The National Association for Proton Therapy

February 9, 2026

Lindsey Baldwin, Director
Emily Yoder, Deputy Director
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare
Hospital & Ambulatory Policy Group (HAPG)
Division of Practitioner Services (DPS)

RE: Proton Therapy National Pricing Considerations in CY 2027 Medicare Physician Fee Schedule Rulemaking

Dear Ms. Baldwin and Ms. Yoder:

On behalf of the National Association for Proton Therapy ("NAPT"), I am pleased to submit the enclosed considerations and attached data to the Centers for Medicare & Medicaid Services ("CMS") as CMS prepares for the 2027 Physician Fee Schedule rulemaking process. As we discussed, NAPT is a nonprofit organization of world-renowned cancer centers both hospital-based and free-standing, a number of which are National Cancer Institute-designated comprehensive cancer centers and National Comprehensive Cancer Network members.[1]

As you know, in the CY 2026 Medicare Physician Fee Schedule Final Rule[2] (the "Final Rule"), CMS considered establishing national pricing for proton beam treatment delivery (CPT Codes 77520, 77522, 77523, and 77525) for 2026. In the Final Rule, CMS clarified that "[CMS] specifically seek comments on how we may establish national pricing … for these services…" and that CMS "will consider [commenters' feedback] as part of future rulemaking."[3] NAPT greatly appreciates its ongoing dialogue with CMS and the opportunity to provide further information to inform the 2027 rulemaking process.

As CMS considers rulemaking for 2027, to the extent that it is revisiting national pricing for proton therapy services using OPPS cost data as precedent, NAPT wishes to reiterate its position that no lower than a one-to-one ratio between hospital and free-standing proton therapy sites of services, taking into account the unique circumstances of each respective geographic market, is appropriate due to the parity in the disproportionately high capital equipment costs in providing proton therapy that are consistent across sites of service. However, in the absence of a one-to-one reimbursement methodology between hospital outpatient departments and free-standing proton therapy centers, NAPT believes that the most appropriate methodological

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[1] Listing of members can be found on the NAPT website, please visit: https://proton-therapy.org/findacenter/

[2] 90 Fed. Reg. 49266 (Nov. 5, 2025) (CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies): https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other

[3] *Id.* at 49390.

approach for reimbursement of proton beam treatment delivery is to retain carrier pricing and ensure that such pricing is grounded in actual and validated cost data.

Furthermore, a clear understanding of the methodology CMS may propose to use is critical for stakeholders like NAPT to provide meaningful input on potential national pricing, and to ensure that any resulting rates accurately reflect the reasonable costs of care delivery. We recommend that the methodology be grounded in actual and validated cost data. If actual and validated costs are not appropriately considered, a national proton therapy rate risks eroding access to proton therapy for both Medicare beneficiaries and other patients, including children.

As evidenced in attached report from Dobson | DaVanzo ("Dobson") independently assessing the actual costs associated with providing proton therapy replicating CMS' practice expense model, the primary basis to drive cost and payment is disproportionately the proton therapy capital equipment. The report empirically demonstrates that the disproportionately high cost of capital equipment (including, for example, the costs of a cyclotron and beam line, gantry, fixed beam, treatment vault, test equipment and software, etc.) is the same regardless of the site of service regardless of the reimbursement system. As CMS is aware, the APCs for proton therapy in 2026 for hospital sites of service are 5623 (77520) and 5625 (77522, 77523 & 77525) under the OPPS reimbursed at $564.41 and $1,276.81, respectively. Dobson's report demonstrates that, based on Dobson's survey results and analysis of equipment costs, the estimated PFS reimbursement for codes 77250, 77523, and 77525 would be *higher* than currently paid under these APCs under the OPPS using the CMS practice expense methodology based on consensus cost data, even without adjusting for inflation of equipment costs.

In addition to Dobson's report, NAPT wishes to provide additional context to CMS regarding the nature of free-standing proton therapy centers. While there are a subset of traditional free-standing providers, due to the investment necessary for the development of proton therapy, many centers are structured as joint ventures or financed through complex structures to bring services to communities. As a result, many of those centers are free-standing centers (notwithstanding hospital/academic medical center affiliations), but otherwise have substantially similar clinical models, quality oversight, operational infrastructure and deploy the same few capital equipment options. Our members, who are predominately hospitals but also include several free-standing centers, believe that, for this therapy, the relative resources are the same regardless of site of service. As a result, payment parity in this paradigm between hospitals and free-standing centers would be supported.

From a patient access perspective, future payment stability is critical not only for sustaining operations at existing proton therapy centers but also for enabling the continued and responsible development of new centers in underserved regions. Without confidence in the long-term adequacy of reimbursement, future development of proton therapy centers may falter, which would limit not only Medicare beneficiary access but other patient populations, including children, to clinically appropriate proton therapy. Access to proton therapy is vital for these patients and, beyond the patient-level benefits, proton therapy has the potential to reduce total healthcare system costs. The attached report prepared by ADVI replicated CMS RO model methodology by using four years (2019-2022) of 100% Medicare Fee-for-Service Research Identifiable Files data to assess episode volume, payment, patient demographics, and downstream events. The report demonstrated that, when compared to other radiation therapy modalities, proton therapy offered:

- Lowest 90-day mortality rate (~2%) across all years,
- Lower inpatient admission rates (10–11%) compared to other modalities (≥14%),
- Longest time between treatment and ER visits, and
- Lowest cost per ER visit.

Lastly, NAPT respectfully requests that the ultimate model CMS may propose for national pricing be transparent and replicable. We would greatly appreciate any additional insight as to which features of the model may be dynamic or static as OPPS cost data and rates change over time. Similarly, NAPT hopes to understand whether the initial proposed parity between hospital and free-standing proton therapy sites of services could be subject to volatility in future rulemaking. NAPT looks forward to further engagement with CMS on this matter so that we can ensure future appropriate reimbursement and access for this critical tool in cancer treatment.

We appreciate the opportunity to submit these critical considerations and the attached report as CMS considers rulemaking for the CY 2027 MPFS Proposed Rule and look forward to working with CMS on these issues. Please contact Jennifer Maggiore at jennifer@proton-therapy.org if you have any questions or need additional information.

Sincerely,



Jennifer Maggiore
Executive Director, NAPT

Encl.
Dobson | DaVanzo report
ADVI report

cc:
Jason B. Caron, Latham & Watkins LLP, Counsel to NAPT
Patrick McMahon, Dobson | DaVanzo, Consultant to NAPT
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