HHS Announces Intention to Institute MANDATORY Bundled Payment Model for Radiation Oncology Procedures; Responds to 2019 Physician Fee Schedule Concerns

We all might end up filing this one under the category of "Be careful what you ask for..."

At a recent Patient-Centered Primary Care Collaborative meeting, Health and Human Services Secretary Azar announced that CMS intends to institute a new **mandatory** payment "bundle" for radiation oncology episodes, and two voluntary episodic bundling models for cardiovascular services. While organizations representing radiation oncology have proposed **voluntary** episodic bundles for radiation oncology services, mandatory bundles have never been on the wish list. In fact, it has been broadly assumed until relatively recently that CMS remains opposed to making participation in new payment models mandatory, an assumption based on the well-publicized views of the former Secretary of HHS. However, more recently, it has become clear that Secretary Azar takes a different view, and has moved boldly into this area, starting with a mandatory drug pricing demonstration announced late last month. At this stage, the details of the coming mandatory radiation oncology model demonstration project remain unclear: Keep posted for further details and analysis of how the new model may affect freestanding centers.

In the meanwhile, CMS has released the final Physician Fee Schedule for 2019, including rates for radiation oncology services. According to CMS estimates, Medicare payment for radiation oncology in 2019 will be reduced by approximately 1%, at the specialty level However, Medicare payment changes for individual procedures vary widely, as set forth on the accompanying chart. In general, in 2019:

- Medicare payment for the technical component of many external beam radiation therapy planning codes will be reduced in the range of -2% to -4% while brachytherapy planning payment will increase.
- Changes in Medicare payment for the technical component of hyperthermia treatment will vary widely (-11% to +11%), depending on the specific service involved.
- Medicare payment for most non-IMRT treatment delivery will decrease marginally (in the range of -3%) , and payment for IMRT treatment delivery will increase by 1%.

- Medicare payment for linear accelerator based stereotactic radiosurgery/radiotherapy billed under CPT codes 77372-77373 will decrease (by -3% to -7%).

Some of these changes are the result of updated equipment prices that will be phased in over several years.

The 2019 Medicare payment reductions for radiation oncology technical component services were mitigated substantially by the advocacy efforts of AFROC and other associations representing radiation oncologists, which were strongly supported and complemented by the efforts of radiation oncology equipment manufacturers. Specifically, the radiation oncology community responded strongly and in a unified manner to proposed changes in equipment pricing for radiation oncology equipment, including especially radiation treatment planning, brachytherapy, and LINAC-based stereotactic radiation oncology treatment units, in order to mitigate payment reductions included in the 2019 Physician Fee Schedule Proposed Rule issued earlier this year. In the final rule, CMS agreed to adopt higher equipment prices than those proposed, based on these joint efforts.

Over the next several months, AFROC will be analyzing the data underlying the final rates in further detail to ensure that equipment pricing increases resulting from this effort are properly incorporated into the final rates.