answer one question before Jan. 1: where does our cancer program make and lose money under the new rules, and what should we do about it? I co-founded Bridge as an oncology administrator with Arpit Chhabra, MD, a board-certified radiation oncologist and Director of Theranostics and Director of Education at the New York Proton Center. Our premise is that a clinician and an administrator should work the problem together, from the same side of the table.

That pairing shapes the strategy work. Bridge models the final rules against each hospital's own service mix, payer mix, 340B status and site footprint, rather than relying on national impact tables. The output is a service-line view that shows how a gain in radiation can offset, or fail to offset, a loss in infusion.

From there, Bridge helps leadership make the structural calls the rules now force. Those include which off-campus sites still make sense as provider-based departments, where on-campus or freestanding settings change the economics, and whether to build, partner or exit in services like theranostics.

Because the final rules can still move, Bridge builds the analysis as a scenario playbook rather than a single forecast. Each scenario is tied to specific final-rule outcomes, such as where the 340B rate lands or whether imaging site-neutral payment survives, with the actions leadership has agreed to take if it happens. That lets the board approve a plan now and lets management act within weeks of the final rule, not quarters.

The same lens applies to volume that is starting to move. As procedures leave the inpatient-only list and imaging and infusion pay less at off-campus sites, Bridge helps systems decide how to keep cancer patients inside their own network, whether through on-campus capacity, ASC strategy or joint ventures with physician groups.

Bridge has expanded well beyond its radiation oncology roots, with operational leadership across medical oncology, infusion, pharmacy, theranostics and enterprise oncology strategy.

The operational opportunities

Strategy only pays off when it reaches the floor, so Bridge pairs its analysis with hands-on execution. The firm describes itself as execution-focused, working inside programs rather than handing over a report. Seven areas are drawing the most attention as the final rules land.

- **Pharmacy and 340B readiness.** Mandatory 340B modifiers require inventory, administration records and billing to line up claim by claim. Bridge helps pharmacy, nuclear pharmacy and revenue cycle teams build that workflow before errors turn into denials.
- **Oncology pharmacy strategy.** With 340B payment falling, four oral cancer drugs at negotiated prices and Part B drugs entering negotiation, drug margin is shrinking from several directions. Bridge helps hospitals revisit purchasing, contracting, specialty pharmacy and biosimilar strategy for a lower-margin drug environment.

- **Infusion redesign.** With drug administration already site-neutral at off-campus departments and 340B margins under pressure, chair utilization, scheduling, staffing and drug mix all matter more. Bridge helps hospitals rebuild infusion economics around the new payment reality.
- **Radiation oncology capture.** The higher non-drug conversion factor rewards hospital-based radiation, but only if coding, charge capture and documentation are clean under the code set introduced in 2026. Bridge's radiation roots run deepest here.
- **Workforce plans before layoffs.** Bridge builds scenario-based staffing models for radiation, infusion and pharmacy, so that any reductions come through attrition, redeployment and cross-training tied to each service-line decision rather than across-the-board cuts.
- **Theranostics.** Since June 2025, Bridge and Integrated Theranostics Solutions have offered a turnkey program that brings nuclear medicine, radiation oncology, regulatory, imaging, staffing and revenue cycle expertise together to stand up radioligand therapy.
- **Physician coverage.** Bridge supports a hybrid physician model for radiation oncology, with physicians licensed across the United States. The firm says its data and advocacy work contributed to direct virtual supervision in the 2024 physician fee schedule final rule, a flexibility that helps community hospitals keep care close to home.

Independence is the point

If hospitals are going to trust a partner with their cancer strategy, the partner's incentives have to match theirs. Bridge calls itself a fiercely independent oncology consulting partner, with no equipment affiliations, no vendor relationships and no conflicted incentives. Its only stated obligation is the long-term performance of the client's oncology program.

That matters most when the right answer is to buy less, not more. When the rules shift margin from drugs to services, or from off-campus sites to on-campus ones, a hospital needs advice that is free to recommend consolidating a site, delaying a linear accelerator purchase or partnering rather than building.

It also mirrors what Emerson Health's Schuster described: independence as the freedom to choose the right partners, not the obligation to do everything alone.

What hospital leaders should do now

The window between the final rules and Jan. 1 is short, and the hospitals that use it well will start 2027 ahead. Bridge recommends that cancer program leaders take seven steps now.

1	Model the final rules and the 2027 drug-pricing changes together against your own service mix and 340B status, not the national impact tables.
2	Map every off-campus cancer site to its new payment status and attestation deadline.
3	Test 340B modifier workflows across pharmacy, nuclear pharmacy and billing before January claims go out.
4	Audit radiation oncology coding and charge capture under the 2026 code set.
5	Benchmark radiation oncology staffing, coverage and operating costs against volume, and plan for continued per-fraction pressure.
6	Build a trigger-based scenario playbook the board can approve before budgets lock.
7	Decide where to build, where to partner and where to step back, especially in infusion and theranostics.

The health systems quoted at the top of this story reached the same conclusion from different directions. Ownership is not the only path to quality and control. In oncology, under rules that change every year, the best-performing programs will be the ones that know which partners are best at what they do and build deep relationships with them.

Start with a 2027 Oncology Exposure Briefing

A working session with your CEO, CFO, chief strategy officer and cancer program leaders to size exposure by site and service line and set priorities before budgets lock. Learn more at bridgeoncology.com

Sources

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