2025 – No. 1

ACROinsights – History of Medicare Conversion Factor and Impact in Radiation Oncology

The goal of this series of articles is to ensure that radiation oncologists are aware of and provided with the knowledge to ensure day-to-day processes are being addressed in a compliant manner. This installment will discuss the history of the conversion factor from Medicare and its impact on radiation oncology under the Medicare Physician Fee Schedule (MPFS). The information contained within this ACROinsights article is meant as general guidance and is not intended to replace appropriate legal or authoritative guidance.

What is the Conversion Factor?

When the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS) first implemented the Resource-based Relative Value System (RB RVS), it was necessary to develop a means to convert the unit values assigned to any service into dollar amounts. To accomplish this transition, they created the annual conversion factor (CF), Every year, Congress allocates funds to CMS for payment under the Medicare Physician Fee Schedule (MPFS). CMS then divides the total number of relative value units into this dollar pot to determine the dollars assigned to the CF. When the first CF was set in 1992 at a value of $31.0010, there were different CFs for the various category of services provided at the time. Beginning in 1998 a single CF was established and until 2015 was set by using a target formula, which resulted in proposed values that could sometimes yield 20-30% decreases from one year to the next. Following immense pressure from medical groups and advocates, Congress often intervened to reduce or eliminate the reductions, and the changes were not finalized, but significant instability remained within the MPFS.

In April 2015 the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) changed the methodology for CF development. The previously employed sustainable growth rate (SGR) algorithms used to calculate the target CF were abandoned and replaced by MACRA rules that established fixed CF rates specified by the legislation. Additional adjustment to the CF such as budget neutrality (lack of annual cost-of-living adjustment to the MPFS) continues to impact the CF value outside of the assigned legislative values. The values established by MACRA were as follows:

Year	Percent Change	Notes
April 1, 2015	0.0%	Addition of 0.0% to the preceding year's CF, plus any changes due to budget neutrality etc.
July 1, 2015	+0.5%	Addition of 0.5% to the preceding year's CF, plus any changes due to budget neutrality etc.
2016 – 2019	+0.5%	Addition of 0.5% to the preceding year's CF, plus any changes due to budget neutrality etc.
2020 – 2025	0.0%	Addition of 0.0% to the preceding year's CF, plus any changes due to budget neutrality etc.
2026 and beyond	+0.75% APM +0.25% non-APM	• Providers participating in an alternative payment model (APM) 0.75% increase to the previous year's CF. • Providers who do not participate in an APM, a 0.25% increase added to the previous year's CF.

Snapshot of Historical CF Values

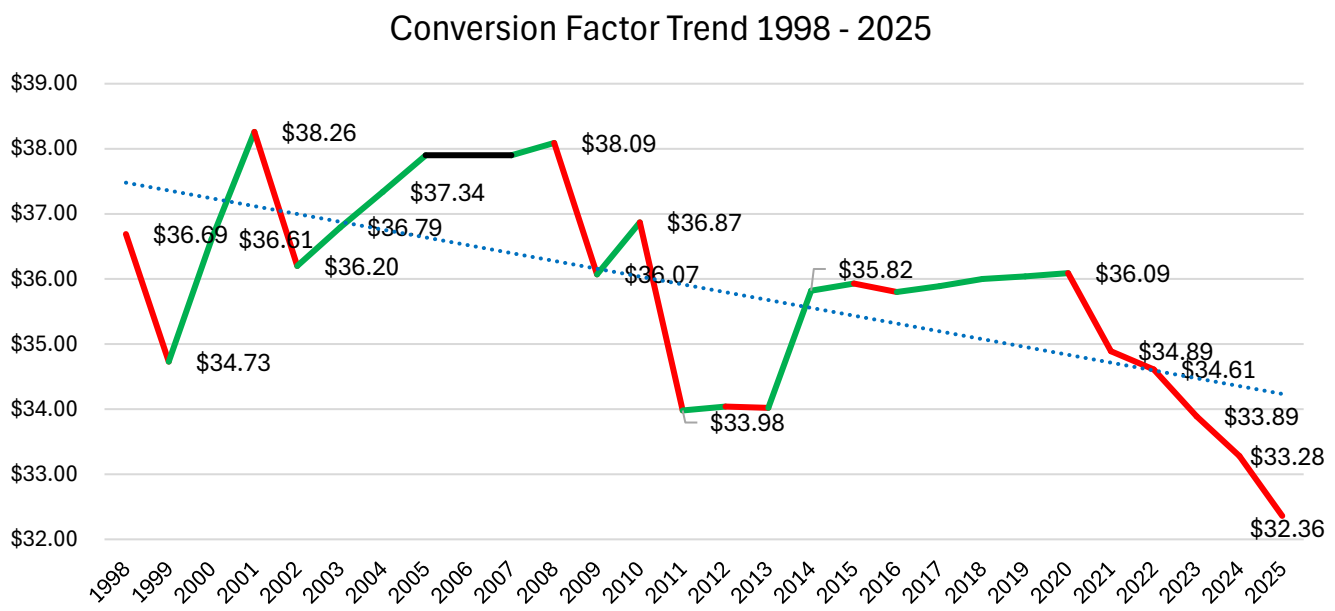
The AMA has compiled a list of the historical Medicare CFs since 1992[1]. The table outlines the finalized values and reflects the mid-year changes enacted by Congress in 2010, 2015, and 2024. In review of the data, it is evident that since 1998 with a CF of $36.6873 to 2025 and CF of $32.3465, payment for services under MPFS have not kept up with inflation and the cost of all goods and services.

The following table and graph reflect the Medicare CF values since 1998. No values are included for 1992-1997 as these were calculated differently and do not provide comparison for the purposes of this article.

History of Medicare Conversion Factors

Year	Conversion Factor	% Change
1998	$36.69	
1999	$34.73	-5.3
2000	$36.61	5.4
2001	$38.26	4.5
2002	$36.20	-5.4
2003	$36.79	1.6
2004	$37.34	1.5
2005	$37.90	1.5
2006	$37.90	0.0
2007	$37.90	0.0
2008	$38.09	0.5
2009	$36.07	-5.3
1/1/10 – 5/31/10	$36.08	0.03
6/1/10 – 12/31/10	$36.87	2.2
2011	$33.98	-7.9
2012	$34.04	0.18
2013	$34.02	-0.04
2014	$35.82	5.3
1/1/15 – 6/30/15	$35.75	-0.19
7/1/15 – 12/31/15	$35.93	0.50
2016	$35.80	-0.36
2017	$35.89	0.24
2018	$36.00	0.31
2019	$36.04	0.11
2020	$36.09	0.14
2021	$34.89	-3.3
2022	$34.61	-0.80
2023	$33.89	-2
1/1/24 – 3/8/24	$32.74	-3.37
3/9/24 – 12/31/24	$33.29	1.66
2025	$32.35	-2.83

[1] American Medical Association, History of Medicare Conversion Factors, https://www.ama-assn.org/system/files/cf-history.pdf



Impact of CF Changes on Radiation Oncology Payments for Services

The CF is not the sole value which can impact the Medicare payment under the MPFS. Adjustments to RVUs can also impact the overall payment rate. However, it is the CF which is the value easiest to identify as the proximate reason for any payment adjustment.

Since the initiation of the CF, there have been changes to the overall process for calculating payment rates under the MPFS. These changes include the final adjustments to include professional liability insurance (PLI) as the third and final RVU factor under MPFS. This inclusion began on January 1, 2002. Within the CMS website, the historical files are only available back to 2003. The table below reflects a snapshot of a few radiation oncology CPT® codes to demonstrate how changes to the CF have impacted payment rates. There may be other impacts such as changes to RVUs which may have also resulted in payment adjustment increases and decreases over the years.

The following table provides a snapshot of the payment rates in the non-facility setting for four selected codes: 77263, physician clinical treatment plan, 77290, complex simulation, 77295, 3D plan, and 77427, physician weekly management. For these codes , the physician work RVUs have maintained a stable value over the years included. It is the practice expense which is in addition to the CF that has varied. This can be seen particularly with CPT® 77295, which decreased from 35.74 total PE non=facility RVUs in 2006 to 18.43 in 2009.

MPFS National Payment Rates Non-facility Setting – Global Rates Reflected[2]									
HCPCS	**DESCRIPTION**	**2003**	**2006**	**2009**	**2012**	**2015**	**2018**	**2021**	**2025**
77263	Radiation therapy planning	$163.33	$167.13	$157.97	$157.25	$166.73	$170.64	$169.93	$164.97
77290	Set radiation therapy field	$328.13	$341.84	$546.05	$533.03	$513.49	$538.55	$501.41	$427.62
77295	Set radiation therapy field	$1,299.64	$1,354.46	$491.59	$433.98	$491.57	$509.03	$490.95	$471.94
77427	Radiation tx management, x5	$168.11	$172.05	$191.87	$175.97	$187.57	$191.16	$191.91	$187.93

The Take Home Message

Radiation oncologists should have a basic understanding of how they are paid and how values such as the conversion factor impact those payments. As we have discussed in other ACROinsights articles, radiation oncology is a profession, but practices must function as businesses. For physicians to be able to treat patients and keep the doors open they must be paid adequately for their services. It appears likely that more cuts will be seen by radiation oncology within the near future. There are many opportunities for ACRO members to learn about and participate in conversations related to MPFS, but first radiation oncologists must understand how payments are calculated and the impact the conversion factor has on those payments.

[2] The Centers for Medicare and Medicaid Services, PFS Relative Value Files, https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files